

**ADMINISTRATION'S FISCAL YEAR 1994 BUDGET
REQUEST FOR MEDICAL CONSTRUCTION FUNDING**

**HEARING
BEFORE THE
SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
FIRST SESSION**

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ADMINISTRATION'S FISCAL YEAR 1994 BUDGET REQUEST FOR MEDICAL CONSTRUCTION FUNDING

WEDNESDAY, MARCH 3, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. J. Roy Rowland (chairman of the subcommittee) presiding.

Present: Representatives, Rowland, Kennedy, Edwards of Texas, Tejeda, Gutierrez, Baesler, Bishop, Brown, Stump, Smith, Bilirakis, Hutchinson, Everett.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. We would like to come to order now so we can get started.

This morning's hearing is a particularly important one. It will prepare us to review with sharper focus, the Administration's fiscal year 1994 budget request for medical construction funding at our upcoming budget hearings. And it will provide us a framework for exercising a responsibility given this Committee in law last year, namely to develop and report out a construction authorization bill.

One point should be acknowledged from the outset. We are tackling a broad and complex subject when we review a national medical construction program with an annual budget of several hundred million dollars. We're likely to hear some strong and possibly divergent views on its strengths and weaknesses. We need to appreciate that many hands get into the construction process, from the directors of VA medical centers at one end, to Congressional appropriators at the other. Each plays a role in a process that seems often to take too long and to be too costly. At the same time, if we're to avoid repeating mistakes, we have to acknowledge that they've occurred.

To illustrate the issue before us, consider that a major medical construction project can take fully 10 years to move from conception to completion. Delays, and with their higher costs, can occur at numerous points, and often for reasons beyond VA's control, whether due to failure to appropriate funds at the earliest time or to adjust for significant changes in medical technology, for example.

Some of the questions before us are not new. VA itself has gone through seven different studies of its construction and process and organization over the last two decades. And it went through a major reorganization last year. We certainly want to learn whether the reorganization is meeting its goals.

But VA has yet to make as much headway as we would expect, in its planning role. In fact, VA's construction process and its planning process are simply not "in sync" in my view. To illustrate the point, let me read from the Department's own reorganization report: "The objective to have a timely and cost-effective construction program is critically dependent upon the completion and implementation of the National Health Care Plan which establishes the mission of each VA medical center."

In other words, in order to make intelligent decisions about future construction at any VA medical facility, one has to know what role that facility will play. Should a given hospital be exclusively a high-tech acute care facility, or should hospital bed space be converted to provide a specified number of nursing home beds, for example?

The former Secretary and his chief medical director talked for several years about restructuring the VA system to meet the changing needs of aging veterans. The Secretary even established a blue ribbon advisory commission to aid in that effort. Assigning each hospital the mission it will be charged to carry out, whether it's primarily long-term care, primary care, high tech, or some combination, is a first step toward real planning for the future.

No one disputes that that's a necessary step and one VA is certainly technically competent to carry out. Unfortunately, the prior VA management appears to have abdicated that responsibility.

What I think we'll learn today is that VA has no real national plan that identifies precisely the role each VA hospital will play in the future. Absent that framework, individual hospital directors have an incentive to try and expand their hospital's role beyond what the system can justify. That problem has substantial implications, given what's at stake.

We should explore several big questions this morning. How can we assure that we're really building intelligently for the future? Can we achieve greater timeliness in the construction process? Can we do more to contain costs? What can we learn from the private sector?

In looking to the future, what implications does the development of national health care legislation hold for VA and for the need to build new hospitals? The General Accounting Office has recommended that VA and the Congress consider limiting construction of additional acute care capacity until the impact of anticipated national health care legislation on VA can be assessed. The competition for the relatively limited funding available for major construction may well compel us to examine the GAO recommendation closely. But I'm concerned at GAO's related proposal to contract out veterans' hospital care, which sounds to me like "mainstreaming."

I think we'll learn this morning that the VA system has far-reaching construction needs. And I hope this hearing, as our first step this Congress, will move us forward towards addressing them.

In doing so, I would only add a concern that as this Committee exercises our responsibility to authorize construction projects, that we not permit politics to override the priority needs of our veterans.

And I want to recognize ranking minority Member of the Committee, the gentleman from Arizona, my good friend Bob Stump, for any remarks he may wish to make.

OPENING STATEMENT OF HON. BOB STUMP

Mr. STUMP. Thank you, Mr. Chairman. It's a pleasure to be here at this first meeting of the subcommittee on the Hospitals, and Health Care. I'd like to take this opportunity to welcome you as our new chairman. I know that you've been a strong defender of health programs in the past and I'm sure the veterans will be well served with you as chairman of this committee.

I was going to also welcome our nine new Members, but I only see Tim Hutchinson here. So, I'll welcome him, at least, from Arkansas.

Tim, welcome to the committee.

Mr. Chairman, as you know, the future of health care systems is dependent upon the ability of the system's facilities to provide access to individual health care services. In fact, VA's construction planning process is an integral element of overall VA planning. Therefore, this hearing is a very important one to assist in this subcommittee's deliberation of the VA's future course.

For as long as I can remember, the VA has had problems with its construction program. For many of the reasons already identified by you, Mr. Chairman, it is a VA program which has had a lot of critics and very few fans. Now on the verge of national health reform, the VA's construction program must become more responsive to the changing needs of veterans and the budget realities of the system.

Mr. Chairman, I'm not going to take any more time. I do have a statement that I'd like to put in the record, but I imagine the quicker we can get on with the hearing, the more time we will have.

Mr. ROWLAND. Without objection, your statement will be included in the record.

[The prepared statement of Congressman Stump appears on p. 53.]

Mr. ROWLAND. The gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Well, thank you, Mr. Chairman. I don't have a prepared statement, sir. Actually, your words basically say it all, yours and those of Mr. Stump.

We go through the records here and we sit through these hearings and we find out about 5-year plans and that sort of thing. And I've been here for 10 years, as have you, and I'm not sure that there are any 5-year plans that actually have been completely satisfied. There seems to be a lot of flexibility to those which, I suppose, in one sense, there should be. But there's a lack of consistency as I see it.

Now, I'm not maligning the VA system and the people responsible for these particular areas because I know they get caught up in politics. I mean, it's going on right now regarding the facility in

Florida, for instance, where you get different members of Congress, pulling and tugging, and shoving, and that sort of thing. And so, it gets caught up in politics, gets caught up in funding, lack of funding, and so, I'm certainly not maligning those people. I know they're doing the best they can under the circumstances.

But there's got to be some stability on the basis of foreseeability and that's what a 5-year plan is all about. I don't know if we're going to come to that as a result of this hearing or not, but hopefully, we will under your able leadership. Thank you, sir.

Mr. ROWLAND. Thank you, Mr. Bilirakis.

Mr. Hutchinson.

Mr. HUTCHINSON. I will forego, Mr. Chairman.

Mr. ROWLAND. All right. Very well.

The first witnesses to come to the table will be Ms. Marjorie Quandt, Mr. David Lewis and Mr. David Baine. He's accompanied by Mr. James Linz and Mr. Timothy Hall.

We would ask that your opening statement not exceed 5 minutes each, and then we'll have sufficient time for questioning.

Ms. Quandt, we ask you to proceed as you so desire.

STATEMENTS OF MARJORIE QUANDT, FORMER EXECUTIVE DIRECTOR, COMMISSION ON THE FUTURE STRUCTURE OF VETERANS HEALTH CARE; DAVID LEWIS, FORMER ASSISTANT SECRETARY FOR ACQUISITION AND FACILITIES, DEPARTMENT OF VETERANS AFFAIRS; DAVID BAINE, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE ACCOMPANIED BY JAMES LINZ, ASSISTANT DIRECTOR, GENERAL ACCOUNTING OFFICE; AND TIMOTHY HALL, EVALUATOR, GENERAL ACCOUNTING OFFICE

STATEMENT OF MARJORIE QUANDT

Ms. QUANDT. Mr. Chairman and Members of the Subcommittee, my testimony is based largely on the Commission on the Future Structure of Veterans Health Care discussions and recommendations, review of DVA reports and discussions with DVA employees. Public Law 102-40 charges the Committee to approve by resolution, major medical facility projects and major medical facility leases to be authorized in the budget. Your task is difficult and compounded for the following reasons.

Some of the tools that DVA uses are less than optimum, although there have been attempts at improvement due to Inspector General studies, OMB and Congressional complaints. These tools are the facility development plan, the VHA planning model, and the prioritizing criteria for ranking priority of construction.

Increased costs are imbedded in the DVA construction system. The Department culture of catch-up on the part of local facility directors for more space, more programs, and more FTEE to get more money is often beyond the veteran population needs. The reliance on the VA hospital building system is an expensive model not routinely used in the private sector and judiciously used in the military. That is the system which requires interstitial space and leads us to say we build everything in one envelope.

The use of VA's empirical consensus standards rather than industry standards add more. Failure to provide funds for construction on time adds to cost.

Commissioners saw the system as inflexible, cumbersome, uncoordinated, functioning almost without relationship to operations and not necessarily responsible to veteran's needs. Several Commissioners believe the construction had gone too far, forgetting its purpose. There was a complete lack of confidence the DVA could build in a reasonable time frame.

Since the Commission, there have been steps at improvement. The FDP guides have been updated. The VA planning model has been corrected, but not updated. And the prioritizing criteria have been updated. They are extremely complex tools to be used by local management. There has now been more use of delegated projects. And I think the Martinez Clinic which came in at six months instead of 49 months should be a model.

The Commission recommended that DVA develop alternatives to the current construction program. These were leasing, lease purchase, and sharing with existing facilities either in the private sector or the military. DVA building, in their mind, was to be the last resort and a few new procedures were to be implemented. The new reorganization dodges the issue. It is largely status quo. I would gather from one of the working papers for the fiscal year 1994 major construction requests that the VA Hospital Building System is still in place.

The committee has a serious problem in attacking your new charge. The inter-linked policies of eligibility reform, the VHA National Health Care Plan, and what will be the role in national health care reform have yet to be determined. Until these interrelated issues are settled, I do not believe you should approve any new, major, or modernization replacement facilities including East Central Florida. The only exception should be a state without a DVA facility or where there is grave patient potential for harm because of safety deficiencies.

I would also consider a moratorium on the FDPs. Much as I should like the VA to sell the West Los Angeles campus to earn someplace between \$1.3 and \$1.7 billion, it can not be done. There is a reverter clause. The Committee needs to give greater delegation to local management to use its real estate, land or buildings, to be able to achieve funds either to assist the construction program or patient care. Twenty-seven hospitals have been studied since fiscal 1992 to determine if there was excess land. Nothing has been done. Perhaps a little over 20 acres may, at some future point, be excessed and they are in Martinsburg and Minneapolis.

You must require, Mr. Chairman, that all DVA construction be reasonably priced. Not log-rolling, as one Commissioner called it. This would mean industry standards, projects assigned to local management to complete as a design build, guaranteed maximum price, turn-key effort. There should be oversight from Central Office to be certain that all those goals occur. Delegating to the facility level will also permit savings of FTEE in Central Office.

I would ask that my summary and my statement appear in the record, Mr. Chairman.

Mr. ROWLAND. Without objection. Thank you very much, Ms. Quandt.

[The prepared statement of Ms. Quandt appears on p. 54.]

Mr. ROWLAND. Mr. Lewis.

STATEMENT OF DAVID LEWIS

Mr. LEWIS. Mr. Chairman, Members of the Committee, I am pleased that you have asked me to appear before you today to provide my observations on the Department of Veterans Affairs construction program. These observations are collected from three-and-a-half years' experience as the senior VA official responsible for execution from concept to activation of all construction projects and leases.

First of all, by way of background, what was until October 1, 1992, the Office of Facilities, has been comprised of a highly capable, dedicated work force which over the years, was continually faced with a declining authorized work force level to implement a reasonably constant but evermore complex workload. For example, in 1987, the number of personnel authorized, stood at about 700 to implement approximately a \$460 million major construction budget. In 1990, the number authorized was about 650 for a budget near \$550 million. In 1992, the authorized number of 530 for a budget of \$564 million. Projects initiated in the early to mid-1980s, resulted in significant cost overruns in the late 1980s. Some of this was the result of poor estimating, some changing market conditions, and some the result of long delays from start to finish because of a Congressional or Administration rethinking. A large number was a result of user-requested changes during design and construction after the budget for the project was submitted.

Recognizing these problems, the Department initiated certain actions recommended by the Office of Facilities to address these issues, namely streamlining project implementation, instituting alternative methods of acquisition or construction which have successfully been used by other federal agencies, and sharpening the estimating process and limiting user changes after the budget. These efforts, however, were short-circuited by the Appropriations Committees who imposed a \$5 million cut. In other words, an 11 percent reduction of the 1992 Office of Facilities general administration budget. This is the budget which supports the architects, resident engineers, project managers, expert biomedical technicians and all the rest of those who make up the Office of Facilities. Since the budget was 80 percent personnel dollars, the work force was further reduced by 121 individuals. It is interesting to note that in fiscal year 1992 with the implementation of the Department's initiatives, there were no cost overruns.

But, I fear the punishment for past sins or, simply, past bad luck, almost insured that there would be in future years significant overruns, bid busts and, more importantly, that the volume of claims would escalate significantly because personnel in the field were insufficient to effect good control over contractors. The only solution to prevent a chaotic situation from developing from the cutbacks was to consolidate the functions of the Office of Facilities with sev-

eral offices within the Veterans Health Administration, the principal customer of the Office of Facilities.

I believe that this was a sound decision because it placed responsibility back where it belongs, with the individual medical center director who initiates the construction request. The reorganization was well thought out by the responsible Department officials. It may, however, have provided the dubious opportunity to obscure, to a degree, the actual personnel level needed to carry out the program, thereby making it theoretically possible to subsidize the construction process with funds from other accounts.

The reorganization also created another office independent of the VHA, the Office of Facilities Oversight. This was also a well conceived move to provide oversight of all projects to prevent scope creep or expansion of projects beyond mission requirements, duplication of facilities and programs with affiliated institutions, and control over change orders. The concept was sound, but the means to effect it were severely lacking.

After redistributing the number of authorized work force from the old Office of Facilities to the Veterans Health Administration, only 11 slots were left for the all important oversight function. The result is that this small group can not do much more than spot check the 3000 or more projects that are in the pipeline annually. Before the reorganization, while some oversight was performed by the Office of the Assistant Secretary for Finance and IRM, there was little performed by the Office of Facilities because it found that oversight was incompatible with its role as a service provider to the Veterans Health Administration. With only 11 in the Office of the Deputy Assistant Secretary for Facilities Oversight, VA is probably back to where it was pre-reorganization. Or possibly worse, into a situation where the fox is really in the chicken coop because the service provider, the Office of Facilities, now reports to its customer, VHA.

There is a solution which can take advantage of having program execution within VHA and yet provide proper checks and balances to insure that the program is meaningful and productive. It is simply to increase authorized personnel levels in the oversight group to a level sufficient to carry out thorough oversight. The tendency of the Appropriations Committees, either as a cost-reducing effort or as punishment for perceived poor program execution, has been to cut administration accounts like the Medical Administration and Miscellaneous Operating Expenses, or a MAMOE as we know it, for VHA and the Office of Facilities General Administration budget. This has created a self-fulfilling prophecy.

In effect, the Committees say, "You have done a poor job with the resources we have given you, so, we'll give you less so that you can do an even worse job." The approach should be one where if program execution is not properly managed, managers should be changed rather than cutting the program's resources. One should avoid a situation where the management function is so weakened by budget cuts that managers can not function. More money should be put into oversight of program management even at the expense, if need be, of more projects, if the Department is to carry out the projects it executes well.

Mr. Chairman, I have about 2 or 3 more minutes. I will submit the balance for the record, if you so desire.

Mr. ROWLAND. Without objection, then we appreciate that. You can probably bring out what you wish to say there during the questioning period.

Mr. LEWIS. Yes, sir, surely.

Mr. ROWLAND. Thank you very much, Mr. Lewis.

[The prepared statement of Mr. Lewis appears on p. 66.]

Mr. ROWLAND. Mr. Baine.

STATEMENT OF DAVID BAINE

Mr. BAINE. Thank you, Mr. Chairman. Thank you for the opportunity to discuss several issues relating to VA's health facilities program. Our testimony this morning focuses on the need for VA construction projects if proposed health reforms, that is to say, reforms to reduce the number of uninsured Americans and to revise the eligibility system for VA health care are implemented.

Mr. Chairman, we believe the Congress should proceed cautiously, as you mentioned in your opening statement, with construction of additional VA capacity until such reforms take shape. This does not have to mean, an interruption in meeting the health care needs of American veterans. Rather, a limitation on the construction of new VA medical capacity could provide the opportunity to test alternative methods of delivering care to veterans. Use of such methods could, at least on an interim basis, provide veterans acute care services in their home communities years sooner than could be provided through construction of new or replacement VA facilities.

During the last 3 years, we have assessed VA's plans for constructing medical centers in Hawaii, Northern California, and East Central Florida. In each location, there are two common conditions. Veteran populations are split between two or more population centers making it difficult for one VA hospital to effectively meet the inpatient needs of all veterans. And second, adequate capacity appears to exist in community and/or military hospitals to meet these needs. These local conditions create the potential for VA to provide outpatient care through its clinics in each population center, but provide inpatient care through contracts or sharing agreements with community or military hospitals.

Let me turn now to some of the potential effects that reforming the nation's health care system could have on future demand for VA care. Any program that would expand insurance coverage among veterans could substantially reduce demand for VA sponsored care. Under the most far-reaching proposals for providing nationwide universal coverage, we estimate the demand for VA inpatient care could drop by as much as 50 percent. Likewise, outpatient use could drop by 40 percent.

Reform of the nation's health care system could also have significant effects on the demand for VA-supported nursing home care. This is dependent on how the health reform proposal takes shape, whether it includes long-term care, and to what extent long-term care would be covered.

Just as reform of the nation's health care system could affect demand for VA health care services, so too could reform of the VA eligibility system itself. VA's Commission on the Future Structure of Veteran's Health Care recommended major eligibility reform in its November 1991 report to the Secretary. A task force VA established predicts widely varying workloads depending upon which, if any, of the eligibility options it developed is adopted.

Our point in mentioning this, Mr. Chairman, is not to comment on the merits of the eligibility reform options. Rather, we want to emphasize the uncertainty that surrounds the future structure of the VA system. Until the Congress and VA reach a consensus on decisions on eligibility reforms, accurately depicting how many hospital and nursing home beds will be needed in the future will be difficult.

I would like to now turn to one of the recurring factors that we've noticed concerning the VA construction process. That is the inadequate consideration of alternatives to new construction. For more than 10 years, we have been recommending that the VA consider the availability of community and state nursing homes in its facility construction process. Using such resources to the maximum extent possible is important because care in community nursing homes costs VA about half as much as it does to provide care in its own homes. And care in state veterans homes is even more cost-effective.

While most of our work has focused on the use of state and community nursing homes as an alternative to construction of VA homes, we found during our recent reviews of VA's planning for construction of medical centers in the areas I mentioned that existing capabilities in community and military hospitals appeared to be adequate to meet VA's acute care needs. My full statement details our findings for these areas under consideration for new centers.

Mr. Chairman, the Congress faces a dilemma. If VA hospitals are built to meet the current health care needs of veterans in these three areas and perhaps others, the hospitals could have significant excess capacity before they're opened. On the other hand, if construction is delayed until all the details of health reforms take shape, the health care needs of an aging veteran population might go unmet.

One potential way to deal with that dilemma, in our view, would be to test alternative means of meeting the health care needs of veterans and improving access to hospital care. For example, the acknowledged excess hospital capacities in non-VA facilities in the three areas provide opportunities to test the feasibility of contracting for inpatient care at community or military hospitals.

Several options could be tested. Under one option, VA physicians from the outpatient clinics, like private physicians, could obtain patient admitting rights to community hospitals which could supply nursing and other personnel. Another option would be for VA to contract for space in existing facilities and operate the space itself. Demonstrations such as these could test the cost-effectiveness of such alternatives, and assess the difference in satisfaction of veterans under these options.

Mr. Chairman, VA, like other federal departments and agencies, is likely to face severe budget constraints during the next several years. Because of the uncertainty concerning future demand for VA services, we believe it would be prudent to delay most construction of additional capacity until the effects of health care and eligibility reforms fully take shape. This could free up funds for deficit reductions or other uses that the Congress may decide upon, without affecting current VA health care services. It could also prevent construction of VA facilities that could quickly lead to excess capacity.

That concludes my summary, Mr. Chairman. We'll be happy to take your questions.

Mr. ROWLAND. Thank you very much.

[The prepared statement of Mr. Baine appears on p. 71.]

Mr. ROWLAND. Members will be recognized in the order of their appearance here at the Committee and we will use the 5-minute rule.

I wish to recognize at this time, Mr. Stump from Arizona.

Mr. STUMP. Thank you, Mr. Chairman. I have a couple of questions not directed to any one particular person, so whomever feels they can answer it best.

Lacking clear facility mission statements at the present time, how can the Congress ensure that a facility's current construction proposals are consistent with that facility's mission for the future?

Ms. QUANDT. Mr. Congressman, you can not. Until you have a firm mission accepted by the Secretary, upon recommendation of the Chief Medical Director, and that mission is based on absolute veteran population need, you can not determine that the building you're approving is the correct one.

Mr. STUMP. Well, I don't know that I understand that. If the need is obviously shifting to the sunbelt, why can't we do something about that then?

Ms. QUANDT. If it's a growth question of where veterans are going, yes, we should put emphasis in the sunbelt. But if you want to know what is in that facility—is it to be a nursing home or a nursing home and an outpatient facility? Or is it to be a tertiary care hospital, or a primary care? You can not tell that today.

I believe you have a statement from another federal executive which says that you do not have the data available. And I've pointed out in my testimony that there is no fiscal 1992 data available for the VHA planning model, and the 1990 projection of veterans over 40 years which show a growth shift, aren't going to be available until next November. So, if you're going to build anything, you need to have current data.

Mr. STUMP. Let me ask you one more. The current VA prioritization methodology is heavily skewed towards acute inpatient care. Recognizing the current shortage for both outpatient and long-term health care facilities, what steps is the VA taking to place a greater emphasis on such projects in its prioritization methodology?

Ms. QUANDT. I noted in my testimony that when the model was revised in 1990, it was revised to take in the needs of the National Cemetery Service and the Veterans Benefit Administration. The acute care weights were skewed, meaning lowered slightly, so that infrastructure, patient safety, patient comfort would have a higher

rate. However, I think the values are still such that the majority of funds goes to acute care. I would ask that you ask that question of the VHA panel.

Mr. STUMP. All right. In your opinion, what would be the impact on VHA operations if major construction funds for the coming fiscal year were spent primarily on enhancing VA's psychiatric and long-term health care needs, as well as addressing the most pressing infrastructure needs?

Ms. QUANDT. In my opinion, you would be doing a far better job in meeting patient and veteran needs. The system, whether it likes it or not, is moving in that direction because of veterans aging, and psychiatry has been given short shrift over the years.

Mr. STUMP. Thank you.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you, Mr. Stump.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Ms. Quandt, do you have some inside information on the future of health care in this country regarding the national health care plan that looks like it is on a fast track, and on the role of VA health care in relation to it?

Ms. QUANDT. I wish I did. I'm in the same position that you all are. We don't know yet.

Mr. BILIRAKIS. And you're suggesting basically, that we just virtually stop until we know?

Ms. QUANDT. If the President holds to his plan that that study will be done in 100 days, and makes a presentation to Congress and Congress acts, I think you would have lost maybe 1 year. However, if it's going to limp along as eligibility reform has been limping along, I think there could be another problem.

I simply am pleading that you don't put money into facilities that you may not need by 2020, and that you wouldn't be able to sell to someone.

Mr. BILIRAKIS. Yes. Well, ma'am, I commend your thinking. Common sense dictates that until we really know what is out there and where we're going, that we shouldn't be spending money uselessly.

I don't think it's going to take place within 100 days. What's that mean? Would that result in the slippage of, 2 years? If it's within 100 days, you indicated a slippage of 1 year, so in excess of that—

Ms. QUANDT. I'm assuming there's a health care package that Congress would have to act on. That's why I said it could go to two.

May I come back to your other remark?

Mr. BILIRAKIS. Please.

Ms. QUANDT. Veterans, at the rate they're aging in Florida, are going to need long-term care and outpatient care. You have within the existing facilities, capability to handle acute care if you will have a transportation network.

Mr. BILIRAKIS. In existing facilities, meaning existing VA facilities?

Ms. QUANDT. Right. And remember, you have West Palm Beach going to come on stream.

Mr. BILIRAKIS. Yes.

Ms. QUANDT. The current facilities in their surgical services ended the last fiscal year essentially with a 50 percent occupancy. The psychiatric sections are rather full, but the others are at a lower level. And you need to remember all of the empty beds that if you were to provide staff, could be opened up to take care of acute care.

Mr. BILIRAKIS. Are you taking into consideration, ma'am, what we call very fondly, "the snow birds" that come down during the winter. Our veteran population probably comes pretty darn close to doubling, or are we just considering permanent resident population?

Ms. QUANDT. Sir, after my testimony last year in May, I had them run the entire file of the VA to check the snow birds. The snow birds and the north birds, oddly enough, evened out.

Mr. BILIRAKIS. Not from my part of the state.

Well, you know, there's also the question of dollars. If you stop construction and you have \$400 to \$500 million allocated for construction, what happens to those dollars? There's no way it's just going to sit there and wait until you start construction again. It's going to be used for something else and go down the drain. And then when you decide to maybe go forward, it probably would not be available.

Mr. BAINE, you're suggesting that those three areas that you used as an illustration of optional ways to handle the problem—you mentioned East Central Florida—

Mr. BAINE. Right.

Mr. BILIRAKIS. —Hawaii, Northern California.

Mr. BAINE. Yes, sir.

Mr. BILIRAKIS. Those aren't mentioned because they're three great places to visit, are they?

Mr. BAINE. They certainly are not.

Mr. BILIRAKIS. I'm just being facetious, thank you.

Mr. BAINE. I know.

Mr. BILIRAKIS. You're suggesting those be formal demonstration projects?

Mr. BAINE. We're suggesting that that's an alternative, Mr. Bilirakis. As Ms. Quandt said, with all the uncertainty surrounding the national health reform it's quite likely that the demand for VA care will be reduced if an employer mandated insurance-type package is put forward, and would be reduced even further if a universal access package is put forward.

Until these things have taken shape and the impact on the VA is better known, we're suggesting that the Congress may want to consider delaying the decision to construct facilities and rather, try some other alternatives that will serve the veterans now. And in our view, in each of those three areas, the capability exists, with some modification, some additional construction of outpatient capacity and so forth, to do that very thing. Although we have not seen VA's health care plan and the missions for each hospital—I believe that's still under consideration—it's our view that this kind of proposal would be consistent with that.

Mr. BILIRAKIS. Do you have statistics that would show us how many people who are eligible for Medicare, are also eligible for VA care, and what their chosen health care is? I mean, do they choose

VA? How many of them chose veterans health care versus Medicare?

Mr. BAINE. We do have those statistics available, Mr. Bilirakis.

Mr. BILIRAKIS. You do have those?

Mr. BAINE. I don't have them with me. My recollection is that more Medicare-eligible veterans chose to go the Medicare route than chose to go the VA route. Jim, I think, would know more about that.

Mr. LINZ. We are developing some information under a different job on the extent to which Medicare is paying for health care for veterans. And basically, what we're finding is that Medicare expenditures on veterans' health care exceed the VA expenditures. That they're paying closer to \$20 billion-a-year on veterans' health care.

Mr. BILIRAKIS. You have that, also, by percentages of those that fall in that category? Now, you're talking about dollars when you say that, but I mean in terms of percentages?

Mr. LINZ. Yes. We do have information on the number of veterans using Medicare exclusively, the number using Medicare and VA, and the number using VA only. I don't have that information with me.

Mr. BILIRAKIS. But that is available?

Mr. LINZ. Yes.

Mr. BILIRAKIS. Do you have names too?

Forgive me, Mr. Chairman, but I know we're really attacking eligibility reform and this may be a large part of all of that.

Do you have names of certain people that you've surveyed in that regard so that someone could maybe contact them to find out why they chose one versus the other?

Mr. LINZ. We potentially could do that. We have not done it. What we've done is matched databases, VA's patient treatment file and eligibility records against Medicare payment records.

Mr. BILIRAKIS. I see. Okay, that's available. Thank you.

Mr. STUMP. Could the gentleman yield for one second, please?

Mr. BILIRAKIS. Well, I don't know how much more time I have left, but certainly because—

Mr. STUMP. I asked the Chairman, he said he didn't mind.

Either Mr. Baine or Mr. Linz, could you give me a reason for what you just said? Why are more people going the Medicare route rather than the VA?

Mr. BAINE. I don't know all the reasons, Mr. Stump. I believe part of it has to do with the fact that under Medicare, folks can choose their own providers. They can go to their doctor. They can be treated in a hospital close to their home, and they're willing to pay the co-payment and the cost shares for that purpose. That's my sense. I don't know that for certain and we have not done, Mr. Bilirakis, a survey of veterans to find that out.

Mr. BILIRAKIS. That's relatively easy to do though, isn't it?

Mr. BAINE. Surveys of veterans are not easy to do, but that could be done, yes, sir.

Mr. BILIRAKIS. Thank you.

Thank you very much, Mr. Chairman.

Mr. ROWLAND. Mr. Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman.

I can understand your concern about the health care reform package that's being formulated and what impact that's going to have on excess VA facilities. I would hope that with the assurances that veterans' groups have been given, that they will have full input on the formulation of that health care package. That whatever reform package comes out, it would take those considerations and would insure the continued full utilization of VA facilities, and that it all would be factored in whatever recommendations the task force comes out with.

But with your concerns in view and your recommendation that construction be delayed, my question is, what impact does that have upon projects that are in progress? And if you're saying delay, are you referring to those projects that are at various stages? Also, is there the risk then of duplication should, 2 years from now, we go back and pick up those projects again and having to duplicate what has already been done to this point? Is that a risk?

Mr. BAINE. Our suggestion is really pointed toward those projects which have not yet been authorized by the Congress, or for which construction funds have not been appropriated.

Mr. HUTCHINSON. So, it's only perspective? It would not impact anything currently in the pipeline at any point, is that correct?

Mr. BAINE. That's correct.

Mr. LINZ. The projects we're talking about are in the pipeline, in that they're in the planning stages: East Central Florida, the replacement hospital for the closed Martinez Medical Center, the Hawaii project, are all in various stages of planning. They have not designed the facilities or started construction on any of them.

Mr. HUTCHINSON. All right.

Mr. LINZ. There clearly is a risk if you delay those projects. There's also a risk if you go forward with them that if there is major health reform, you could end up redesigning those projects as they progress.

Mr. HUTCHINSON. So, our task is to evaluate where the greater risks are and make our decisions on that basis.

I'm real tempted to ask about the north birds because that's new to me. And from Arkansas, we have them coming south, not going north.

As a freshman and in view of some background, help me understand. I understand that there has been a bias toward acute inpatient care. Why has that bias existed, if that's true, given the demographic changes in veterans and—certainly, in my area at least—I think, the need for long-term care and if there should be a bias, it should be in that direction? Can you give me some background on that?

Ms. QUANDT. May I respond?

Part of that bias exists in the fact of our medical school affiliations and medical schools have wanted high-tech, high-cost medicine, specialization. Part of it is the culture within the system. We used to have Class A, B, C hospitals. The Class A, the elegant ones, were always acute care and therefore, as a director, you would strive to be the director of a Class A, which had high staff, high technology. It was a glamour hospital—compared to running something such as a remotely located psychiatric hospital.

The other is, without ever intending it, the resource allocation model created a competition to get dollars. So, when everyone was striving for dollars, the dollars came with acute care. They did not come with long-term care. And that's just part of the behavior that caused that.

Mr. HUTCHINSON. Do you see that correcting itself? Do you see there being movement in the right direction on that?

Ms. QUANDT. There is movement in the right direction, that I see more nursing homes and outpatient clinics on the construction lists. There is more movement to the extent that the Veterans Health Administration appears willing to bite the bullet on converting existing hospital beds to nursing home beds. There is movement because of the pressure that has come about from the Commission.

Medical schools are finally understanding that geriatrics and everything involved in it—and that does also involve some acute care—is an important specialty that they should finally begin to engage in. And the VA has had a lot to do with that, in starting its GRECCs and its geriatric evaluation management units. So, it's getting there.

The thing you have to worry about is that Doctor Eisdorfer, one of the Commissioners, pointed out that for aging veterans—and he was looking at anyone from 75 up—after 18 months, the cost of care could almost triple. And when you look at the age of VA veterans, that is what's frightening in the future.

Mr. HUTCHINSON. Well, thank you. In my area, we think geriatrics is pretty glamorous, so I hope that trend continues.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you, Mr. Hutchinson.

I have two or three questions and then I'll come to the other side here. This is for the entire panel and I'll ask this question. Last year, this Committee initiated legislation aimed at preventing pork barreling in the selection of new geriatric research, education, and clinical care centers.

Would you endorse legislation that would limit funding of construction projects to those which achieved a certain objective level of need under the VA's prioritization methodology? If not, why not?

Mr. LEWIS. Mr. Chairman, I would. I think it would be a smart move to keep this system under control. I think you properly state, however, that you would only do so in a manner that was consistent with VA's prioritization methodology. I think if we have two bodies, namely VA and the Congress trying to establish priorities, we're headed for a morass which we don't want to get into.

Ms. QUANDT. I basically believe I would. It bothers me that the GRECC is the example because GRECC never should have come up. Since it is a research project, I would have assumed that had a very low level priority, and yet it obviously did.

After the decisions on the VA health program and the mission of hospitals, I would hope the prioritizing criteria is again updated, and then I would agree with Mr. Lewis.

Mr. BAINE. Mr. Chairman, I believe we would agree with Mr. Lewis. There are some improvements that could be made in the prioritization methodology, but the notion of funding or authoriz-

ing projects on the basis of objective criteria is certainly reasonable.

Mr. ROWLAND. We're going to be looking at this morning, and we'll hear from another panel, the process that major construction projects go through from conception to completion.

I had the opportunity to visit East Central Florida this last Friday. As you know, there's been a hospital—free standing outpatient clinic and long-term care facility that's been bouncing around there for about 10 years. Many of the veterans that came to the forum that we had said, "if you don't do something very soon, a lot of us won't be around here anymore because of aging."

I want to ask—and you mentioned, Ms. Quandt, that area specifically in your remarks a few moments ago. My understanding is that there has been a great increase in the population of veterans in that particular area there, as well as population in general. So, my question would be, since you indicated that new facilities should not proceed at this time, what happens with those veterans there who now require care? Several of them gave testimony about having to travel 50 and 60 miles just to purchase medicine—just to get medicine, not to purchase it—and there were numerous other examples of the problem that many veterans are facing now.

Mr. Baine, you mentioned alternative methods of delivering care. While this hearing is focusing on the process of construction of major projects, that's something that I really want to get you to elucidate on, if you will.

Mr. BAINE. We've just finished some work on the East Central Florida project that had to do with the siting of the project. It was our sense throughout this work that the veterans in the East Central Florida area could benefit from a situation in which, if VA or this Congress were to delay, the construction of the project, and if VA were to build outpatient clinics in particular parts of that area, and contract with community hospitals, it could then provide care to those veterans in those community hospitals or in the military hospital in the area, much faster than—

Mr. ROWLAND. Let me just interrupt at this point.

Mr. BAINE. Sure.

Mr. ROWLAND. Let me just make a point. You said the military hospital, and of course, sharing is one of the things that has seemed to have worked so well.

Mr. BAINE. Right.

Mr. ROWLAND. Patrick Air Force Base there is in need of additional hospital facilities at this time. And in fact, they're talking about a sharing arrangement.

Mr. BAINE. That's correct.

Mr. ROWLAND. So, I don't believe, based on that information, that there is a military facility there, is there, to deal with that?

Mr. BAINE. It's our understanding that the Orlando Naval Hospital has excess capacity for acute care, inpatient needs. It is also true, and one of the reasons we concluded the way we did on the siting of the East Central Florida project, is that the Patrick Air Force Base is in dire need of a hospital. And to do that as a joint venture in which you take into account the cost not just to VA, but to the government as a whole makes a lot of sense to us.

Mr. BILIRAKIS. Mr. Chairman, if you'll yield for a moment? Just a point of information.

I don't think it's official yet, but as I understand it, Orlando is on the list for closure. So, if that were to take place, it would not be available. So, it's a perfect illustration—I certainly don't fault Mr. Baine—but it's a perfect illustration of the right hand sometimes not knowing—

Mr. ROWLAND. You're talking about the Naval facility at Orlando?

Mr. BILIRAKIS. Yes, I am, yes.

Ms. QUANDT. Mr. Chairman, I'd like to go back to the 50, 60 miles to get a prescription. I don't know why the veterans were doing that, but there is a possibility that they could have mailed prescriptions. That is a major program in the pharmacy service of VA. I would like someone to check that out.

With respect to that particular area, if I may digress, during the time of the Commission when Congress was still talking about psychiatric beds for Gainesville, I received from a friend in Florida, the fact that a hundred bed psychiatric hospital was available for purchase. It was new. We could have had it for \$6 to \$7 million. I referred it over to Mr. Lewis' office since that was their responsibility. The VA looked at it, decided it couldn't use it. But it could have had that hospital at that price.

When Mr. Thompson was regional director in the southeastern region, he and I believed that the quickest way to serve veterans was to put a nursing home and an outpatient clinic with that Orlando Naval hospital. We talked about that at least 5 to 6 years ago. Program managers want nursing homes to be attached to a hospital, thinking that's the very best thing. And they want it to be a VA hospital. It's part of the culture in getting people within both those bureaucracies to give in order to obtain what veterans need.

Mr. ROWLAND. I see that my time has expired.

Mr. Edwards.

Mr. EDWARDS of Texas. Thank you, Mr. Chairman.

Mr. Lewis, I'd like to address my question to you. I would like to ask if you've had a chance to review President Clinton's proposed \$1 billion in savings which I believe to understand, is to come from better management of VA construction projects.

Could you tell me your best understanding of that proposal and if, in fact, what we're really going to be doing is cutting VA construction projects by \$1 billion?

Mr. LEWIS. Well, Mr. Congressman, I have not reviewed the proposal. I was frankly unaware of it until you just mentioned it.

In my testimony, I think I focused on the fact that certainly from a point of view of managing the process and from the point of view of controlling it and overseeing it, VA has been cut back severely, to the point where it is close to not being able to oversee. And certain management functions of the process are falling by the wayside with a result—and I'm particularly concerned about this—that our claims are going to go through the ceiling.

Now, yes, we'll save some money here and there by cutting back on FTEE, but we're going to pay for it at the other end when the claims start to roll in.

Mr. EDWARDS of Texas. Well, if you get a chance to review that, and I may be mistaken but I think that's part of the President's plan to discuss—I think it's a billion dollars, but I'd have to review it. But if you could look at that part of his plan and provide any thoughts on that in writing, I would certainly be appreciative of that.

Mr. LEWIS. I'll do that.

Ms. QUANDT. May I respond?

I think I read the document as you did, and I got very excited when I read that because for construction to impact the hospital operations that much would be unusual.

I am told those should be read as two separate lines and that "the improvements" is the new buzz word for cutting staff. When I asked about this in VHA's budget office, they said "oh, no, it's just like productivity. We will give up a certain percent over the years of FTEE in the hospitals." It's not really tied to construction.

Mr. EDWARDS of Texas. Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you.

Mr. Baesler.

Mr. BAESLER. As I understand the thrust of your testimony, I believe, is that prior to us embarking on any major construction, we should do two or three things. Number one is to wait and see how the new health care reform will effect veterans.

Number two—and I don't know that you said this. One of the other folks might have said this—is that this might be the opportune time to see whether or not alternative type treatments for veterans might be more productive, and also, more caring for the veterans in maybe historical type treatments whether it's outpatient care or whether it's whatever else you were talking about.

And the third thing—and I don't think you said this, but I read it in this report—that you sort of approve the construction recommendations from the President because you felt that they were for maintenance and so forth that might improve the care. I think I concluded that correctly, didn't I?

Ms. QUANDT. Yes, sir.

Mr. BAESLER. Now, having reviewed the request from our veteran's hospital in Lexington, Kentucky, which I happen to represent, I notice through all of their wish list, they referred continually to the need of the FTEE, which I suppose we're talking about employees. More people to provide the care.

My concern here is that when I reviewed the construction allotted for the facility in Lexington, I was somewhat concerned because in that was an example of \$30,000 for a flag pole. And I was concerned because I felt that when I saw their list of needs, it all had to do with how to provide the better care. And then when I saw the money that they were going to get sort of over here on the left, which I didn't see how it could help much with care, and if you had a choice—I think I know the answer, but I want to ask anyway. If you had a choice of putting a lesser amount of money in FTEEs or the same amount of money in the construction, which would you make?

Ms. QUANDT. One would have to be Solomon. Normally, I would opt for the FTEE. However, when you look at Lexington, that is a two plant facility. You have the downtown hospital which is near

the university, and you have the old plant which is the former psychiatric hospital. That has to have, in the older plant, a lot of infrastructure needs.

And having directed a hospital such as that where the steam line blew up every three months, where the plumbing system broke down almost monthly in one of the buildings, hospitals have to have that kind of money. And that's why I applaud the President for this \$236 million. We might make a dent in that grave need. I would be inclined to put the flag pole on the bottom of the list unless it is what a friend of mine would call shaky and apt to fall on a patient.

Mr. BAESLER. I appreciate it. And in addition, I notice here that in your testimony also that it's estimated it would take over \$11 billion, I think, to rehabilitate the existing facilities that we do have, and then \$1.-something more billion—I forgot exactly what that was for—to correct all the minor miscellaneous. And you, I would assume, include in that \$1.2 billion minor miscellaneous, the \$245, or whatever we just got through talking about, that the President has allocated at this time. That's part of that \$1.2 billion?

Ms. QUANDT. That's right. The \$236 million, I'm hoping, is new money from the President, and that that will just cut down a small part of that backlog on minor miscellaneous and non-recurring maintenance backlog.

Mr. BAESLER. Thank you very much.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you.

Let the record show that Mr. Gutierrez was here.

Mr. Smith.

Mr. SMITH. Thank you very much, Mr. Chairman. I want to thank the panel for their testimony.

Ms. Quandt, if you could tell us, does VA construction planning factor in local non-VA resources when determining the size and scope of a major construction project such as a new nursing home?

Ms. QUANDT. That part of planning falls to Veterans Health Administration. When planning is done and a hospital decides it needs something new and major, it is required to do surveys of the community. How many community nursing home beds are available? How many private sector beds are available if they are needed? What kind of sharing agreements or exchanges could be worked out?

I will admit to you, the other issue is state home beds. In my opinion, there has been no holding of many directors responsible to carry out those rules or procedures. And I can remember going through planning meeting after planning meeting saying, "this is in the community." "We don't want to use it." And so, they either don't look at it, or they come in and wipe it off. That isn't construction's fault. It rests with the group operating the health care system.

Mr. SMITH. You in your comments to the previous questions noted the stimulus part of the package that Clinton has sent up. We were given a list of proposals that would be funded for hospitals in New Jersey. As best as I could tell in looking at that, there was no prioritizing as to what is really needed, as opposed to what

is ready to go. What has been through the trap, so to speak, and could be funded within a 60 day time period.

How do you rate the advisability with very scant federal dollars available of the proceeding in this manner? When we're looking as to previous questions that were, as well mentioned, the possibility of losing a billion dollars over a few years and then on the very short-term basis, looking to perhaps fix that flag pole you mentioned before and that project might be ready to go and is on a wish list, but is not a real priority.

In addition to that, when we were given the list—and you know, as politicians sometimes, we run right out with press releases to say “look what is being provided for our area.” I held back and did not release the list for one simple reason. I questioned whether or not the money might be spent more prudently elsewhere, particularly for perhaps a surgical unit or something else. But I had no clue as to whether or not these were real priority issues. If you could comment on that?

Ms. QUANDT. As I understand the projects which are to fall into that group, there are some projects which are essentially, because of their dollar level, delegated to a failed field facility. They aren't in what I call the big buck projects.

Every director out there knows what he or she must do to keep that plant going and they may want to do a project that moves a wall or gives some service more space. But if you want to redo a surgical unit, you could end up paying well over a million dollars, and that would be beyond what is delegated. So, what I believe is on the list—if they were all smart—a director would keep up almost every quarter or at least twice a year, what are non-recurring maintenance, minor miscellaneous needs in the hope that money might come. So, you're ready when it comes.

You're looking at very small projects which might go out to purchase and hire or which might be done with new local employees put on the rolls. You're not looking at major things such as surgical suites.

Mr. SMITH. So, the impact might be very marginal in terms of veterans' health care—

Ms. QUANDT. No, the impact, I think, could make a difference. I mentioned—

Mr. SMITH. Have you looked at the list?

Ms. QUANDT. I have not seen in. But I'm thinking of the dollar level. If I need new locks on my buildings and I've got 90 buildings, and the patients aren't safe because there are people wandering away in there, that may not be a large dollar item but that adds to patient safety. And the first criteria of your facility should be patient safety, then you move up to the others.

So that, I'm assuming that's the level of projects. Now, that doesn't sound like much but the patient would be safer and the morale of the staff, I guarantee you, will go up if they don't have to worry about that.

Mr. SMITH. I have several questions, but I'll just ask one, if I could, Mr. Chairman.

You, on page 8, Ms. Quandt, have made a very, very strong statement regarding how Commission Members “with considerable experience in managing construction of health care facilities were ap-

palled at a system they found to be inflexible, cumbersome, uncoordinated, and not necessarily responsive to veterans' needs."

You make, I think, a very good case that there is a lack of confidence on the part of some Commissioners that the VA that could build in a reasonable amount of time. And I think you do equate it with the private sector, and there ought to be a closer matching with how they do business. What specific steps would you recommend to this Committee and to the VA should be followed to improve that process?

Ms. QUANDT. First of all, that the system start operating on industry standards. Let it be more flexible. I talked to several hospital directors in preparing this testimony and all of them said, "please say for what's happening to us, we almost need a multiple purpose hospital, the way you get a multiple purpose room." We have to be able to take this physical plant, in 2 or 3 years move things around and do better than we do with the "fixed-in-concrete" facilities that we have.

So, one, get away from the long time. I said that you've got the Martinez Clinic operating in six months compared to the 49 months that was planned for it. Those are some of the differences that you're looking for. This cost containment has an interesting philosophy in it. Shorten the planning time so they won't ask for so much. That's part of the problem.

So, you need to make it more flexible and more responsive. And I still think it should be delegated down so that the local director is responsible for the total operation. The local director will be a lot more careful in what's requested.

Mr. SMITH. Thank you.

Mr. ROWLAND. Thank you.

Mr. Everett.

Mr. EVERETT. I have no questions, Mr. Chairman.

Mr. ROWLAND. Let the record show that Mr. Kennedy was here, and let the record show that Mr. Bishop was here.

Mr. Tejeda.

Mr. TEJEDA. Thank you, Mr. Chairman.

I've got a concern for some of the rural areas and how some of the veterans are being served in rural areas. In South Texas, there are several counties that have no primary care providers, period. There are no hospitals in many of the counties and the closest VA hospital is in San Antonio, which may be 250 miles away, 200 to some. So, there's a vast area. There are many veterans there who reside there. There are many others who are relocating to that portion of South Texas.

What is some of the criteria, or what is being provided to some of the veterans who live in these rural, oftentimes isolated, areas where there are no physicians in the county? There are no hospitals in many of the counties, and they've got to travel many, many miles to get to a hospital.

Ms. QUANDT. There are clinics at Corpus Christi and McAllen which, hopefully, start to pick up some of that workload. But I hear you saying they still have to drive too far.

The Department, at the urging of some people who had interests in mobile clinics, in selling big buses with clinics in them, is testing mobile clinics in at least five areas. I do not believe Texas is one of

them. To have a community clinic, I think one has to have at least 3,000 outpatient visits a year. And so, therefore, one would have to look at the various communities you are talking about to see if the workload is met. And you will notice, I cited Victoria, Texas, as a Congressional intervention because it doesn't meet workload. So that becomes the problem.

The only other thing that can be done which has been resisted, would fit in with GAOs recommendation of a test. Which is that under VA medical decision-making, they would decide to voucher, if you want to use a term that is a flair word, certain of those veterans. That is the other option, but that has never been taken.

Mr. TEJEDA. I'm still concerned about these mobile clinics in that first of all, we don't have them there in South Texas. I know it's an experimental program that you're trying, but even if we had them, if a veteran has to be hospitalized, that still would put him or her many miles from family and from any support groups. And I know there is a clinic in Corpus and in McAllen. There are many counties, be it Duval, Starr, Zapata, McMullen, La Salle, and Frio that are many miles away from McAllen.

Ms. QUANDT. If one of those veterans is service-connected and has an emergency, he can be hospitalized locally until that emergency is over, and he can then be moved. The history of VA and that program is that the local hospitals never like to give up a patient. So, they don't say the emergency is over until just about the day of discharge. So, that takes care of service-connected. That doesn't take care of your non-service-connected.

If we were to look at outpatient and it was done in Alabama years ago—probably 15 to 18 years ago—they recognized certain of their patients weren't getting care. And they used to put a staff in a station wagon and they would go out to parts of Alabama, set up their little outpatient clinic in a veterans' home, meaning a post, and see veterans there. That is another option. Other places have leased space from a private facility to put in a traveling clinic, if there's workload.

Mr. TEJEDA. Again, that's fine when there's private hospitals there. In many of these counties, there are no private hospitals at all; no hospital and no doctors at all. So, it's a problem. And I don't want to belabor the point, but I'd like to work a little further on this and I'll have my staff contact you.

Ms. QUANDT. I would suggest that you work with Mr. Hawkins since I am retired.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you, Mr. Tejeda.

Ms. BROWN, we're on our first round of questioning with this panel. Do you have questions?

Ms. BROWN. Thank you, not for this panel. The next panel, I'll have questions.

Mr. ROWLAND. Okay, thank you.

I have a couple of questions that I want to ask. Mr. Lewis, I want to ask you if you would comment on the feasibility of the recommendations of the "Mission Commission" that VA rely more heavily on leasing and lease purchasing, in preference to construction.

Mr. LEWIS. Well, I would support the lease purchase side, but certainly not the simple leasing side for this reason. VA, when it

executes a normal or conventional, long-term lease, effectively is paying over the life of that 20-year lease, about twice as much as it would pay if it were simply to construct the facility.

Lease purchase has many good attributes to it, namely that at the termination of the lease, you wind up with a facility or an asset that goes into VA's asset base and you don't just have a bunch of rent receipts to show for your tenancy. A concern is that the way the system is handled, namely that leasing is used, unfortunately, as the only alternative to getting an outpatient clinic very, very often because an appropriation is not required. Well, it's all well and good to say that but the appropriation is required in that the lease cost comes out of the medical care budget.

So, it is being paid for, but if the intent is to show the public the kind of money that's being expended for "construction," we really don't do a very good job of it because we obscure so much of it in leasing. I think this year's leasing costs will be about \$40 million. Not a huge amount of money, but a significant amount of money.

Mr. ROWLAND. So, leasing would work best in outpatient—

Mr. LEWIS. Yes, sir. I don't see how you're going to lease a whole hospital, or even lease purchase it. It's just too big a project to work that way.

Mr. ROWLAND. Well, a few moments ago, we were talking about what could happen in East Central Florida if the hospital were not built there. If you built an outpatient clinic, and then you could contract, I suppose, with community hospitals there in the event that inpatient care was needed.

If you did do this type of mainstreaming, it appears it would involve potentially enormous cost in doing that. My experience or my information has been that it costs considerably more in the private sector to provide care than it does when our hospital and health care system in the VA provides acute care. Do you have any estimate about what that would cost? How would you envision testing its cost effectiveness and what you would expect to learn from such tests? How would you envision applying the lessons that were learned? Would you care to comment on some of those questions?

Mr. LEWIS. Well, first of all, I certainly agree that the cost of placing these patients out in the community would be higher than it would be within VA. I think that's pretty much of a given.

I think there's another solution to East Central Florida. As you probably know, two outpatient clinics are envisioned in the current plan, one right near Orlando and one over in Brevard County. Now, those outpatient clinics can be erected much more quickly than the normal process as Ms. Quandt has alluded to in the Martinez situation, where I think a superb job was done in getting something up and going. I think those outpatient clinics perhaps could be expanded to make them a little bit bigger, more like the Martinez model, so that they handle a lot of more routine kinds of situations. And then those situations requiring tertiary care could be exported to Palm Beach.

There is another consideration in the East Central Florida situation, however, which I think the Committee ought to be aware of. That is, my recollection—again, like Ms. Quandt, I'm retired too—but my recollection when I left VA was that some \$12 million was being expended by the county around Orlando to buy land. Now, I

believe that has been done or certainly committed to, and there's some serious, I believe, ramifications to saying "good-bye Orlando. You've got \$12 million worth of land which the taxpayers have subsidized. That's your problem." So, I think that's something that ought to be taken into consideration.

Mr. ROWLAND. I don't want to stay on that East Central Florida subject, but since we're still talking about it, my understanding is that if the hospital was built in Brevard County, for example, an outpatient and long-term care facility would be built in Orange County or vice-versa. There would not be an outpatient clinic in both of those—

Mr. LEWIS. Well, there would be an outpatient clinic resident within the hospital. That is correct, sir.

Mr. BAINE. Mr. Chairman, could I go back to your comment on the cost-effectiveness or the relative costs of VA care versus private sector care?

Both Jim and I have been dealing with VA health care issues for a long time and I don't believe either of us have seen what we would consider to be a comprehensive or really valid study of the comparative cost of VA care vis-a-vis private sector care that would take into account all the costs on both sides of the equation.

This is something that we believe needs to be done and we've started on that. We know there's going to be lots of arguments about what to include and what not to include and so forth. But one of the difficulties with all these trade-off situations is that there is really not a lot of good data as to the comparative costs.

Mr. ROWLAND. I see that my time has expired. Ms. Quandt, do you want to have—

Ms. QUANDT. I wanted to tell you a piece of ancient history, Mr. Chairman.

Before Jack Chase became the chief medical director, he designed a study that he called the Beckley Plan. In the Beckley Plan, at one point in time, we could not hire surgeons in Beckley, West Virginia. Doctor Chase opened the medical staff to the community physicians, had them do the surgical work, and the patients were hospitalized in the private sector until they could be moved back into Beckley. That was a successful plan. It worked.

So, I think your asking to set up a test model is worthwhile and I believe it could be done, if they set the right hypotheses in what they wish to measure. If you wanted to go in and lease major floors, you would run into the problem of the pay of federal employees versus what the pay is in the private sector and that gets difficult in of the support areas of housekeeping and dietetics. Otherwise, you are comparing what it would cost for care in a similar hospital with contracting for your lab, X-ray, and total nursing care, but it can be done. I believe it's possible and I would say in some rural hospitals in the Dakotas, you could open the staff both ways: the VA to the private sector and the private sector to VA, and improve patient care.

Mr. ROWLAND. That, in fact, happens with affiliated hospitals now, does it not?

Ms. QUANDT. Yes.

Mr. ROWLAND. Mr. Stump.

Ms. Brown, did you have a question?

Ms. BROWN. Yes, sir. There was a discussion about Central Florida. I just wanted everyone to know it's not abstract. It's my district and I think the total commitment from that community is close to \$14 million including the purchase for the clinic property that would be—

Mr. ROWLAND. Right. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. So, we're talking, Ms. Brown, about actual outlays of money that's already been spent or committed to, legally, is that correct?

Ms. BROWN. Yes, sir, from that community.

Mr. BILIRAKIS. I just wanted to make that clear.

Ms. BROWN. Stretching the taxpayers' dollars.

Mr. ROWLAND. Mr. Smith.

Mr. SMITH. Ms. Quandt, maybe you can provide this for the record. On page 5 of your testimony in dealing with "why are replacement or modernization projects so costly?" you list reasons from asbestos abatement to Congressional intervention to minority set asides to buy American. Is there any breakout as to how much each of those factors might contribute to the overall additional cost that we can quantify in a real way?

Ms. QUANDT. I could not supply that.

Mr. SMITH. It would be helpful for the record.

Ms. QUANDT. I believe between construction and VHA, they could supply it.

Mr. SMITH. Okay, I would make that request. Thank you.

Mr. ROWLAND. Are there any additional questions from the Committee Members?

I want to thank all of you very much for coming. You've been most helpful and we do appreciate it.

Mr. ROWLAND. Our next panel is Mr. C. Wayne Hawkins, who is accompanied by Mr. Lester Hunkele, and Mr. John Fears, and Mr. Robert Neary.

Thank you very much, and we would ask that you would limit your opening statement to no more than 5 minutes.

Mr. Hawkins, you may proceed.

STATEMENTS OF C. WAYNE HAWKINS, DEPUTY UNDER SECRETARY FOR HEALTH, ADMINISTRATION AND OPERATIONS, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LESTER HUNKELE, DEPUTY ASSISTANT SECRETARY FOR FACILITIES OVERSIGHT, DEPARTMENT OF VETERANS AFFAIRS; AND JOHN FEARS, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR RESOURCE MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; AND ROBERT NEARY, ACTING ASSOCIATE CHIEF MEDICAL DIRECTOR FOR CONSTRUCTION MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF C. WAYNE HAWKINS

Mr. HAWKINS. Thank you, Mr. Chairman. What I'll do if the Chairman pleases, is to go ahead and make some brief opening comments and that at the request of the staff, they've asked that we be prepared to have Mr. Fears walk through the planning proc-

ess that we use in the VA construction program. And then to have Mr. Neary talk about the execution phase, if you so please, sir?

Mr. ROWLAND. That would be most helpful, thank you.

Mr. HAWKINS. I am pleased to appear before you this morning to present testimony concerning the Department of Veterans Affairs Construction Program. As you are aware, the VA will be forwarding its request for 1994 construction funding to the Congress in late March. At that time, we also plan to provide the VA's 5-year facilities plan and expanded project descriptions to the Committee.

The VA health care system represents a tremendous capital investment, including over 5,000 buildings and approximately 26,000 acres of land at over 1,000 locations nationwide. Accomplishing our mission depends on our ability to maintain this capital investment and modernize the physical plant where necessary. The VA employs a number of processes to ensure that needed health care programs are identified, and that when those needs require renovation or new space, the space is appropriately planned, designed, and procured through sharing, construction, lease, or public/private venture.

To determine facility needs, we must first assess veterans' needs for health care, then plan our health care programs. The VA is working with the President's task force on health care reform to define the role of the VA health care system as part of the nation's health care delivery system. We are also developing a proposal to reform rules for determining a veteran's eligibility for VA care.

As part of these efforts, we are also developing a strategic health care plan to provide a blueprint for meeting the health care needs of the nation's veterans. This plan will describe current VAMC missions, provide guidance for establishing certain programs and construction needs, and outlining a planning process for the future. This baseline will begin to shift the VA system to a managed health care system.

Mr. Chairman, Secretary Brown and the new VA leadership is currently reviewing VHA's planning mechanism and proposals and will move forward with these processes in the near future, as soon as the Secretary approves and gives us guidance.

Mr. Chairman, after health program needs are determined, a facility development plan is developed for each VA medical center. The FDP, as we call it, is a comprehensive plan for the physical development of a VAMC over a long-range period of time currently, through the year 2005. It includes a selected facility development strategy and logical grouping of construction, leasing, sharing, or DOD joint venture activities to meet the needs of our patients. FDPs have been completed or are in process at two-thirds of our VA medical centers. The FDP is used by the VAMCs to develop specific projects for their 5-year facility plans. The 5-year facility plan is an implementation plan which depicts the magnitude of efforts required to meet the facilities' future needs.

The nation's Medical Facility Development Plan, the MFDP, which must, by law, be submitted to Congress by June 30 of each year is developed from the highest priority projects from individual facilities' 5-year plans. These projects are prioritized using criteria such as workload, functionality, life safety, and building code requirements, and are weighted for high priority health care pro-

grams such as outpatient care, psych care, or long-term care. Projects proposed for accomplishment in the plan are limited to funding constraints dictated by the Administration.

In October of last year, after careful examination of our construction program, the Department implemented a number of process and organizational changes designed to improve the planning and construction of VA facilities. From the process perspective, these changes grew out of a desire to improve accountability and increase the role of the medical center in the development and management of projects; reduce the time required to plan, design and construct VA facilities; improve cost control and establish incentives for medical centers to develop less costly projects, as well as to control the scope.

We sought to achieve a balanced program beginning with planning from the bottom-up at the medical center, appropriate oversight, delegation of projects to medical centers where appropriate, and central management of the larger, more complicated projects using the best methods available, including design build, construction management, or conventional design and construction.

In addition to the process changes at the Central Office level, we reorganized those involved in the construction program. The VA's Office of Facilities which previously reported to the Assistant Secretary for Acquisition and Facilities is now a part of the Veterans Health Administration under my supervision.

The Office of the Deputy Assistant Secretary for Facilities Oversight will expand the technical oversight of facilities and projects in conjunction with the financial, budgetary, scope and need oversights currently provided by the Deputy Assistant Secretary for Budget.

In addition to the process and organizational changes, the VA has implemented a number of initiatives to improve the effectiveness and timeliness of acquiring facilities. These include the use of alternative acquisition methods such as design build, increased use of consultants to the use of construction management firms and public/private ventures; more intensive comparison with private sector standards; vigorously marketing the VA projects to elicit competition; and the use of partnership and alternative dispute resolutions, two industry concepts intended to bring together the parties involved in projects to seek resolutions of differences.

Mr. Chairman, the reorganization of construction functions and the implementation of the process reforms were initiated in October of 1992. These are presently in the process of implementation and we think they will have a major impact on the way we do business in the future.

At this point, if the Chair pleases, Mr. Fears could describe for you the planning process.

Mr. ROWLAND. Thank you. We would be grateful for that.

[The prepared statement of Mr. Hawkins appears on p. 83.]

STATEMENT OF JOHN FEARS

Mr. FEARS. Last year, we had a major reorganization committee that got together and took a look at how the VA does business. How we plan and how we decide which projects are picked and the

processes by which projects are picked, as well as looking at the way we are physically organized in terms of who answers to whom. We identified many, many problems and I'd like to go through very quickly, the process that the Secretary, has approved, in terms of planning for our construction projects.

The base for our planning process is a Facility Development Plan, the FDP. There's a lot of misconception about what a facility development plan is, but in its very simplest format, it's an inventory of what's there. It then takes a look at what is there and how well that space can be used to treat people. And then it has the third part, which is a plan, as to how we are going to take that space that's there and change it for the future for medical care.

I just recently looked at a couple of FDP's and one that I looked at was the one in Mr. Stump's district. So, I'll mention this one to show how the process works.

An outside consultant was called in and took a good hard look at the Phoenix facility. They identified the fact that Phoenix was doing over 200,000 outpatient visits in space that was set aside for about 60,000 visits. They then looked to see if there was any way that you could use the current facility to meet this need. It recommended—the FDP will recommend that an outpatient addition be put on the Phoenix facility to take care of this need.

Now, the process should then take a look at the national health care plan as it's developed, and look at the mission of the facility to see if you really do need outpatient care in Phoenix. Now, I think we can all see that outpatient care is a primary thing that any national health care plan you develop is going to say is needed. You might also look at that facility in terms of long-term care or tertiary care. I'm going to kind of stick with this one example of outpatient care as I go through the process because I think it is something that we all would say is needed no matter what happens in terms of the VA's national health care plan.

So, your FDP shows an inventory of what's there and it shows what's needed and it ties it into the national health care plan. The facility will then have a list of projects that they think is needed to meet the future needs. The facility director then will make an application for the project or projects that he thinks he or she needs for that individual hospital. This application will contain what we call a design program. It's not an open-ended request to help the facility in construction. It is very specific in what is needed by individual project.

For example, in the Phoenix situation, my feeling is that the director will probably identify ambulatory care as a strong need to take care of the veteran population in Arizona. He or she will take a look at the space that is needed and will come up with a very specific application which will show block plans: where he intends to put it, how much space he needs, what types of visits he intends to, and he will come up with a cost based on that particular design program.

He also will take a look at what sort of resources are going to be needed in the future to activate the project if it is selected. That will then come to Central Office. We will take a look at the national needs, and we will prioritize all of those local projects, looking at the cost of the project, looking at the FDP and the need for the

project, looking at whatever future resources are going to be needed to activate that project, and generally, take a look as to whether it meets what the Secretary considers his or her strategic initiatives.

We are going to try very hard to encourage people to come in with cost-effective lower cost projects so that we can make the limited dollars that we get, go further. We're therefore going to try to, every year, put out projects in the \$5 to \$10 million range, \$10 to \$15 million range, \$20 to \$30 million range, with an emphasis on the smaller projects that will meet the needs of the population within the dollars that we're given. Once those applications come in, a competition, so to speak, goes on and we will pick a list of projects that we will be submitting to the Congress that we say are needed to take care of our future veteran population.

The decision will be made on how the projects are to be accomplished very early in the decision process. We will take a look at the size of the project and the amount of help the facility might need in the construction process, and we will make a decision right up front if we are going to go with lease purchase, whether we're going to go through design build, whether we'll go through our normal contract management system, or maybe hire some outside contract managers to come in and help us with some fully delegated projects.

I think what the process is doing is trying to correct many of the problems that have been presented to you by the previous panel. We hope to hold scope creep down. We hope to be able to identify future resource needs. We hope to identify the most cost-effective way to do the construction. We hope to tie our facility development plan and construction plan into our national health care plan, we hope to make sure that whatever we build in the future is planned for in terms of the type of patient care that we will be delivering.

STATEMENT OF ROBERT NEARY

Mr. NEARY. Once a decision is made to proceed with a major construction project, we begin the more specific physical planning, design, and subsequent construction. In doing so, we use standard industry activities of schematic design, design development, construction documents.

The seed money for the early planning and design of a major project is appropriated by the Congress in the VA's Advanced Planning Fund. That money enables VA to contract with an architectural engineering firm to work with our Central Office and the medical center in beginning the early designs, and specific layouts, and translating that into more detailed designs and ultimately, the contract documents, legal documents sufficient for the bidding process.

For a project that's in the cost range of less than \$50 million, we would typically approach the Congress for funding in one instance. We would seek full funding in a single appropriation year. We do have our design fund which enables us to begin in 1 year the preparation of contract documents design of a project that will be budgeted for construction in the following year. So, the funds that are available to the VA in fiscal year 1993 in the design fund will be

used to prepare the final designs for projects that will be in the fiscal year 1994 budget.

All construction work in the VA is performed by non-VA personnel for the most part, general contractors. In instances where we use a design build construction methodology, usually a joint venture of a general contractor and an architecture and engineering firm will be used.

For the larger projects, we approach the Congress usually twice. First, for specific in design appropriation, and hopefully, in the following year for the construction appropriation. And we do that in an effort not to hold such large, unobligated balances that would come with getting construction money for a job that has to be designed before construction award.

Mr. HAWKINS. Mr. Chairman, we would be happy to respond to questions at this time, if you would so like.

Mr. ROWLAND. Thank you.

Mr. Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Mr. Fears, you mentioned all the statistics about the Phoenix Indian School land facility there and the need for doubling the capacity. You mentioned that you started out at 60,000 and now is currently treating 200,000. I think it had 90,000 the first year that it opened.

That facility is not even on the 5-year plan, is it regarding increasing the capacity? You stated in your report that it needed to be doubled.

Mr. FEARS. Yes, sir.

Mr. STUMP. And yet, it's still not in the plan?

Mr. FEARS. That's correct, sir. That, to me, is one of the big deficiencies in the system and that's the reason that the facility development plans were initiated. What we have done at Phoenix is finish this contract that has really identified a true need. Now what we want to do is to take that true need, take it forward and develop a construction plan for that facility.

Mr. STUMP. But it would appear that we're always looking backwards at what we've done years ago when we knew darn well what was going to happen the first year it opened.

How many other facilities need to be doubled in their capacity? Have you identified any others?

Mr. FEARS. We recently did a very quick and dirty study to take a look at the amount of money it would take to take care of the ambulatory care needs alone of the system. It was about \$1.2 billion.

So, we do have that information. The facility development plans now give us that information, and we are developing our projects based on that.

Mr. STUMP. You don't know in numbers how many would require that kind of capacity, or doubling the need?

Mr. FEARS. I don't have that number off the top of my head, but I could get you that number very quickly. I do remember the dollar amount. It was \$1.2 billion, I believe.

Mr. STUMP. Well, if the Phoenix facility wasn't even in the 5-year plan, what is the reason it has such a low priority when we've known for years that it was so far behind in capacity?

Mr. FEARS. I used the Phoenix hospital as an example because that was an FDP that I just recently took a look at. There are many, many other FDPs that show the exact same need. We have been responding to those needs over the years, and hopefully, we'll get around to the Phoenix and other hospitals that are out there, as soon as the dollars become available.

We have been taking care of needs like that all over the system over the last 4 or 5 years. I think what we're going to try to do is focus much more on the things that we know need to be done, looking at the future population, that is, ambulatory care, long-term care, that type of thing.

Mr. STUMP. Let me ask you a couple of questions about the Prescott facility, the nursing home care unit that they just completed up there with 60 beds. Everybody said at the time that wasn't nearly enough. We repeatedly said the need was at least 120 and sure enough, the first day it opened, they were filled to capacity.

How can we be sure that the VA's planning takes into account the true demand for a facility like that? I mean, there's a waiting list there since the very first day.

Mr. FEARS. I think Ms. Quandt explained fairly well what we do when we look at long-term care needs. For example, we look at the ability of the community to take care of some of them, the availability of community beds. We then take a look at what the VA's share of that market will be.

Now on long-term care, we do constrain the numbers of our market share that we do take over. We have said—and don't ask me where this came from. Somewhere in the past, we have said that we will only take care of about 16 percent of the market share. Therefore, many times, we are under-sizing VA long-term facilities in terms of demand that might come in. That was a purposeful decision, I presume, because of resources.

Mr. STUMP. Design funds for the addition of 60 beds was included in last year's appropriation by Senator DiConcini over there. Is that design phase complete?

Mr. FEARS. No, sir. I believe the contract has been let. Mr. Neary probably has more information.

Mr. NEARY. We're in the process of hiring the architect engineer. The advertisement for interested firms closed on February 11th and we're in the selection process. As soon as the architect is under contract, they will proceed with the design.

Mr. STUMP. Mr. Chairman, I have a couple of other questions I would like to submit to be answered for the record, if you would, please?

Mr. ROWLAND. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thanks, Mr. Chairman.

I'm curious, and I think we probably all are, as to some of the comments, some of the responses from these gentlemen to some of the points made by the prior panel. I'm not going to go into that though, unless my time allows me to because I'm going to get parochial, too. I mean, after all, that's part of it all and I guess my parochial concern is going to take up all of my 5 minutes.

And at the outset, I would say that really, particularly Mr. Fears and Mr. Neary, and all of these people have always been just great

in terms of communicating with us. They've never turned away. They've never been wishy-washy, you know, that sort of thing. And I guess maybe that's part of my frustration here. They've never been wishy-washy. They've always come in there with specifics, specific dates and that sort of thing—and John is starting to smile over there.

I'm talking, obviously, the spinal cord injury addition in Tampa. You know, we can talk about—I'm not picking on East Central Florida, and because I'm certainly with you, Corinne—but my point is that we can talk about different facilities and locations and there may be different contentions as to whether it ought to be here, whether it ought to be there, whether an outpatient clinic is adequate, et cetera. But nobody, nobody has said that we don't need additional spinal cord injury beds in Florida. There are a handful of them down in the Miami area, as we know.

But the spinal cord injury facility in Tampa, Florida, it is for the entire state, this state which has tremendous growth. But we've got a time-line going all the way back to 1971 on that particular facility, and some of the conversations that have been taking place and some of the promises, some of the money has been spent, design funds that have already been spent and all sorts of things like that. And here we are in 1993 and the 1994 budget, and I guess maybe that will take me right into it.

Does the 1994 budget request include dollars for the Tampa SCI? Do we know?

Mr. FEARS. I'm sorry. I can't give you that information right now. It's in the process of going through the President's budget.

Mr. BILIRAKIS. Well, can you tell us whether or not you all are requesting—

Mr. FEARS. The Veterans Health Administration has brought the Tampa spinal cord injury project to the point where if it is funded, we are ready to go with it. We don't generate the funds, but we agree with you that it's a needed project. It has always been a high priority. It is at the point now where if the construction funds are made available, we will be able to proceed with the project.

Mr. HAWKINS. Mr. Bilirakis, I might respond to that. As Mr. Fears indicated, we are in current negotiations with OMB on the 1994 budget. In fact, we have submitted our recommendations to the Secretary and to OMB and in fact, at 4:00 this afternoon, I'll be meeting, along with Mr. Neary, with the Secretary to talk about the 1994 list. But at this point, it has not been finalized.

Mr. BILIRAKIS. Well, it has, for a long time, been a high priority item. How many high priority items are there? Have they expanded so very much over the years so that many high priority items have really become more of a low priority item within the high priority category?

Mr. FEARS. What has really happened—

Mr. BILIRAKIS. And you gentlemen—I know the pressure is on you and I appreciate that. I really do. And I hate like hell to think that it's always the case of the squeaky wheel getting the grease, or something of that nature. But my gosh, what we've gone through on this.

Yes, sir. Yes, sir, John.

Mr. FEARS. What happens in terms of a lot of high priority items is that the major construction budget has been shrunk, considerably, over the past 6 to 7 years. When we started our planning process, we were looking at construction budgets, major construction budgets in the \$600 to \$800 million range. So, you plan for that in the future when you look at that number of projects.

Time goes by and those dollars have decreased, and what happens is, you have too many projects in the pipelines with high priorities for the dollars that are available.

Mr. BILIRAKIS. So, how is the decision made, on the basis of the most pressure coming from members of Congress, specific members of Congress?

Mr. FEARS. Veterans Health Administration uses our priority methodology to select the projects. Those that have the highest priority looking at the needs of the system are the ones that we put forward. Sometimes the Congress changes those priority systems for other needs, for other reasons.

Mr. BILIRAKIS. The answer is yes to my question.

Well, you know, I don't like to play that kind of a game—and I'm a member of the minority party, so I'm not sure I have the power to play that kind of game if I wanted to. We're talking about people's lives and health and what-not, and real true needs—and there are a lot of needs out there. There's no question about it—a lot of veterans' needs and you know where I've been on all those issues. But this thing has been in the works for so very, very long. Gentlemen and ladies—I would hope that we're going to, once and for all—

Mr. Chairman, I am not going to get anything specific here. I realize that.

But anyhow, before we finish up with this panel—hopefully, when you go around again or maybe you plan to cover it, I'd sure be curious—

Mr. ROWLAND. We'll come back.

Mr. BILIRAKIS (continuing). As to their opinion on some of the points made by the prior panel. Thank you, sir.

Mr. ROWLAND. We'll come back.

I do have a couple of questions I want to ask.

Mr. Fears, let me ask you this. VA's former chief financial officer maintains that since VA still has no meaningful guidance as to hospital missions, facilities, or free to plan based on local interest or desires often with no meaningful attempt to comply with system-wide needs. Do you think that conception has validity?

Mr. FEARS. Yes, sir, it does. I think there are some definite problems with that and that's why we're trying so hard to develop specific mission statements for every one of our hospitals.

The tendency in the past is for a hospital director to make the hospital, you know, "all we can be" in the VA. We think that we need to start working together as a system. And once the mission is established and the facility director is told to take that mission and be what he can be, that we will work much better in terms of many of our programs, our construction programs as well as our patient care programs.

Mr. ROWLAND. I have long been an advocate of allowing the local directors to have as much flexibility as they could have to properly

care for the veterans population in a specific area. But it's a lot more glamorous to have a tertiary hospital than it is to have a long-term care facility.

Mr. FEARS. That's correct.

Mr. ROWLAND. So, I guess in that respect, we need to look at system-wide needs on the one hand, but be careful that we do not impinge on local directors to the extent that the veterans suffer in that area. I don't know exactly where that medium is, do you?

Mr. FEARS. It seems to me that where you should allow the director to have the maximum flexibility is to do what he needs to do within the mission that's assigned to him. And hopefully, the system will look at that mission that's assigned to him and make sure that it is appropriate within the system. I couldn't agree with you more that facility directors need a lot of latitude and a lot of flexibility. But they can't continue to just operate as an independent entity when we as the veterans health care—we are a system.

Mr. ROWLAND. What is the mechanism in the system that would make the determination about what we need to be doing in a given area?

Mr. FEARS. The national health care plan that has been in the formulation for the last year, and there are some initial documents that are in with the change in Administration. We're re-looking at that in light of what the new Secretary wants to do.

Mr. ROWLAND. Well, you mentioned the national health care plan. In your personal view, are there some inherent weaknesses in that proposed plan? What are they?

Mr. FEARS. When you're dealing with a system as big as the VA, it's very, very hard to come up with missions. I think Ms. Quandt would tell you that when the Mission Commission looked at this—and Mission Commission, that's what they were supposed to be doing. They had a terrible time with it. It's just a very, very difficult thing to do.

I think some of the problems that we'll have with the national health care plan is the parochial interests of the Congressmen. I mean, they don't want to have their tertiary care hospital changed to a secondary care hospital, or they don't want their secondary care hospital changed to a tertiary care hospital. I think individual directors are a problem. And I think engineering change is the hardest thing. And I'm not so sure that we're at the point where we can engineer the change that we're going to need to meet the future needs of our veteran population, but I think we're well on our way. It's just very hard to do, very hard to do.

Mr. ROWLAND. You know, an outpatient clinic that I've heard a good bit about and how well and rapidly it was constructed was the one at Martinez in California. It was on a fast track with significant dollar savings.

What's your response to the suggestion that the design bill approach should become standard operating procedure rather than the exception?

Mr. FEARS. There were several things that really helped us in the Martinez outpatient clinic, and I hope that it is kind of a model for the future.

The first thing is, we had all the money right up front. We had an emergency and we came over and said, "we need \$25 million to

build an outpatient clinic and a nursing home." They gave us the money and we could just go with it. We didn't have to go through this thing that Congressman Bilirakis has pointed out.

Mr. ROWLAND. What did you say to them to get them to agree that quickly? I mean, maybe you ought to write that down so you don't forget it.

Mr. FEARS. We told them if there was an earthquake in Martinez and the building fell down, we were going to kill 2,500 people.

Mr. ROWLAND. I don't believe we can do that in other places.

Mr. FEARS. Yes, I think you're right. I wish we did have that sort of leverage. We're hoping that in our new construction process that we're going to be able to get some projects funded right up front.

We're recommending some pilots using contract management, where dollars are given to us up front and then the project is decentralized to the director. Then he will take the dollars that he has, working with local construction people, to build as much as he can possibly build with the dollars that are given to him. So, we are looking at those sorts of things.

Mr. NEARY. If I might comment on the Martinez situation, Mr. Chairman. One of the things that I think was critical to the success in Martinez is that there was a goal out there that everyone on the team could see. We had closed the hospital. The lives of the people were severely disrupted. VA Central Office people, medical center staff, the contractor that we were dealing with, the architect: everyone knew why they were there and it went very well.

We were also assisted by a very depressed market in Northern California and we got very good prices. We had a contractor who has told us that they viewed this as an opportunity for them to demonstrate their skills to others in the Northern California area. To show what they could do. So, it has been very successful and we look to replicate it where we can.

Mr. HUNKELE. Sir, on point with that, two things. One, Martinez was not a delegated project. It was done out of the Central Office by very highly skilled people. I don't think Martinez would have been able to do it themselves for a number of reasons.

The second point is your specific question: could we do design build everywhere or much more? Clearly, we can't do design build everywhere. You can not build a major hospital through design build. It's excellent for certain, what I'll call, medium to small projects like an outpatient clinic or a parking garage. It's also highly useful for maintenance and repair type projects at the medical centers and they're not using design build very much.

But we should not be doing large facilities. They're simply too complex. In order to protect the government, you have to write a specification known as a performance spec. It's very, very difficult to do on a complex facility of any real size.

Mr. ROWLAND. Thank you very much.

Mr. Bishop.

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

I don't have a lot of questions for the panel, but my question is very, very basic in terms of the veterans in the area of Southwest Georgia and East Alabama. Our veterans are complaining desperately that they just don't have access to the quality of service that they need. We've got some primary clinics that are outpatient fa-

cilities, but the closest facility is in Tuskegee. And it's very, very inconvenient for a large number of veterans that we have in the Fort Benning, Georgia area, the Warner Robins area, the Moody Air Force Base area, the Albany, Georgia area. There's just not enough available health care there for them.

What can we do to accelerate consideration for another facility, or for some additional facilities, or some cooperative relationships between the military facilities in that area? Our folks are really suffering there.

Mr. HAWKINS. Well, Mr. Chairman, I think one of the things we've been pushing for several months now and project that into the future, that certainly, one of our largest problems that we deal with is the outpatient care. And most of our clinics do have quite a long waiting list and we are projecting more satellite clinics, more storefront clinics on an outreach basis.

Part of the eligibility reform package that we have been working on for the last several months, will be an emphasis on preventive care and more home health care. I think as the eligibility reform package is approved by the Secretary and by the Congress, that will be able to provide a full range of care from preventive to home health care all the way through hospice care.

Mr. BISHOP. The eligibility reform that you're referring to, can I distill that into a suggestion that what you're talking about is just reducing the number of people you're going to serve?

Mr. HAWKINS. I don't think that's Secretary Brown's intent at all. From what I understand, his guidance has been to try to take care of as many veterans as we possibly can within the VA system. And as you know right now, we have about 27 million veterans in this country and the VA's market share of that right now is somewhere between 2.5 to 3 million veterans per year. And the Secretary's guidance has been to try to open up the VA system, as he puts it succinctly, in terms of trying to meet the needs of the veterans through various options of care.

Our current eligibility, as Ms. Quandt alluded to, is driven towards acute care. The process we're under now will place more emphasis on long-term care, psychiatric care and ambulatory care. And to certainly enhance sharing wherever we can with DOD facilities, as we're doing in several places around the country. We feel very strongly—I know the Secretary does—that anywhere we can, we should affiliate with DOD facilities or other facilities to maximize the resources available to treat patients and at the same time economize on the cost.

Mr. BISHOP. I like what you're saying and it seems to make a lot of sense. But one particular DOD facility that I'm familiar with, which is the Martin Army Community Hospital at Fort Benning, seems to be inadequate to meet the needs of its primary mission, which is the active duty personnel. Many of our retired people, our retired veterans who want to go out there and get care are just put in line on a tremendous waiting list.

Do you work jointly with DOD in trying to expand those facilities if you're considering a combined mission?

Mr. HAWKINS. Yes, we do. We have several joint ventures going now. Our first was Albuquerque with the Air Force. We've got one at Nellis Air Force Base that we're doing a joint venture with.

We're looking at Travis Air Force Base in Northern California, Tripler Army in Hawaii, and Richardson Army Hospital in Anchorage.

So, we have put on a real push to do as many joint ventures as we can. In some areas of the country like Fort Benning where you have a major concentration of troops and dependents and retirees, the facilities don't allow that. But in terms of expansion, just like in East Central Florida, we do have a requirement before we build or do anything to have a discussion with DOD in terms of what their plans are. And then if a joint venture is possible, that's certainly the priority that we go with.

Mr. BISHOP. One follow-up on that. I know, having talked with the Commanding General at Fort Benning, that it has been on their priority list for a number of years with DOD, to have a new hospital, more expanded hospital at Martin Army Community facility. It has not been on the front burner as far as the Defense Department is concerned.

I was thinking that in moving toward the joint venture aspect of it, if the VA were to get with facilities like the Commander at Fort Benning, it seems like that could be a joint push and it could serve the needs of veterans. You already have an existing facility and you're talking about a major expansion there for that facility, and you wouldn't have to start from scratch. That's how it would appear to me. I would suggest that you might want to look into that expeditiously.

Mr. HAWKINS. We'll be happy to. In addition to that, the other piece of the program that we deal with very aggressively is new sharing agreements with DOD facilities where they have excess space or where they have areas that we can refer veterans to, or on the other hand, they can refer beneficiaries or active duty personnel to us under the sharing agreement. And we have several of those going nationwide.

We will certainly pursue the sharing with DOD whenever we possibly can to meet joint needs.

Mr. ROWLAND. Thank you.

Mr. Tejeda.

Mr. TEJEDA. Mr. Hawkins, you asked the question that I asked the previous panel concerning services provided to veterans who live in rural areas?

Mr. HAWKINS. Yes, sir.

Mr. TEJEDA. Just to follow up on that, when you're determining the projects to fund, how does the VA weigh the needs of a rural population versus the needs of a new facility being renewed or expanded or upgraded? And also, assuming that the rural area demonstrates a need for a new facility and meets all the criteria. And as a follow-up to that, what are the major criteria for determining whether a rural area is in need of a new facility? Can that be quantified?

Mr. HAWKINS. Well, being a Texan, sir, and understanding South Texas very well, I can understand some of the issues that do exist in South Texas with the distance in the rural areas as well as the lack of even civilian facilities.

Mr. TEJEDA. Then, as you just mentioned, you're very aware that there are many counties in South Texas that have no primary care providers?

Mr. HAWKINS. Yes, sir.

Mr. TEJEDA. That have no private hospitals whatsoever?

Mr. HAWKINS. Yes, sir.

Mr. TEJEDA. And that the nearest VA hospital is in San Antonio, 200, 250 miles away?

Mr. HAWKINS. Yes, sir.

Before coming into this position I now occupy, I spent 15 years as the director of the Dallas VA Medical Center and worked very closely with Mr. Coronado at the San Antonio Hospital. Through our medical district there, we looked at the needs of South Texas. Again, going back to the thing that I mentioned earlier—and I did have the privilege of going down and helping to dedicate the new McAllen clinic. I know that we've talked about the Del Rio area and that part of Texas also, as being under-served.

But to answer your question more succinctly, what we do look at in the rural areas are the under-served areas. We try to meet those needs through either satellite clinics or community clinics or the thing that we mentioned earlier, is the mobile clinics that are being studied in several rural areas. I believe Ms. Quandt in her Mission Commission recommendations, also made the point that we need to look at, in those areas that are sparsely populated, any community resources that we have as an alternative, to provide an access to care under either a fee basis or if it's service connected, through the fee basis card.

But I understand when you don't have those facilities available to start with, it's even a double whammy in terms of access to care. But the demographics, the under-served area, the workload, and the proximity to VA facilities are the major criteria that we use in trying to locate storefront clinics or community based clinics, as well as satellite clinics.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. ROWLAND. Ms. Brown.

Ms. BROWN. Thank you. And thank you, Mr. Chairman for having this Committee.

Wherein construction is very important, I just want to say a brief word about operation and service. I would hate to tell Congressman Bishop that recently in visiting our facilities in my area, Lake City and in Gainesville, the VA hospital, the number of people that have come down from Georgia and Alabama, not because the services were not available but because of the quality of service. That is really disturbing and I think this is another time and another hearing, but it's something we certainly need to be looking into.

My question pertains to under the area of construction. I would like to see a list of projects that you all are requesting. In addition, I would like to see what factors—whether it was growth factors—how did the projects get on your list?

And in addition, I would like to know about the project that we've discussed over and over again, to the East Central Florida. Where is it ranked? Whether or not the money is in the budget this year for design and what we'll design?

And also, I want to know when you all develop factors—and you don't have to give me all of this at one time—but when you develop factors, do you consider the input from the community when they—like in Florida, when we did construction projects, we definitely took into consideration whether a community came forward and said “these are things that we will do if you all locate this project in this area.”

I think that's enough to start.

Mr. FEARS. Legislation that was passed last year requires that the Veterans Health Administration and our construction people furnish you just the information that you asked for. We're kind of struggling with exactly how to work it through the whole resource allocation, resource obtaining process, but that's, I think, kind of the reason for this hearing today.

So, we will be giving you a list of projects that we plan for 1994, 1995, 1996, and 1997. We will show you our priorities on those projects and we will tell you specifically how we developed those priorities. And it will take authorization legislation for us to have those projects funded. So, you will get into that.

By the way, I think it's an interesting process. It probably has been needed for a long time.

Another part of your question is, you talked about do we bring communities into the process? Yes, we do. And I think East Central Florida and the decision process that was gone through there was one of them. We did get a lot of community input from it. We do deal with the veterans' organizations, the medical community. There has been a lot of dialogue going on back and forth. We do look at that very, very closely.

Mr. HAWKINS. Let me respond to the East Central Florida question that you raised.

Ms. BROWN. Let me ask just one quick question. Do you consider the financial contribution from these communities?

Mr. FEARS. Yes, ma'am.

Ms. BROWN. Okay.

Mr. FEARS. Yes, ma'am.

Mr. HAWKINS. As I understand it—Mr. Neary can expand on this if he likes—the advanced planning fund that we have that is not a line item for a specific project, will be used to do the advanced planning for the East Central Florida hospital. Funds are available to do that starting this year, and we will pursue that once the final site selection is approved.

Mr. ROWLAND. Additional questions?

Ms. BROWN. Sir, I thank you.

Mr. ROWLAND. Thank you, Ms. Brown.

Are there additional questions for members of the panel?

Mr. BILIRAKIS. Well, Mr. Chairman, not to belabor, were you here when the previous panel testified?

Mr. HAWKINS. Yes, sir.

Mr. BILIRAKIS. If the moratorium were to take place as recommended, what would happen to these construction dollars that ordinarily we would have appropriated and allotted for construction?

Mr. HAWKINS. Well, that's an excellent question, Mr. Bilirakis because let me point out, on a short-term basis—and we're talking about fiscal year 1994 at this point as far as the construction dol-

lars and the budget that will be coming to you. Those recommended projects in the 1994 budget are going to fall, basically, in the areas that deal with building and safety codes, accreditation requirements, patient access, environmental deficiencies. And regardless of what happens to the national health care plan or reform, I don't think any of those projects would be affected.

Now, on the other hand, as we get into the long-term, as you heard Ms. Quandt testify, with a \$11 billion backlog in projects with something over \$200 million in minor projects and \$800 million with non-recurring maintenance needs, we have a major, major infrastructure problem of trying to maintain our old facilities. Any delay to our construction program would not help us in the long run.

I would point out that the issue that was raised by GAO as well as Ms. Quandt, in terms of building new acute beds, all of those projects that they mentioned: East Central Florida, Hawaii, Northern California are in the advanced planning stage and any changes that would occur as a result of the national health care plan or the national health reform planned by the White House, would still leave enough time to make adjustments to acute bed levels.

Again, going back to the Florida which I know you have an interest in, I would like to point out again that that is a secondary hospital that is being proposed there to meet, again, access needs of an under-served area. And almost half of those beds are psychiatric beds and, as you pointed out earlier, long-term care nursing home beds, and an outpatient clinic. So, I think when you look at those kinds of needs, certainly, again, Florida is severely under-served on psychiatric beds. They certainly have needs for ambulatory care and we don't see a lot of major changes that would occur.

What would be important, I think, is how we work with the DOD facilities. Just yesterday I talked with General Sloan, the surgeon general of the Air Force, about the joint venture with the Air Force. They still have an interest. And I think as we look at unfolding plans for the future that the VA construction program should continue and particularly focus upgrading existing facilities that need infrastructure, life and safety code requirements, and accreditation deficiencies, so that we can maintain some kind of movement.

Mr. BILIRAKIS. So, very quickly, Mr. Hawkins, what we're saying is that the usual construction dollars would still be there but rather than being used, if there's a moratorium for new construction, it might be shifted over to basically do some of the things that have needed to be done for years and years. Is that right?

Mr. HAWKINS. Yes, sir, that's correct.

Mr. BILIRAKIS. All right, thanks, Mr. Chairman.

Mr. ROWLAND. Mr. Tejeda.

Mr. TEJEDA. One last follow-up question. The same question I asked you a minute ago, you said you were familiar with the situation in South Texas. Have you ever had any requests for clinics or hospitals, or have you heard that there is a need for these facilities there in those specific counties that I mentioned? For example, Starr, Zapata, Duval, McMullen, La Salle, Frio.

When I asked you if you could quantify it, you said "well, we look at need and we look at proximity to other facilities." Is there

a mileage that you look at, or do you look at whatever other transportation may be available: trains, busses, conditions of highways? Do you look at the veterans population there? What exactly do you look for? And has there been a study? Is there a written study on the situation there in South Texas?

Mr. HAWKINS. Let me respond to part of the question and we'll ask Mr. Fears to pick up on the criteria, mileage, and so forth.

Yes, Congressman de la Garza has many times brought this to our attention. I know under the previous Administration, the Secretary personally took a tour of the area with Mr. de la Garza. We have done a study in terms of a hospital need for a location in the valley. I've asked the staff just in the last few months, because of additional Congressional interest, to re-look at that in terms of any changes towards a 1990 census is concerned. We are looking at that and are very much aware of the interest has been expressed many times in the past. That is one reason that we have a new clinic at McAllen that was opened last year.

Mr. TEJEDA. May I have a copy of that report?

Mr. HAWKINS. We'll be happy to furnish it to you, sir.

Mr. TEJEDA. And now on the quantifying?

Mr. FEARS. There are a series of things that we look at in terms of demographics, the number of veterans in the service area. We look at the incomes of those veterans. We look at the availability of community resources. We look at transportation networks. We look at just about all of those things that you've stated and that you indicated should be looked at. We do look at that when we determine these needs.

I think you have to remember that it's a very, very large country and we get a lot of questions like this. I'm not familiar with my office doing anything in South Texas. We have done a major study in Florida, a major study in Northern California, in looking at those things.

Now, when Mr. Hawkins said we look at the distance factors, it's a little different than I think the way it came out. What we look at is, we don't want to put outpatient clinics real close to hospitals who already have them. So, we do have distance criteria. They have to be away from the facility more than 75 to 100 miles, depending on the type of facility. We don't want to try to serve the same population with just an expanded outpatient care that's very close. So, we look at how far a proposed clinic is away from a hospital, so that you can get out and get more population in there to take care of.

Mr. TEJEDA. Is there any hard number in terms of there are 10,000 veterans in the area with incomes below \$8,000-a-year? At what point do you say, "yes, there may be a need" or "yes, we need to explore this further"?

You did mention the 75 miles from a major facility or a hospital.

Mr. FEARS. Right.

Mr. TEJEDA. In terms of numbers though of veterans.

Mr. FEARS. Okay, there's two kinds of clinics—community and satellite clinics.

But we look at that need that's out there and if there's a need for 3,000 to 25,000 visits, we say we'll put in a community clinic. If it's more than 25,000 we put in a larger satellite clinic. There is a

minimum number of visits that we look at. If the workload isn't going to be generated, we're not going to build a clinic.

Mr. TEJEDA. Well, let me ask you at this point because I'm a little confused. You say in terms of visits. If there are no clinics or hospitals in the area, how will you have visits? And you understand that if a hospital is 200 miles away, you're not going to have that many visits because it's a burden. It's problematic to some people to get 200 miles away, particularly when you're talking about some of the poorest counties in the nation.

Mr. FEARS. I understand that. It's a projection that we do. It's not an actual number that we look at.

Let's take South Texas for an example. We would take a look at the veteran population that's there. We would take a look at the resources that are available. We would take a look at the income level and we would project how many visits, how many patients we would take care of if we were to put a clinic there to see if there is a need for it. And if there is a need for it, then we would prioritize it with other studies that we've done for all other areas of the country. We would come forward with a request to put a clinic in South Texas if it was a high priority for the system. So, it's a projection methodology based on the things that you were talking about.

Mr. TEJEDA. Yes, I would like to follow up with a copy of that report and then I'd like to discuss this further with you.

Mr. FEARS. Certainly.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. ROWLAND. Ms. Brown.

Ms. BROWN. Yes, sir. In your comments, I think, Mr. Hawkins, you mentioned that you recently had some discussions with the Air Force. Would you expand on that a little bit because you mentioned Central Florida?

Mr. HAWKINS. Well as, I think, Mr. Bilirakis mentioned earlier about the naval base in Orlando—and we have no official information on that. Since the Secretary came on board, he has asked us to review with him the existing major projects, not only because of the operational cost but the construction cost.

He has asked us to reverify with the Air Force, their plans for Patrick Air Force Base over in Brevard to see if they still have an interest in doing a joint venture with the VA, and that's what we were confirming with the Air Force. They have come back and told us that they very definitely have a need in Brevard County at Patrick Air Force Base and would be very interested in a joint venture with the VA. They did caveat that by saying that because of the delay in the site selection at Orlando, that they had dropped this out of their budget for the next year or so, and they would have to reprogram or reevaluate their timetables of a line item budget request to be able to make a firm commitment.

Ms. BROWN. Okay. Mr. Chairman, just a brief statement. I would hope that in any decisions that you all make, you take into consideration when we're right-sizing and down-sizing, the contribution that the community is going to make. We don't know where the Air Force facilities or other facilities are going to be. But one thing we need to keep in mind is how we can stretch that taxpayers' dollar and get the most for our buck.

Mr. ROWLAND. Thank you.

I thank the panel this morning. You've been most helpful and we do appreciate you coming.

Mr. ROWLAND. Our next panel is Mr. Terry Grandison who is with PVA. And by the way, this is Terry's first appearance before this Committee. We appreciate him being here. Mr. Frank Buxton, who is with the American Legion.

Gentlemen, thank you very much for being here this morning. We do appreciate it.

Mr. Grandison.

STATEMENTS OF TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; FRANK BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF TERRY GRANDISON

Mr. GRANDISON. Thank you and good morning.

Mr. ROWLAND. We would ask that you limit your remarks to no more than 5 minutes and then we will cover any additional comments that you may have in the question period.

Mr. GRANDISON. Yes, sir.

Mr. Chairman and Members of the Subcommittee, I will address three issues in my testimony today. One, the VA Facility Development Planning Program, FDPP; two, spinal cord injury construction projects, and three, funding of VA construction programs.

The VA created the FDPP in the fall of 1987 to identify individual medical centers' current and projected facility needs. However, the FDPP approach has not yielded accurate data in a format VA can analyze, model, or update, as the system in the veteran population changes. The FDPP approach is costly and construction projects are unduly protracted. The typical time-line for major construction from design through completion is 10 years.

PVA recommends that an outside party evaluate FDPP and recommend a plan to implement a simple, efficient, and cost-effective process. Such a process should profile each VA medical center's construction needs and reduce the cost and time required to develop individual facility development plans. In addition, PVA urges a resumption of the quarterly VSO/VA Construction forum so that we may appropriately monitor the progress of much needed improvements.

In the area of spinal cord injury construction projects, PVA is dedicated to the completion of the Tampa SCI construction project. PVA, for almost 20 years, has discussed the need for this modernization and enlargement of this center. A series of VA planning blunders have long delayed the construction of this much needed clinical wing containing the expanded SCI center. Although the design stage of the project is complete, the required funds needed to complete the project have not been approved. PVA strongly encourages the Congress to appropriate necessary funds to complete the construction of this clinical addition and SCI center unit.

And lastly, PVA and the Independent Budget co-authors recommend a \$788.7 million major construction appropriation for fiscal year 1994. To achieve less funding in the fall of 1994 would be cata-

strophic, given the extended replacement cycle for facilities, rapidly changing clinical requirements, and the existing plants' excessive age.

Mr. Chairman, that concludes my testimony. I'll be pleased to answer any questions you may have.

Mr. ROWLAND. Thank you, Mr. Grandison.

[The prepared statement of Mr. Grandison appears on p. 90.]

Mr. ROWLAND. Mr. Buxton.

STATEMENT OF FRANK BUXTON

Mr. BUXTON. Good morning, Mr. Chairman and Members of the Subcommittee. We've submitted a revised comprehensive statement which we ask to be included in the record.

Mr. ROWLAND. Without objection.

Mr. BUXTON. The American Legion appreciates this opportunity to offer comments on the VA's medical construction program and its planning process. We would first like to welcome Doctor Rowland as the new Subcommittee Chairman, and those other members who are new to this Subcommittee.

As you are aware, Mr. Chairman, the Department of Veterans Affairs medical construction process recently underwent a major reorganization which united the operation of the VA's Capital Facilities Program with the Design and Construction Program. The American Legion believes that this reorganization could create a cohesive team concept which would focus on the prime missions of the VA. The creation of the Under Secretary's Construction Advisory Board would also provide needed oversight for the vital construction projects. We support these new concepts which would allow each medical center to play a more active role in the construction process.

However, Mr. Chairman, reorganization, in and of itself, will not resolve the VA's construction problems. Construction appropriations for major projects have not kept pace with the demand and rising costs. The American Legion believes that no less than \$600 million a year for the balance of this decade would permit the completion of necessary renovation and new facilities.

The VA has a national health care plan on the drawing board and this plan would hopefully allocate VA resources to provide care to the optimum number of veterans based on demand and on population density. Mr. Chairman, we and other veterans' service organizations, have repeatedly urged the Congress to revisit the issue of eligibility reform in the VA health care before embarking on any expansive or expensive reorganization and construction programs. The population of veterans to be served and the services to be provided can only be determined after the truly deserving and needy veterans have gained access to the system. The American Legion proposal for improvement of veterans health care offers such recommendations for change in eligibility.

Mr. Chairman, serious under-funding and cannibalization of major and minor construction accounts over the last decade have resulted in a backlog of approximately 800 uncompleted projects. The non-recurring maintenance accounts have suffered a similar fate. We're pleased to hear that President Clinton's economic stim-

ulus package includes some funds to help eliminate the backlog. However, we can not consider this windfall as quantity sufficient to solve all the problems of an aging facility infrastructure.

Mr. Chairman, the American Legion wishes to indicate our support for amendments to Title 38 of the U.S. Code, which would raise the contract dollar amount to \$5 million for designation as a minor construction project. Such a change would allow for expanded local control of construction projects, reduce the number of necessary contracts, and therefore, improve the timeliness and reduce the cost.

In fiscal year 1990, the VA indicated that it planned to convert 5,000 acute care beds within the system to long-term care beds by fiscal year 1998. The VA budget submissions had projected some 1,800 conversions through fiscal year 1993. To date, such conversions are at plus or minus only 1,000 beds with no bed changes expected in fiscal year 1993. The VA is now undertaking a cost benefit analysis comparing in-house costs to those who contracted care outside the VA.

Mr. Chairman, the VA needs to move forward in some direction soon in order to accommodate the expected increase in demand for long-term facilities. We suggest a thorough review of this situation to determine the path that the VA really intends to take. Mr. Chairman, that concludes our statement.

Mr. ROWLAND. Thank you very much.

[The prepared statement of Mr. Buxton appears on p. 94.]

Mr. ROWLAND. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Welcome, gentlemen.

Mr. BUXTON. Thank you.

Mr. GRANDISON. Thank you.

Mr. BILIRAKIS. I'm impressed, Mr. Chairman, with the fact that Mr. Neary and Mr. Hunkele are both here to listen to this testimony. Quite often our witnesses just testify, get out and leave and don't even listen to the subsequent—

Mr. ROWLAND. Let the record show that they are still present.

Mr. BILIRAKIS. So, I appreciate that personally, very much. I know that Mr. Hawkins was here and just left, and I think Mr. Fears left. I'm not sure.

Gentlemen, as you heard from the first panel, GAO states that Congress should proceed cautiously with construction of additional VA capacity until reforms to the national health system and VA's eligibility take shape.

Do you agree with this position?

Mr. BUXTON. Yes, sir, we do.

Mr. GRANDISON. No, sir, we do not.

Mr. BILIRAKIS. You do not.

All right. Very quickly, I don't want to take up all the time, but why do you not?

Mr. GRANDISON. PVA believes that a ban or a moratorium on major construction at this time is not practical. Currently, VA is not meeting its current construction projects on time and many veterans' needs are not being met. For example, many veterans are moving to the sunbelt. This is an area which VA should begin to focus its construction efforts because the general population trend

is congruent with that of the veteran population. But an abeyance at this time is not prudent and I think we should go on, for example, with existing projects such as the SCI center in Tampa.

Mr. BILIRAKIS. I guess I'm interpreting this recommendation as including projects that haven't really advanced to any degree, something where you've spent so much money already on design funds and that sort of thing. It's money down the drain, obviously, if you don't continue on with that sort of thing. So, I would hope that that is an accepted notion. But I would hope that that was accepted, or you know, that type of project was accepted.

Well, we've got to look at the real world here and the real world is that not only is the VA conducting its own national health care look-see, but it is also looking into eligibility reform. And of course, there's national health care reform that the Clinton Administration is looking at and Congress has been looking at for a year-and-a-half. I think everybody in this room wants VA health care to be completely separated from that, but VA health care may turn out to be incorporated therein. There are a lot of plans out there that would incorporate it. So, all of that has to be looked at, obviously, and be a part of the picture.

Let me ask you gentlemen, the opinion recommendation, if you will, of Mr. Baine of GAO—yes, it was GAO, where he recommended those demonstration projects and he picked three areas: North California area, Eastern Florida, and Hawaii, as demonstration projects for, I guess as I understood it, outpatient clinics that would be worked up in such a way that they would act as primary care facilities. And then they would determine where people would have to be shipped, transported, if you will, to West Palm Beach, Florida, and maybe military hospitals or whatever. But anyhow, as demonstration projects.

It's not a case of using VA facilities for civilians, but a case of conceivably using civilian facilities for some VA—mainstreaming, to use the Chairman's words. What do you think about something like that?

Mr. BUXTON. Well, if I may, Mr. Bilirakis, the American Legion has never really opposed. In fact, we support sharing of medical resources, regardless of whether they're community resources or DOD resources, Indian Health Service resources.

As far as demonstration projects go, I think we've learned over time that demonstration projects are not really that; that they end up being permanent projects. To repeat, the American Legion does believe that there can be enhancement of veterans' health care by sharing of medical facilities for the care of veterans. And I think we've mentioned that a number of times.

As far as the reference to outpatient care, I think that as far as health care is going in this country, we know that there's a move and a constant move more, and more, and more, and more to outpatient care. The fact that they're doing cholecystectomies through a tiny incision and sending the patient home the same day. I'm not suggesting we should do that, but I can say that there are many things that are done as inpatients in the VA health care system that could be moved to the outpatient scenario. Many, many things.

Colonoscopies, things that veterans are admitted to the inpatient side simply because there's no way for—well, a couple of things. One of them is that the VA hospital gets credit for that being an inpatient. That's an aside. Also, there are no real good outpatient facilities that could handle simple procedures like that if we're going to be concerned with patients' safety.

So, I think that we could say that we would support any kind of move towards outpatient care—more and more use of outpatient facilities. And, if these demonstration projects are an example of that, then we applaud them.

Mr. BILIRAKIS. Okay, whether they call it demonstration projects or whatever, the point is that the American Legion would be supportive of contracting with civilian hospitals, civilian resources, and of course, military, right?

Mr. BUXTON. Yes, sir. If we can be assured that that does enhance the care of veterans, then we certainly would support sharing military and community resources.

Mr. BILIRAKIS. Mr. Grandison.

Mr. GRANDISON. Congressman, I don't have that particular information with me today, but I'd be more than glad to provide that information later.

I will say this for the record, that PVA does support sharing arrangements with the Department of Defense. We are aware of the aging of our veteran population in the terms of long-term care, hospice, and respite care. In our Strategy 2000 document, which was released last year, we took the position that we must look to other alternatives such as outpatient care—more outpatient use of our VA facilities.

Mr. BILIRAKIS. Possibly use of civilian facilities also?

Mr. GRANDISON. I don't have any information to make a statement—

Mr. BILIRAKIS. In general, we know and we've discussed it up here earlier, that the veterans' organizations have been very much against mainstreaming, and we're aware of that. I guess what we're saying is, are we all going to open up our minds—and not for one moment saying hey, it's going to be done—but just open up our minds to other alternatives and other options. I guess you're both kind of saying that we probably will want to be open-minded so far as these things are concerned, right?

Mr. GRANDISON. Yes, sir.

Mr. BUXTON. Mr. Bilirakis, I would say, if I may, Mr. Chairman, we do not believe that the entire veteran population ought to be vouchered into the private health care system. That's not what we support. We support the maintenance of the VA health care system as the primary source of care for veterans.

Mr. BILIRAKIS. Of course.

Mr. BUXTON. With that in mind then, if there is an access problem for veterans, in fact, we support the suggestion that they might go to contracted care. If I may, I would like to clear up my emphatic no when you asked you asked your construction question—we're not insinuating that all construction in the VA should come to a screeching halt, but we feel that the eligibility reform problem has been dragged out and dragged out and dragged out. The numbers are there.

Everybody knows—Mr. Vic Raymond's group has come up with the alternatives. They put dollar amounts on them. It mystifies us as to why we can't just move ahead with what we envision—and maybe we're being over-simplistic with an eligibility reform package that would give us a clear picture of what the needs and demands are of the veteran population. And then we can initiate new construction programs and so forth. I did not want to insinuate that we were going to stop all—

Mr. BILIRAKIS. Thank you, sir. My time is certainly well up.

Thank you, Mr. Chairman.

Mr. ROWLAND. I called you Mr. Chairman there. I'm so used to saying Mr. Chairman to somebody else.

Thank you, Mr. Bilirakis.

Let me just ask one question here, if I may? Mr. Buxton, could you explain more in detail, what you're proposing in recommending a full review of long-term care within the VHA?

Mr. BUXTON. Well, those words, perhaps, are to insinuate that they need to look at long-term care in more aspects. They're going back to another cost benefit analysis. They should have done their cost benefit analysis before they ever started their construction programs or the conversion programs for long-term care beds. So, we have to assume that they've already done that.

I think what we're saying is that long-term care needs need to be defined and defined very rapidly, and to move on to them. We have the actuarial information to tell us how old veterans are going to be 10 years from now, and we can project how many beds they're going to need. To sit around and do cost benefit analyses or to drag our feet in moving from acute care to long-term care beds warrants somebody to look at the process and say, "What's the hold-up? Let's move ahead." And that's what we mean by taking another look at long-term care.

The VA presently, as you know, is the only one that's including any kind of long-term care capabilities in their projections for health care reform, whether it be national or under the VA's health care plan that they're putting forth.

Mr. ROWLAND. Mr. Grandison, let me ask you this.

Mr. GRANDISON. Yes, sir.

Mr. ROWLAND. You see flaws in the prototype design of VA nursing homes?

Mr. GRANDISON. Yes, sir. The designs that PVA is aware of, are exceedingly large. For instance, the basic internal layout of the prototype nursing homes does not utilize optimal positioning. For example, the nursing station is in such a position where the nurse must walk a great distance just to interact and interface with the patients. So, therefore, it is not a very appropriate utilization of internal space.

Secondly, the external component of the facility is very large and occupies a great deal of land, and it does not efficiently utilize land management. We believe at PVA that a proper design could be found in the private sector by following private sector methodology in designing new nursing homes without the excessive land use and inefficient internal layout.

Mr. ROWLAND. So, you do see some designs that would be less costly?

Mr. GRANDISON. Yes, Mr. Chairman, there are designs that are out there in the private sector which we do believe are less costly than the existing designs, and more efficient.

Mr. ROWLAND. I want to thank both of you very much for being here this morning. We do appreciate you coming.

I want to thank Mr. Bilirakis for staying during the entire hearing.

We stand adjourned.

[Whereupon, at 11:50 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN ROWLAND

This morning's hearing is a particularly important one. It will prepare us to review with sharper focus the Administration's FY 1994 budget request for medical construction funding at our upcoming budget hearings. And it will provide us a framework for exercising a responsibility given this Committee in law last year, namely to develop and report out a construction authorization bill.

One point should be acknowledged from the outset. We are tackling a broad and complex subject when we review a national medical construction program with an annual budget of several hundred million dollars. We're likely to hear some strong and possibly divergent views on its strengths and weaknesses. We need to appreciate that many hands get into the construction process—from the directors of VA medical centers at one end to congressional appropriators at the other. Each plays a role in a process that seems often to take too long and to be too costly. At the same time, if we're to avoid repeating mistakes, we have to acknowledge that they've occurred.

To illustrate the issues before us, consider that a major medical construction project can take fully *ten* years to move from conception to completion. Delays, and with them higher costs, can occur at numerous points, and often for reasons beyond VA's control—whether due to failure to appropriate funds at the earliest time or to adjust for significant changes in medical technology, for example.

Some of the questions before us are not new. VA itself has gone through seven different studies of its construction process and organization over the last two decades. And it went through a major reorganization last year. We certainly want to learn whether the reorganization is meeting its goals.

But VA has yet to make as much headway as we would expect in its planning role. In fact, VA's construction process and its planning process are simply not "in sync", in my view. To illustrate the point let me read from the Department's own reorganization report: "The objective to have a timely and cost-effective construction program is critically dependent upon the completion and implementation of the National Health Care Plan which establishes the mission of each VA medical center." In other words, to make intelligent decisions about future construction at any VA medical facility one has to know what role that facility will play. Should a given hospital be exclusively a high-tech acute care facility, or should hospital bed space be converted to provide a specified number of nursing home beds, for example?

The former Secretary and his chief medical director talked for several years about restructuring the VA system to meet the changing needs of aging veterans. The Secretary even established a blue-ribbon advisory commission to aid in that effort. Assigning each hospital the mission it will be charged to carry out—whether it's primarily long-term care, primary care, high tech, or some combination—is a first step toward real planning for the future. No one disputes that that's a necessary step and one VA is certainly technically competent to carry out. Unfortunately the prior VA management appears to have abdicated that responsibility.

What I think we'll learn today is that VA has no *real* national plan that identifies precisely the role each VA hospital will play in the future. Absent that framework, individual hospital directors have an incentive to try and expand their hospital's role beyond what the system can justify. That problem has substantial implications given what's at stake.

We should explore several big questions this morning. How can we assure that we're really building intelligently for the future? Can we achieve greater timeliness in the construction process? Can we do more to contain costs? What can we learn from the private sector?

In looking to the future, what implications does the development of national health care legislation hold for VA and for the need to build new hospitals? The General Accounting Office has recommended that VA and the Congress consider limiting construction of additional acute care capacity until the impact of anticipated national health care legislation on VA can be assessed. The competition for the relatively limited funding available for major construction may well compel us to examine the GAO recommendation closely. But I'm concerned about GAO's related proposal to contract out veterans' hospital care—which sounds to me like “mainstreaming.”

I think we'll learn this morning that the VA system has far-reaching construction needs. And I hope this hearing—as our first step this Congress—will move us forward toward addressing them. In doing so, I would only add a concern that as this Committee exercises our responsibility to authorize construction projects that we not permit politics to override the priority needs of our veterans.

PREPARED STATEMENT OF HON. BOB STUMP

Good morning. It is a pleasure to be here at the first meeting of the Subcommittee on Hospitals and Health Care. I want to take this opportunity to welcome you Dr. Rowland as our new chairman and tell you that I very much look forward to working with you this session. You have always been a strong and faithful defender of veterans' health care programs and the veterans of this nation will be well-served with you as chairman. I want to also welcome this subcommittee's nine new members on both sides of the aisle.

Mr. Chairman, as you know, the future of any health care system is dependent upon the ability of the system's facilities to provide access to individuals seeking health services. In fact VA's construction planning process is an integral element of over-all VA planning. Therefore, this hearing is a very important one to assist in this subcommittee's deliberation of VA's future course.

For as long as I can remember, the VA has had problems with its construction program. For many of the reasons already identified by the chairman, it is a VA program which has had a lot of critics and very few fans.

Now on the verge of national health reform, the VA's construction program must become more responsive to the changing needs of veterans and the budget realities of the system.

Yet, VA itself has no national health plan, although the agency has been working on one for many months. So this subcommittee is missing two documents which are essential to Congress in fulfilling the obligations established by P.L. 102-405, the 5-year construction plan and the VA's national health plan. Today I hope to find out why.

The hearing will focus on VA's construction planning process and how construction projects are prioritized. How does VA ensure that construction resources go where they are most needed? In times of severe budget crisis, VA must be more interactive in its planning. VA cannot continue to exist in isolation. We are told VA is participating in the national health care debate. I hope it is not overlooked.

Mr. Chairman, I look forward to the hearing and want to thank the witnesses for their testimony and participation.

STATEMENT OF
MARJORIE R. QUANDT
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
U. S. HOUSE OF REPRESENTATIVES
March 3, 1993

Mr. Chairman, you have asked me to review the Construction Program of DVA and the planning processes leading to it. My comments will be based on the work of the Commission on the Future Structure of Veterans Health Care (CFSVHC) and my experience in various assignments while an employee of DVA.

Dr. John Ditzler, a former Chief Medical Director, took umbrage at my colleagues and me when we would proclaim, "This is not a patient care program; we are here to build hospitals and clinics." That remark made in moments of exasperation was probably no more unkind than Dr. James Mongan, a member of CFSVHC saying, "...we ought to make it very clear that we think there is some goofiness in the present way that VA handles its construction." Or as Mr. Walter McNerney, another Commissioner noted, "It is hard to find a more pathological system. We ought to have the courage to say that."

The physical plant assets of DVA's VHA approach in value the cost of operating the system. In 1990 those assets represented almost \$14 billion. Because of slippage in maintenance and repair, age of buildings and shifts in veteran demography it would cost more than \$11 billion to update existing buildings. It would require more than another \$1.2 billion to correct the minor miscellaneous and non-recurring maintenance projects in facilities. Annual budget appropriations in either Construction or VHA have not approached full funding.

PLANNING PROCESS

It was a shock to members of CFSVHC to learn that construction did not seem to have anything to do with operations. They were stunned that a decision could be made to replace or modernize a VA medical center, build it, but then have to scramble for enough FTEE to operate it.

Why Does This Occur?

Part of the difficulty is the size of the bureaucracies in VACO. Until a recent reorganization there were more specialists whose primary concern is construction than those specialists in VHA headquarters. (See Attachments A and B) The construction group assigned to VHA is half the VHA FTEE in the new organizational alignment. The relationship is not always collegial. Historically the Construction arm has held to certain requirements when the medical program was requesting different configurations. For example, VA routinely built 1000 bed hospitals when others thought them inefficient; it built 750 bed facilities long after others found them uneconomical. Part of the cause was in "standard plans." Construction currently clings to the VA Hospital Building System even though VHA, the Assistant Secretary for Finance and Information Resource Management (ASFIRM) and others are willing to utilize a more flexible, faster system.

An August 25, 1986, Inspector General (IG) report of the Construction program determined that efforts to realign

construction planning should include steps to address efforts to improve project justifications so that issues supporting a project's need were better defined; the cost vs benefit should be properly evaluated. The support of projects based on overstated workload projections and bed needs should be avoided, including unsupported adjustments made to the VA/GAO bed sizing model. Alternative solutions for correcting identified problems must be developed to be certain the most cost effective solution is used. Re-evaluation of project justifications sometimes done several years prior to funding is necessary to avoid using outdated information no longer reflecting current needs or operation. It is perhaps time for the IG to do another assessment to determine if there has been improvement.

Two sources of planning lead to Construction's development of its long range (5-year) plan. One is the capital facilities plan (CFP) and the other is the facility development plan (FDP). The first is carried out by local VAMC engineering service to ascertain deficient conditions to operate the VAMC/F. The CFP is a technical review. It is reviewed by the Director and then sent on to the Regional Director. Information is used annually to develop the minor miscellaneous and non-recurring maintenance budgets. The CFP also serves as a source document for the FDP and becomes a part of it.

The FDP process is to provide a systematic approach to establishing a comprehensive plan for physical plant development of a VAMC over a specific long range planning horizon to the year 2000. The final plan for each facility is to develop more fully a selected strategy, showing the physical location of services and functions through block plans, including site plans to show planned land use, phasing plans with independent and dependent actions and logical groupings of actions and costs. The FDP is to be flexible enough to accommodate changes in new modalities of care, missions and demography. A major use of FDPs is to develop a national facility planning data base and allow VA to respond quickly to understanding changes in the opportunities and/or limitations existing in VA's capital facility and real property infrastructure.

Thus planning starts at the local level based upon directives from Central Office. Until the recent realignment of functions there was joint responsibility for FDPs. I would judge the capital facilities plan far more accurate since it has almost direct impact on current operation. The FDP is often seen as an extra chore, especially since directors are still required to program patient care plans over a five year period. The latter plan is internal to VHA and uses many initiatives from the old district initiated planning process.

The FDP process is data-information gathering intense. The management team at each hospital oversees the study process, and the brunt of the work falls to the VAMC members. This can only be looked upon locally as "other duties as assigned." It must be a labor of loyalty as no hospital can be certain its projects will be funded in a timely manner. The FDP process utilizes a contractor whose staff facilitates development at the local level. The statement of task for the contractor is 28 pages and I find it difficult to picture how the voluminous reports can be integrated to a working data base. The cost of the FDP contract is \$30 - \$40 million dollars for 159 hospitals.

I recall some FDPs coming in without regard to the VAMC's role. Many of us saw these FDPs as wish lists to increase scope and operating dollars. Currently the VHA Planning Office lacks the travel dollars to consult or assist with FDPs. This may be by design. Regional planners cannot control or provide the discipline for a rational plan. Regional Directors have been delegated the responsibility for the five year facility plans. Staff in the office of the Deputy Assistant Secretary for Budget (DASB) consider the material in FDPs too old when it is received, facilities are over designed and over specified, and the process is inflexible. Others consider the material comes in in unusable form, impeding good evaluation.

The IG's September 24, 1992, report of the FDP activity illustrated shortcomings and need for improvement. The IG concluded the FDP system does not achieve the goal of enhancing and improving the integration of VA's capital facilities planning with medical and administrative planning. The justification and rationale for FDPs is essentially sound in concept, but the methodology used to estimate future program and facility requirements needs improvement. Optimum benefits are not achieved from implementation of FDPs because of the potential for program and facility mission changes, and the resultant plans lack flexibility to respond to significant changes in modalities of health care. The IG did not consider the FDP process fully coordinated with other program planning initiatives. Thus, plans could cause unnecessary building and could be inconsistent with the future structure of VA health care. There are those throughout VHA who believe FDPs should be stopped until better plan coordination can be accomplished.

What About the VHA Planning Model?

This model is sometimes called the bed sizing model. Some revision was started two to three years ago, but is not complete. This is also not an integrated model. By that I mean one could not run a formula for an integrated continuum of care at a facility, nor do I believe it can yet be done for a network of facilities or a geographic service area. VHA lacks sufficient computer capability for that. As of now there are no FY 1992 patient data in the model, nor is the updated 1990 census file with veteran projections for the next 40 years available. These are not to be provided until late summer. Therefore, any demographic planning will not be too current until the FY 95 budget. The model generally lags behind the speed at which the delivery system changes.

The VHA planning model uses private sector length of stay (LOS) experience for acute care. VHA LOS experience is used for nursing home, outpatient and domiciliary planning. The model has not been able to keep up with changing care patterns, especially in the shift from inpatient to outpatient and the changes in the domiciliary program. There are, for example, rehabilitation doms, homeless doms and traditional doms. Each has somewhat different use rates, LOS and episodes of care. DASB staff do not see this part of the planning process improving. They state it costs as much as the construction process and results are not satisfactory for veterans needs. Because a solid veteran population, needs based model is not the primary factor, local facilities have not always followed veteran demography in planning.

The IG has been critical of the planning model, and the major complaint of "liberal" LOS trends has been addressed. It was my opinion when serving as ACMD/Director of Planning for DM&S(VHA) that it would take about half a million dollars in consultant fees, simulation exercises and travel to really bring the model up to date. This was not a high budget priority at that point in time, and the effort not undertaken. Any changes could be called nibbling at the margin.

Prioritizing Projects

In June 1984, the Senate Appropriations Committee forced DVA to use a prioritizing criteria for construction projects. It was developed by a work group from VHA, Finance and Construction. A 1986 IG study found flaws in the model dealing with unclear guidance leading to inconsistently ranked projects and the use of some data which was not considered accurate. Criteria for rating environmental/patient privacy projects did not properly measure existing deficiencies. The basis for developing and assigning weights to program categories was considered questionable. IG also advised that the practice of assigning only one weight to projects that had multiple program categories should be reevaluated. The methodology was revised again about FY 90 to include National Cemetery System and Veterans Benefits Administration needs. The Secretary's

weights were changed to favor infrastructure as opposed to replacement hospital values. The revised methodology guide which incorporates the changes also attempts to address in a continuing fashion the IG recommendations. The guide is 119 pages of complicated, detailed formulae. Knowing the grades of field personnel, I would not be surprised if errors still might occur. Regional Directors now prioritize projects in their Region. After all projects are received the master priority list is made for the Secretary's budget recommendation.

DASB staff still are not satisfied with the procedure. It is claimed better prepared VAMC directors get the projects, something of an old boy network; that ranking is skewed to acute care and there is a bias against some programs such as psychiatry or intermediate care. There may be some truth to that charge. CFSVHC found that in FY 1991 the construction appropriation was allocated as medicine and surgery 58%, psychiatry 5%, nursing home 4%, intermediate care 2% and other 23%. The latter encompasses such activities as asbestos abatement, seismic correction, current design fund and hazardous waste material abatement.

WHY ARE REPLACEMENT OR MODERNIZATION PROJECTS SO COSTLY?

There are a myriad of reasons. Some of them are: the age of the facility being replaced, changes in medical technology, shifts in the patient care delivery system from acute inpatient to nursing home care or outpatient care, accreditation requirements such as closed end stairwells, OSHA - asbestos abatement, veteran demography, historic site designation, land restrictions with reversion clauses, and uncontrollable and controllable issues.

Some of the uncontrollable conditions are about 16 federal requirements generic to government such as "buy American" and small business minority set asides; there is congressional interest or intervention. A delay in the budget or appropriation of too little money are also uncontrollable costs. OMB may periodically force certain requirements such as downsizing.

Congressional impact comes in favored projects which may not meet population workload criteria (Victoria OPC) or changes in priorities beyond DVA's request through directive report language. The major construction appropriation is seen as particularly susceptible to this, and further compounding the problem is the requirement "to do within available funds." As much as 10 per cent of the construction budget can be skewed by Congress in a fiscal year.

The interests of affiliated medical schools also impact major construction. In my mind, the worst case is the Gainesville facility. This facility was originally planned to incorporate psychiatric beds and services. At the time psychiatry was not of especially great interest to the medical affiliation, and the hospital was reconfigured. The demand of veterans for psychiatric care in their state, rather than travel to Georgia or Alabama, is finally being addressed. This will be at a highly inflated cost compared to the original, proposed construction.

Controllable costs are within DVA. Some of these are VA requirements, construction standard, technical design criteria; equipment guide lists, standard details, construction specifications, site compatibility, program space requirements, collocation of nursing home or VBA regional offices, and a policy decision on building.

That policy decision is worth noting. It came about after building San Diego. The VA Hospital Building System reliance on interstitial space adds \$10 to \$15 more per square foot. While this technique is vital to areas where technology will change rapidly over the life of the building, it is not vital

to areas such as administration, parking garages, canteens, or some bed areas. Requiring the entire facility in one "envelop" adds to cost, as do increased weight bearing footings in case later floors are built. The VA appears to build for 100 years while most private sector facilities are built for 25 years. When I joined VA the life cycle of a building was to be 40 years. At some point OMB is quoted as advising VA to just keep on using the buildings--hence the 100 years.

Change orders are another cost push. These occur because money is not always available on time during the construction cycle; the workload changes during construction, or new programs are added beyond initial design. If these are major changes the whole project might be refigured and rebid.

DVA standards, specifications and space criteria are generally more restrictive than the private sector leading to higher costs. There are standards for net size on a room-by-room basis for new construction and leased projects. Some of these are empirical consensus based standards.

The length of the planning-construction process is another factor adding to cost. The planning cycle for the Hawaii VAMC is now approaching 20 years, I admit I must bear a piece of the blame. CFSVHC observed that it takes 5 - 10 years to complete a major construction project, 2 - 4 years for minor construction, 1 - 2 years for minor miscellaneous projects and one year for non-recurring maintenance efforts. Twenty five per cent of major construction projects take five or more years with the average being 3 to 4. Commissioners noted that any building taking more than five years to build would be obsolete when opened because of changes in technology.

WHY DO REPLACEMENT FACILITY RECURRING COSTS RISE?

This is a frequently asked questions since one assumes a supposedly state-of-the art, more efficient building would have economies of scale. There are several reasons a VA replacement or major modernization project costs more to operate. Such projects are taken as an opportunity by local management to make up for staff shortages. It is catch-up time. By building bigger than the current facility more workload, more staff and programs will accrue to the facility. Catch-up time has been particularly desired because the activation fund formula contained richer FTEE allowances than existing operations formulae. There have been some efforts to revise the activation formula, but I cannot tell you how successful they have been.

The Reality of Zero Sum Funding and Activations

VHA budget staff take activation fund requirements from facilities and build them into the appropriate fiscal year current service budget requests for the year of activation. If Congress appropriates the funds all is well. If Congress does not appropriate the necessary funds - and that has been more common in the last several years - two things can occur: one may have a newly constructed facility sit empty or partial funding (FTEE) may be allocated over several years. Either of these last examples leave the local director in a most untenable position. He/she takes the heat.

Mr. Anthony S. McCann, former ASFIRM, saw this as a self-defeating practice. He pointed out to the CFSVHC that between FY 89 and FY 90, 950 FTEE were added to support new initiatives with a similar number assigned in the past years to such initiatives. Existing VA facilities, also with growing workload, had to compete within a continually declining pool. While it is true these FTEE were for new outpatient clinics, this withdrawal from the operating pool added to the phenomenon of closed beds. To drive home his point the Assistant Secretary provided a chart which showed that between FY 80 and FY 2005 about 38,000 added FTEE will be required for activating construction projects. At the time of his briefing the total

congressionally approved FTEE for medical care were capped at 194,638. Assuming that the cap remained at that level, one fifth of medical care baseline FTEE would be re-allocated for activating construction projects by 2005. Such a high percentage would further compound local management's operating a facility with certain modalities increasing, such as outpatient and nursing home. (This is what caused some of us to claim we build hospitals/clinics we don't take care of patients.)

Commissioners were so dismayed by this finding they concluded if 100 new beds were to be opened in one facility, one hundred beds would be closed in another facility. In other words move the FTEE, and only operate staffed workload. Another solution was not to build unless additional staff dollars for the new facility are guaranteed.

CFSVHC RECOMMENDATIONS AND RATIONALE

Commission members with considerable experience in managing construction of health care facilities were appalled at a system they found to be inflexible, cumbersome, uncoordinated and not necessarily responsive to veteran needs. They voiced a concern that the construction program had gone too far and now that it was urgent to find money to keep clinical care up to date and of quality the construction system could not be tolerated any longer. There was complete lack of confidence on the part of some commissioners that VA could build in a reasonable range of time. Adoption of a protocol closer to that in the private sector was deemed a necessary solution. There was a firm belief by all commissioners that local management should have considerably more responsibility in construction and be held accountable to bring projects to fruition on time and within budget. If done under budget and still meet requirements, there should be an incentive reward system. Maximum flexibility was to be given to local and national managers in terms of delivery of service. Locking into expensive facilities which tend to control access and cost of care are to be avoided.

The strategies of eligibility for care, the health care program to be offered and construction must be interlinked. The health care program discussed by the commission opted for more long-term care, home care and outpatient as opposed to in-hospital aspects. Construction in the future was to be driven by the eligible population and appropriate care as opposed to perceived log rolling and narcissistic objectives. Construction of a facility was an absolute last resort after leasing, sharing or buying existing space was considered.

The primary recommendation of the commission deals with construction and the secondary related recommendation applies to equipment:

Recom. 3d That VA develop alternatives to the current construction program, such as leasing, lease purchasing and sharing. Where VA construction is appropriate, new procedures should be implemented.

Recom. 3e That VA rely on leasing, lease purchasing and sharing of medical equipment--where feasible--rather than purchasing.

Report 102-107 from the Senate Appropriations Committee in July 1991 noted that several projects should not be funded until the Department is better able to manage the escalating costs of the construction program. Concern was expressed that numerous VAMFs were being constructed, costing the taxpayer hundreds of millions of dollars, without any coherent systemwide plan which guides the construction program. It is apparent the Committee understood the hazard of zero sum funding and activations. Concern was also expressed that the construction program was not in sync with DVA's ability to provide adequate

staff and equipment for new facilities. Another point of displeasure was the fact that despite attempts at reforming the program there continued to be excessive construction cost overruns.

Another flag of congressional concern appears in the House Appropriations Committee Report 102-902, dated September 24, 1992. This is the requirement that a VAMC Director approve that a construction project's design is acceptable from a patient care standpoint.

A special task force was appointed by the Assistant Secretary for Acquisition and Facilities (AS/A&F) to respond to CFSVHC recommendations for the Secretary. Rather than approach the commission's goal of a very much reduced Construction staff and function, the existing organization was split apart. The former facilities activity renamed Construction Management was transferred to VHA to be supervised by a newly established Associate Chief Medical Director. The remaining staff was left in the existing office of the Deputy Assistant Secretary for Facilities (DAS/F). The only limit placed by Congress on this re-organization was that resident engineers and staff assigned to regions were not to be paid from medical care dollars. The Office of Management and Budget placed the requirement that the funds and FTEE would be accounted for separately. There is now a MAMOE A and MAMOE B account and the twain do not meet.

Cynics have noted when you do not want something to happen this is the way to do it. Those involved in daily headquarters activities do not find enhanced cooperation. In fact there is said to be no sharing of data bank information from Construction Management to other concerned VHA offices. There is some feeling that the Construction Management group is working to get back to the DAS/F organization.

SOME POSITIVE CHANGE IS OBSERVED

While the re-organization may not be what the commission envisioned, or many staff desired, there are some small changes in the right direction. The fast track design-build Martinez OPC is seen as a success. It saved \$15 million and was activated at least three years ahead of the target FY 96 activation date. The success and speed of this project is much like that of one of the original delegated projects in the mid-eighties. The first teaching nursing home, Ann Arbor, was a delegated project brought to completion on a fast track and at a savings of \$2 million. It is regrettable delegation did not become standard operating procedure.

There is a current move to more delegated projects. I have been told that the Temple project will be handled this way. Other projects have been subject to the cost containment concept for accelerated, widespread construction. The Wilmington OPC, Marion, IL, OPC and the Dallas clinical addition are other examples of this concept. With the cost containment system critical needs are unbundled from a large, complex replacement scope. The concept is based on the assumption that competition for funding should be brief so that planning is purposefully limited. Medical centers can compete for projects within defined cost categories: less than \$10 million, \$10 to \$20 million, \$20 - \$50 million and greater than \$50 million. Regional Directors and Central Office make initial screens of the project, after which medical centers develop design programs refining the scope and project requirements within the given cost category. If satisfactory this all leads to a Memo of Agreement which receives the respective administration concurrence and the Secretary's approval for budget development. FY 96 is to be the first budget containing projects developed in this manner.

Mr. Chairman, I would like to think the above progress is a transition to the commission's plan to get Construction out of the construction business.

OTHER TRANSITION NEEDS

If there is to be more delegation to local management to carry out construction or modernization, there is need for training of field personnel. Directors must be trained to total asset management, not only staff and supplies, but physical plant and land in order to meet local veteran population needs with quality and economy.

Engineers, their staffs, and contract specialists require greater training in contract administration and compliance. Some increased costs are caused by a reluctance to get rid of an improperly performing contractor. I would not want DVA to return to the instances of the Blackhawk Construction problems.

Last year I urged this Committee to allow local management to use the physical plant to "earn money" which could be used to offset backlogs in non-recurring maintenance and equipment.

The February 22, 1993, WALL STREET JOURNAL reported that according to the American Hospital Association 310,000 of the country's 925,000 hospital beds are empty. Over 322 private sector facilities have closed, and others are seeking mergers to stay solvent. VHA is in a similar position, except it cannot close hospitals, and its mergers are not as effective as those in the private sector. It has been almost a decade since VHA operated anywhere near the number required by Congress, let alone those authorized by the President. Facility directors should have broader delegated authority to lease buildings or land to private sector entrepreneurs to acquire funds to help operate the facility. If Congress cannot appropriate the necessary funds to care for an aging, chronically ill, more intensely, acutely ill population, such a move is vital.

I am aware of this Committee's great concern and vigilance in guarding real estate. You were instrumental in the FY 88 prohibition of declaring land or property excess in PL 100-322, even though there was a Presidential Order requiring a survey and declaration of excess land and buildings not needed in a program. Between FY 50 and FY 87, DVA reported 33,950 acres as excess, but none since 1988. Congress was protecting Sepulveda where an acre of land is worth half a million dollars, and the West Los Angeles campus which is valued at three million an acre.

I do not mean to be a heretic, but if DVA sold the entire West Los Angeles campus of 442 acres to developers it would receive at least \$1.3 billion. This would allow DVA to build several ambulatory care/ambulatory surgery centers and nursing home units throughout the Los Angeles basin closer to the veteran population. There would be sufficient funds to build a truly modern 300 bed acute facility also closer to the veteran population. With lowered VA building costs, one might even have enough left over to wipe out a sizable portion of the non-recurring maintenance backlog of all facilities. I admit DVA would lose its oil well.

The golf courses of DVA were built for rehabilitation of WWII veterans. They are reaching an age at which they will not play much longer. Use is diminishing and golf courses are seen by many as an employee perquisite. If the lease of the golf course at North Chicago were renegotiated, there are 45 acres which have prime value to a developer in Lake Bluff. The same could also be said of the Northport course.

I recognize all of these would be one-time sales, but when one has watched the backlog in ordinary maintenance and repair and desperately needed patient care equipment mount for almost a decade, Congress is requiring DVA to hang on to a superfluous luxury while DVA starves for resources and quality of care is

compromised. We must remember that the projections for patient workload flatten out and then begin to drop off after 2005. Land will be even more of a luxury.

DELEGATE TO THE LOWEST OPERATING LEVEL

The commission envisioned that a very small DAS/F would be comprised of perhaps 100 FTEE. Its functions would be limited to researching design and construction methods, technical consulting and reviewing deviations from standard, commercial specification. The office would also assist in rolling up the annual construction budget request. The commission truly meant to delegate more authority to geographic service area managers and local facility directors to simplify and to streamline project development and completion. The type of construction management you now hear the House Appropriation Committee staff discussing is the direction the commission was moving. This level of delegation would obviate the need for the large number of FTEE now in CO supporting the construction activity. Compliance or oversight would come from several offices: VHA operations, the inspector general, the Deputy Assistant Secretary for Acquisition and Materiel Management, the DAS/F through consultation and the so-called Memo of Agreement for a firm project price. In fairness, commissioners also believed other elements of CO, including VHA and Regional Director offices, should have less to do with field facility operations and management. Those offices would also shrink.

It will take time to arrive at such a sweeping re-organization. Until then there should be more personnel in geographic service area offices, or available to them, in CO in VHA operations and ASFIRM with commercial development, construction and leasing experience. If the Committee will review the most recent Independent Budget prepared by the major veterans service organizations, and delivered to you last week, you will find similar recommendations.

AN IMMEDIATE DILEMMA

PL 102-40 places a new charge to this Committee. You are now required to approve by resolution those major medical facility projects and major medical facility leases to be authorized in the budget.

Mr. Chairman, there is a more pressing problem than the material requested in the prospectus required to accompany each proposal. Recall that the CFSVHC recognized an interrelationship among eligibility, the components of the health care program and construction. The issue of eligibility - called eligibility reform - is not yet settled, nor are the components to be offered in the health care program. The former Secretary and former Acting Secretary required a VHA National Health Care Plan which would assign missions to facilities. These have yet to be accomplished. In my opinion the latest version of the plan is status quo in new punch lines. It is not responsive to the former Secretary, Acting Secretary, the present Secretary or current health care needs of the veteran population. Construction issues cannot be determined logically and economically until the other two issues are defined and agreed upon.

Mr. Chairman, VHA does not need any more hospital beds. It is just like the private sector; to care for its patients it must move more funds into nursing home and outpatient care, or other non-bed alternatives. (In the private sector today, acute hospital beds may account for less than half of revenue. VHA is no where near that level in how it disburses its medical care allocation.) It disappointed me greatly that former Secretary Derwinski who was so brave about some things did not bite the bullet and reject the East Central Florida initiative. One must wonder how VHA will fill the new West Palm Beach facility when it comes on line. I predict the same headaches for that director as the one suffered in turn by the directors

at Albuquerque, Minneapolis, Houston and probably Detroit. If you build East Central Florida a similar problem will exist. The veterans of Florida would be better served with two more OPC/NHC configurations and home care, with acute care provided in existing facilities.

Another part of your dilemma is presently beyond your control. What role will the White House Task Force on Health Care Reform define for DVA-VHA? It is worth remembering that Henry Aaron, Ph. D., Brookings Institution, predicts that VHA will lose 50 per cent of its acute care workload if universal coverage becomes national policy.

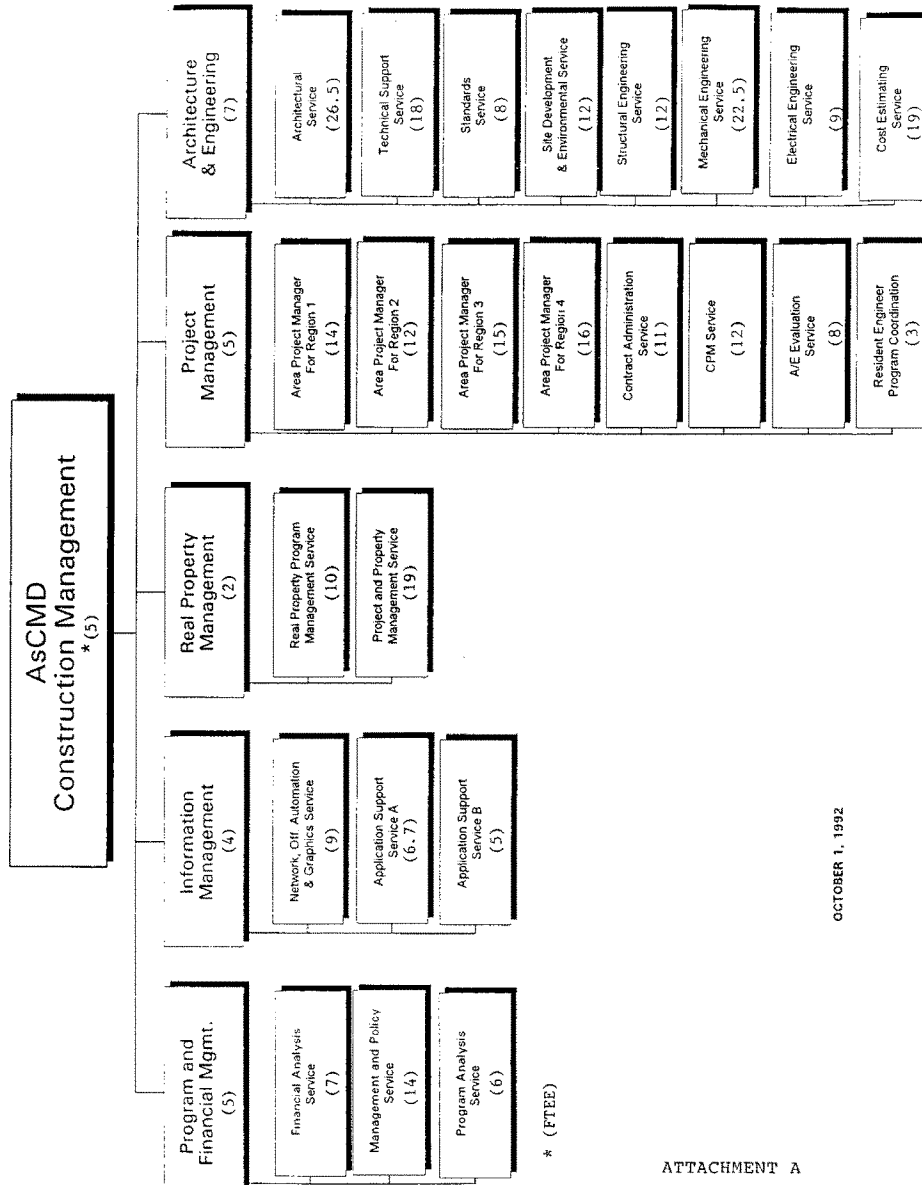
I applaud the new administration's inclusion of VAMC/Fs in its initiative to improve infrastructure. The more than \$200 million assigned to VA for what must be non-recurring maintenance and some minor miscellaneous projects will be of great assistance. Not only will they provide some added employment, but the completion of some long overdue projects will raise staff morale.

If the Committee is to be prudent with scarce dollars and all the emphasis now placed on reducing the deficit, the Committee should declare a moratorium on major/replacement construction projects until the interrelated issues of eligibility, VHA health care program content, and DVA's role in national health care reform are resolved. The only exceptions should be if a state has no VA medical care facility, or there are grave patient care safety issues. I am inclined to believe FDPs should be halted temporarily as well.

If the Congress cannot bring itself to accept a moratorium, Congress must demand of DVA that any modernization/replacement construction be designed for maximum flexibility over the life span of the facility. Future needs will require maximum speed to change the use of a floor, bed wing or clinic. If such changes require costly modifications, you have not helped the taxpayer, facility management or the veteran patient--the most important element.

Should the Committee continue to approve in this intervening time, and you do not obtain buildings designed for "multi-purpose" use the Committee must recognize it is authorizing a facility designed to expensive, inflexible standards--not something that is quickly adaptable to change in medical technology or shifts in the delivery system. I have not heard that DVA has abandoned the VA Hospital Building System or moved to embrace leasing existing private sector facilities. Thus the Committee would also do well to ponder the use of these bloated facilities built to last long after their 30 year life cycle when their workload will have largely disappeared in 50 years or less. Mr. Chairman, the Committee would better serve veterans if it stressed new OPC/NHC projects and those requests that improve the infrastructure of existing VAMC/Fs until some very major health policy decisions are made. These should be done as design-build, turnkey projects at a guaranteed maximum price. Once the interrelated health policy issues of eligibility, DVA health care program scope and DVA's role in national health care reform are settled the Committee can take up its charge of identifying those replacement or modernization projects for VAMCs to be included in authorizing resolutions.

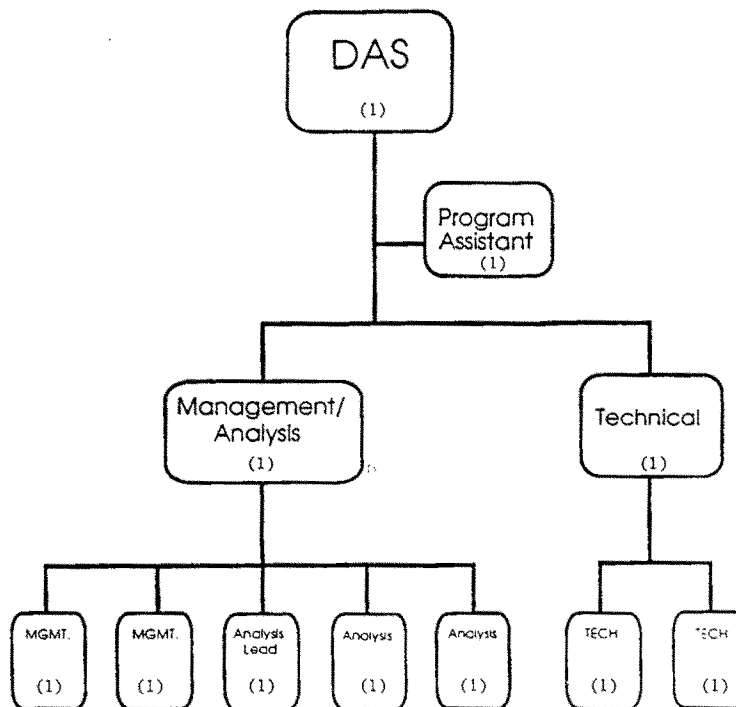
This concludes my testimony. I shall be happy to answer questions, if there are any, Mr. Chairman.



ATTACHMENT A

005A OVERSIGHT ORGANIZATION

*UNDER THE ASSISTANT SECRETARY FOR ACQUISITION AND FACILITIES(005)



30 November 1992

ATTACHMENT B

Statement of David E. Lewis

OBSERVATIONS ON THE VA CONSTRUCTION PROGRAM

Mr. Chairman, Members of the Committee. I am pleased that you have asked me to appear before you today to provide my observations on the Department of Veterans Affairs construction program. These observations are collected from three years experience as the senior VA official responsible for execution from concept to activation of all construction projects and leases.

First of all, by way of background, what was until October 1, 1992 the Office of Facilities, has been comprised of a highly capable, dedicated work force which over the years was continually faced with a declining authorized work force level to implement a reasonably constant but evermore complex workload. For example, in 1987 the number of personnel authorized stood about 700 to implement approximately a \$460 million Major Construction budget; in 1990, the number authorized was about 650 for a budget near \$550 million; in 1992, the authorized number was 530 for a budget of \$564 million. Projects initiated in the early to mid 1980's resulted in significant cost overruns in the late 1980's. Some of this was the result of poor estimating, some changing market conditions, and some the result of long delays from start to finish because of Congressional or Administration rethinking. A large number was as a result of user requested changes during design and construction after the budget for the project was submitted. Recognizing these problems, the Department initiated certain actions recommended by the Office of Facilities to address these issues; namely, streamlining project implementation, instituting alternative methods of acquisition/construction which have successfully been used by other federal agencies, and sharpening the estimating process and limiting user changes after budget. These efforts, however, were short-circuited by the Appropriations Committees who imposed a \$5 million cut or, in other words, an 11% reduction of the 1992 Office of Facilities general administration budget. This is the budget which supports the architects, resident engineers, project managers, expert bio-medical technicians and all the rest of those who made up the Office of Facilities. Since the budget was 80% personnel dollars, the work force was further reduced by 121 individuals. It is interesting to note that in fiscal year 1992 with the implementation of the Department's initiatives, there were no cost overruns.

But, I fear, the punishment for past sins or, simply, past bad luck almost insures that there would be in future years significant overruns, bid busts and, more importantly, that the volume of claims

would escalate significantly because personnel in the field were insufficient to effect good control over contractors. The only solution to prevent a chaotic situation from developing from the cutbacks was to consolidate the functions of the Office of Facilities to several offices within the Veterans Health Administration (VHA), the principal customer of the Office of Facilities.

I believe that this was a sound decision because it places responsibility back where it belongs--with the individual Medical Center Director who initiates the construction request. The reorganization was well thought out by the responsible Department officials. It may, however, have provided the dubious opportunity to obscure, to a degree, the actual personnel level needed to carry out the program thereby making it theoretically possible to subsidize the construction process with funds from other accounts.

The reorganization also created another office independent of the VHA--the "Office of Facilities Oversight." This was a well conceived move to provide oversight of all projects to prevent "scope creep," or expansion of projects beyond mission requirements, duplication of facilities and programs with affiliated institutions, and control over change orders. The concept was sound, but the means to effect it were severely lacking. After redistributing the number of authorized work force from the old Office of Facilities to VHA, only 11 slots were left for the all important oversight function. The result is that this small group cannot do much more than spot check the 3000 or more projects that are in the pipeline annually. Before the reorganization, while some oversight was performed by the Office of the Assistant Secretary for Finance and IRM, there was little performed by the Office of Facilities because it found that oversight was incompatible with its role as a service provider to the VHA. With only eleven in the Office of the Deputy Assistant Secretary for Facilities Oversight, VA is probably back to where it was pre-reorganization or possibly worse into a situation where the fox is really in the chicken coop because the service provider, the Office of Facilities, now reports to its customer, VHA.

There is a solution which can take advantage of having program execution within VHA and yet provide proper checks and balances to insure that the program is meaningful and productive. It is simply to increase authorized personnel levels in the oversight group to a level sufficient to carry out thorough oversight. The tendency of the Appropriations Committees, either as a cost-reducing effort or

as punishment for perceived poor program execution, has been to cut administration accounts like the Medical Administration and Miscellaneous Operating Expenses (MAMOE) for VHA and the Office of Facilities' General Administration budget. This has created a self-fulfilling prophecy. In effect, the Committees say, "You have done a poor job with the resources we have given you, so, we'll give you less so that you can do an even worse job." The approach should be one where, if program execution is not properly managed, the managers should be changed rather than cutting the program's resources. One should avoid a situation where the management function is so weakened by budget cuts that managers cannot function. More money should be put into oversight of program management even at the expense, if need be, of more projects, if the Department is to carry out the projects it executes well.

Another major issue facing the Department's construction program is the intrusion of unneeded and/or overbuilt projects to satisfy outside interests. Too often VA builds facilities with too many beds in places where the needs are less acute than in those where Congressional clout with the Appropriations Committees is less. Opportunities for collocation with Department of Defense hospitals or increased use of those hospitals have been lost because of Congressional pressure. Another more subtle contribution to overbuilding resides within the Department itself. VA has historically been terrified of the Appropriations Committees because of the budgetary punishment which is often directed at its administration budgets. Too often, VA officials will go along with unjustified projects simply to appease perceived powerful Congressional interests. Strong oversight by the Authorization Committees could provide a check to such pressure and abate this weakness.

A few observations in other areas of the construction process might be helpful. The true cost of the overall construction program is often obscured to the public by the Department's resorting to long-term, conventional leases for most of VHA's outpatient clinics. This is not done with any ill intent or intent to deceive. It is simply the only available device to acquire these clinics because there are not enough appropriated dollars to do so. Annual medical facility lease costs for 1993 will be over \$40 million. What really are construction costs are being absorbed in the medical care budget. At the conclusion of a 20-year lease term, the Department has paid in rent an amount equal to twice the acquisition price for the building and has nothing to show for it but a pile of rent receipts with no building ownership for its tenancies. It would be in the public interest if Congress was to appropriate

funds to build or lease/purchase outpatient clinics. The end result would be a significantly larger asset base for VA which, through some innovative financing techniques already available, would result in VA ownership of these facilities at only marginally more cost than the net present value of future lease payments.

The promotion of "caps" on construction appropriations is increasingly in vogue both in Congress and within the Department. While every effort to reduce VA construction costs should be applauded, caps can be short-sighted and in the long run increase overall costs to the Government. In one major new project for a new hospital, the cap was set so low that the use of the widely acclaimed VA building system, which has been used in every new VA hospital since 1977, was eliminated to save about \$5 million. But the life-cycle cost savings, as has been found by the Department of Defense which has employed a building system similar to VA's system in some of its major hospital construction, would far exceed the initial premium. It is very much like the tendency of some American corporations to manage from quarterly to quarterly profit and loss statement while their Japanese competitors take the long view by investing in research and development at the expense of near-term profits. Caps can be good discipline, but they can also result in facilities which might better remain unbuilt because they will not fulfill the long-range mission of the Department. Caps can be circumvented by implementing follow-on construction phases which, in the long run, can be more costly due to loss of economies of scale and inflation.

Can the VA construction process be made more efficient? Certainly. Through the use of "design/build" where private sector contractors under VA oversight handle the whole process except concept planning, construction costs can be reduced and so can the time it takes to construct. The new 72,000 square foot Martinez Outpatient Clinic is testimony to both benefits. This project took only 6 months from contract award to activation. It came in at 67% of the estimated cost if VA had designed and built it through conventional methods.

Very happily, the Appropriations Committees at the Department's request have, over the last few years, significantly increased the minor construction budget. This has resulted in keeping many facilities "glued together" and the avoidance of a major appropriation request, which too often results in overbuilding because it represents a once in a lifetime opportunity for a director to acquire a "dream"

facility. An increase in the minor construction budget authority from \$3 million to \$5 million would in the long run be a valuable cost containment step. A good start has been made, more should be done.

In closing, I would urge the Committee to take the long view of the construction process, to be as active as the Appropriations Committees in reviewing projects, providing direction, and even protecting such projects. This may mean, given budgetary constraints, authorizing fewer projects with the goal of improving quality, oversight and the ultimate reduction of costs.

I would be pleased to take your questions.

Respectfully submitted,

David E. Lewis

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
House of Representatives

For Release
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VETERANS' HEALTH CARE

Potential Effects of Health Reforms on VA Construction

Statement of David P. Bañe, Director
Federal Health Care Delivery Issues
Human Resources Division



SUMMARY

GAO believes that the Congress should proceed cautiously with construction of additional VA health care facilities until reforms to the nation's health care system and VA eligibility take shape. This is because of the uncertainty surrounding the potential effects of such reforms on demand for VA health care. First, any national health care reform that expands insurance coverage among veterans could substantially reduce demand for VA-sponsored care. GAO estimates that under a nationwide universal coverage plan, for example, demand for VA inpatient care could drop 50 percent. Reform of VA's system for determining eligibility for health care could similarly have dramatic effects on VA utilization. For example, the number of outpatient visits, which totaled about 22 million in fiscal year 1991, could increase to 24 million to 57 million if the Congress adopts any of the reform proposals VA developed.

A limitation on construction of additional VA health care facilities, however, does not have to mean an interruption in meeting the health care needs of America's veterans. Rather, the Congress and VA could take the opportunity to test alternative methods of delivering services to veterans that could, at least on an interim basis, provide veterans acute care services in their home communities years earlier than could be provided through new construction.

The Congress could consider authorizing VA to conduct such demonstration projects in one or more locations where unused capacity exists in community or military hospitals. Possible locations include Hawaii, northern California, and east central Florida.

Mr. Chairman and Members of the Subcommittee,

We are pleased to be here today to discuss several issues relating to the Department of Veterans Affairs' (VA's) health facilities construction program. Our testimony this morning primarily concerns the need for and size of VA construction projects if proposed health care reforms--reforms to reduce the number of uninsured Americans and revise the eligibility system for VA health care--are implemented. In addition, I will discuss the extent to which VA considers construction alternatives, such as the availability of state and community resources, when it determines the need for VA construction projects.

Mr. Chairman, it is our overall belief that the Congress should proceed cautiously with construction of additional VA capacity until reforms to the nation's health care system and VA eligibility take shape. This does not, however, have to mean an interruption in meeting the health care needs of America's veterans. Rather, a limitation on the construction of new VA medical care capacity could provide an opportunity to test alternative methods of delivering services to veterans. Use of alternative delivery methods could, at least on an interim basis, provide veterans acute care services in their home communities years earlier than could be provided through construction of new or replacement VA facilities. Through demonstration projects, VA could determine whether (1) veterans are satisfied with the new methods of providing care and (2) services can be provided closer to veterans' homes without increasing health care costs.

Our views are based on our work over the past 3 years. During this period, we have assessed VA's plans for constructing medical centers in Hawaii, northern California (as a replacement for the closed Martinez medical center), and east central Florida. In each location, there are two common conditions: (1) veteran populations are split between two or more population centers, making it difficult for one VA hospital to effectively meet the inpatient

care needs of all veterans, and (2) adequate capacity exists in nearby community and/or military hospitals to meet these needs. These local conditions create the potential for VA to provide outpatient care through its clinics in each population center, but provide inpatient hospital care through contracts or sharing agreements with community or military hospitals. As I will discuss later, such demonstrations could be structured in several ways.

Let me turn now to some of the potential effects that reform of the nation's health care system could have on future demand for VA health care services.

NATIONAL HEALTH REFORM
COULD REDUCE DEMAND FOR
CARE IN VA FACILITIES

Any program that would expand insurance coverage among veterans could substantially reduce demand for VA-sponsored care. For example, last year we estimated that demand for VA inpatient services, as measured by days-of-care provided to veterans, could drop by 18 percent if employers nationwide were mandated to either provide health insurance coverage for their workers or pay a tax that would be used to obtain the coverage. Similarly, demand for outpatient services could drop by about 9 percent.¹

Our estimates are based on the premise that veterans obtaining alternate health insurance under employer mandates would, over time, reduce their use of VA health care to the lower rates that characterize veterans who now have private health insurance. For example, veterans without private coverage were eight times more likely to use VA inpatient care than veterans with private health insurance. Although several factors, such as the differences in

¹VA Health Care: Alternative Health Insurance Reduces Demand for VA Care (GAO/HRD-92-79, June 30, 1992).

the incomes of the employed-insured and employed-uninsured, could reduce the effect of employer mandates, we believe that there would be significant decreases in demand for VA care if employer mandates were implemented.

Under a nationwide universal coverage plan, we estimate that the effect could be even greater--demand for VA inpatient care could drop by 50 percent. Likewise, use of VA outpatient care could drop by 40 percent. Under a universal health insurance plan, veterans who would not be covered by employer mandates--including unemployed, retired, and part-time workers--would be provided coverage.

Because veterans with private insurance tend to use VA care at a lower rate than veterans with public insurance; that is, Medicare or Medicaid, the decrease in demand for VA services might vary depending on whether the universal plan resembled a private or public plan. In either case, we believe that the decrease would be substantial.

Reform of the nation's health care system could also have significant effects on demand for VA-supported nursing home care. Most health care programs, other than VA and Medicaid, currently provide limited coverage of long-term nursing home care. If the reformed health care system includes long-term nursing home coverage, it could lead to a decline in demand for VA-supported care. The extent of the decline in demand for VA care would likely depend largely on the extent of cost sharing imposed under any new program.

Conversion of excess hospital beds to other uses, such as nursing home care, could also reduce the need for and cost of future nursing home construction. This is because it costs about twice as much to construct new nursing homes as it does to convert

existing hospital beds to nursing home beds.² In addition, conversions of excess health care capacity to nursing homes can generally be accomplished faster than new construction.

As you can see, under either employer health insurance mandates or some form of universal coverage, there would likely be a significant decline in demand for VA health care services. Such a decline could create significant excess capacity in VA facilities.

REFORM OF VA ELIGIBILITY COULD
AFFECT FUTURE DEMAND FOR VA SERVICES

Just as reform of the nation's health care system could affect demand for VA health care services, so too could reform of the VA eligibility system itself. This issue is likely to be the subject of extensive congressional debate before this and other committees in the coming year. The decisions made on eligibility reform, like the decisions on how to reform the nation's health care system, could have a significant effect on future demand for VA health care. Let me explain.

VA's Commission on the Future Structure of Veterans Health Care recommended major reform of VA eligibility in its November 1991 report to the Secretary. The Commission noted that eligibility rules are complex and confusing. VA eligibility differs for hospital care, outpatient care, and long-term care, and varies according to the veteran's status and the type of care needed. As a result, a veteran eligible for hospital care may not be eligible for outpatient care other than to prepare for or as a followup to hospital care. Similarly, a veteran may be able to

²VA Health Care: Improvements Needed in Nursing Home Planning
(GAO/HRD-90-98, June 12, 1990).

obtain outpatient care for a service-connected disability but not for nonservice-connected conditions.

In March 1992, the Deputy Secretary of Veterans Affairs established a task force to develop proposals for eligibility reform. The task force developed four alternative proposals for reforming VA health care eligibility. The task force predicts widely varying VA workloads depending on which, if any of the proposals, is adopted. For example, the predicted number of inpatient hospital patients treated ranges from 1 million to about 3 million; the number of outpatient visits ranges from 24 million to 57 million, and the average daily census of long-term care patients ranges from 70 million to 593 million.

Our point in mentioning these numbers is not to comment on the merits or costs of the various eligibility reform options. Rather, we want to emphasize the uncertainty that surrounds the future structure of the VA system. Until the Congress reaches decisions on eligibility reforms, predicting how many hospital and nursing home beds will be needed in the future or, for that matter, how large outpatient clinics should be is impossible. It is this uncertainty that leads us to conclude that construction of additional capacity should, at this time, be approached with caution to avoid overbuilding.

To this point, I have focused only on the uncertainty surrounding future demand for VA services. I would like to turn now to one of the recurring factors that we have noticed concerning VA's construction planning process--inadequate consideration of alternatives to new VA construction.

VA DOES NOT ADEQUATELY CONSIDER
COMMUNITY AND MILITARY RESOURCES

For more than 10 years we have been recommending that VA consider the availability of community and state nursing homes in its facility construction process. Using such resources to the maximum extent possible is important because care in community nursing homes costs VA about half of what it costs to provide care in VA nursing homes.³ Care in state veterans homes is even more cost effective for VA; VA pays a per diem of about \$22 for nursing home care in state veterans homes and 65 percent of the cost of constructing and renovating state homes.

In addition, to the extent VA can increase its use of community nursing homes and state veterans homes, it can avoid the costs of constructing VA nursing homes. VA expects to spend about \$13 million to construct a 120-bed nursing home in east central Florida.

While most of our work has focused on use of state and community nursing homes as an alternative to construction of VA nursing homes, we found during recent reviews of VA's planning for the construction of three medical centers that existing capacities in community and military hospitals appeared to be adequate to meet VA's acute care needs. As I mentioned earlier, one common feature of all three projects is that the veteran population is split between two or more major population centers, making it difficult to adequately serve veterans with one facility. What follows are our primary findings for the three areas under consideration for new medical centers.

³Average obligations per patient day were \$155 for VA nursing home care units and \$79 for community nursing homes in fiscal year 1990.

- Northern California: The veteran population is roughly split between the East Bay (Oakland) and Sacramento areas, approximately 70 miles apart. Although there is no VA inpatient hospital capacity in the northern California catchment area as a result of the closure of the Martinez medical center, there is significant unused capacity in community hospitals located near the Oakland, Martinez, and Sacramento VA outpatient clinics. For example, two community hospitals within 10-15 miles of the Martinez clinic told VA in 1991, shortly before the Martinez hospital closed, that they each had adequate capacity to absorb the entire Martinez medical, surgical, and neurological workload. Similarly, officials at the University of California (Davis) hospital in Sacramento indicated that they were expanding the facility and would consider leasing six floors of the planned bed tower to VA for an indefinite period.
- East central Florida: The veteran population is split between three population centers--Orlando, Daytona Beach, and Cocoa/Melbourne. The nearest VA medical centers are in Tampa, about 80 miles west of Orlando, and Gainesville, more than 100 miles northwest of Daytona Beach. There are, however, about 2,100 empty community hospital beds in the Orlando and Cocoa/Melbourne areas on any given day, a local health planning agency reported in 1989. Only one Orange County hospital had had an occupancy rate above 60 percent. Similarly, a Volusia County (Daytona Beach) official told VA in 1991 that an entire 300 bed hospital was available for VA use. Finally, unused capacity exists at the Orlando Naval Hospital.
- Hawaii: About 22 percent of the veteran population is located on the outer islands. Because there is currently no VA hospital in Hawaii, veterans are authorized to use either the Tripler Army Medical Center, which was renovated with adequate capacity to meet VA's current and anticipated needs, or community hospitals on Oahu and the outer islands. The Administrator of

Hawaii's health planning agency told us that there is no shortage of acute care beds in Hawaii. Excess capacity is so prevalent that local officials estimate it could be as long as 15 years before a certificate of need is approved for private construction of additional acute care capacity.

While none of the three areas I just described currently has a VA hospital, each area appears to have adequate capacity in its nearby community and military hospitals to meet VA's needs. However, the cost advantages of providing inpatient hospital care in community facilities are not as clear as the advantages of providing nursing home care in community nursing homes. Reliable data are not available to show whether providing care in VA hospitals is less costly than in private sector hospitals.

The Congress faces a dilemma: If VA hospitals are built to meet the current health care needs of veterans in these three areas, the hospitals could have significant excess capacity before they even open; on the other hand, if construction is delayed until health reforms take shape, the health care needs of an aging veteran population might go unmet.

DEMONSTRATION PROJECTS COULD
IMPROVE VETERANS ACCESS TO ACUTE
CARE WHILE DECISIONS ARE MADE ON REFORMS

One potential way to deal with that dilemma would be to test alternative means of meeting the health care needs of veterans and improving access to hospital care. For example, the acknowledged excess hospital capacities in the non-VA sector in northern California, east central Florida, and Hawaii provide excellent opportunities to test the feasibility of contracting for inpatient care at community or military hospitals. By contracting for care in such hospitals in Orlando, Daytona Beach, and Cocoa/Melbourne, for example, veterans in all three communities could obtain

hospital care close to their homes. Similarly, because VA operates northern California outpatient clinics in Oakland, Sacramento, Martinez, and Redding, it could potentially contract to meet the inpatient care needs of veterans in each community. Finally, as we pointed out in our report on the need for a VA hospital in Hawaii, VA could enter into a joint venture with the Department of Defense (DOD) at the Tripler Army medical center to meet the hospital needs of veterans living on Oahu in existing wards and continue to meet the hospital needs of veterans on the outer islands through contracts with community hospitals.

Several options could be tested: Under one option, VA physicians from the outpatient clinic, like private physicians, could obtain patient admitting rights to community hospitals. Such an option was proposed by one of the hospitals offering to care for veterans following the closure of the Martinez hospital. The private hospitals would supply nursing and other personnel. The VA patients could, depending on the contract, be treated on separate wards or interspersed with other hospital patients. Another option would be for VA to contract for space in existing facilities and staff and operate the space itself. Yet another option would be to contract for all inpatient services.

Demonstrations such as these could (1) test the cost effectiveness of alternative delivery methods and (2) assess differences in veteran satisfaction under the options.

In summary, VA, like other federal departments and agencies, is likely to face severe budget constraints during the next several years. Because of the uncertainty concerning future demand for VA services, we believe it would be prudent to delay most construction of additional capacity until the effects of health care and eligibility reforms can be more fully assessed. This would free up funds for deficit reduction without affecting current VA health care services and prevent construction of VA facilities that could

quickly lead to excess capacity. To prevent construction delays from adversely affecting veterans, the Congress could authorize VA to conduct one or more demonstration projects to test the concept of contracting for acute care services in community facilities in proximity to VA outpatient clinics.

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Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or the other Members of the Subcommittee may have.

STATEMENT OF
C. WAYNE HAWKINS
DEPUTY UNDER SECRETARY FOR HEALTH
FOR ADMINISTRATION AND OPERATIONS
DEPARTMENT OF VETERANS AFFAIRS
MARCH 3, 1993

Mr. Chairman and Members of the Subcommittee,

I am pleased to appear before you this morning to present testimony concerning the Department of Veterans Affairs Construction Program. As you are aware the VA will be forwarding its request for FY 1994 Construction funding to the Congress in late March. At that time we also plan to provide the VA's five year facility plan and expanded project prospectuses to the Committee.

The VA health care system includes 171 VA Medical Centers, 362 Outpatient activities, 129 Nursing Home Care Units, and 35 Domiciliaries. The VA has at least one medical center in each of the 48 contiguous states. In addition, VA is developing joint venture facilities with the Department of Defense in Hawaii and Alaska. This system represents a tremendous capital investment including over five thousand buildings and approximately twenty-six thousand acres of land at over one thousand locations nationwide. The VA system utilizes over 135 million square feet of building space. Of this, approximately 125 million square feet is owned by VA and 10 million square feet of space is leased.

It is critical to our mission that we maintain this capital investment and modernize the physical plant where necessary to ensure that the VA health system can provide state-of-the-art medical care and respond to the changing needs of our nation's veterans. To accomplish this the VA has the largest medical facility construction program in the nation. The VA employs a number of processes to ensure that needed health care programs are identified and that when those needs require renovation or new space, the space is appropriately planned, designed, and procured through sharing, construction, lease, or public-private ventures.

HEALTH PROGRAM PLANNING PROCESS

The VA is working with the President's taskforce on health care reform to define the role of the VA health care system as part of the nation's health care delivery system. We are also developing a proposal to reform rules for determining a veteran's eligibility for VA care. As part of these efforts we are also developing a strategic health care plan to provide a blueprint for meeting the health care needs of the nation's veterans. This plan will describe current VAMC missions, provide guidance for establishing certain programs, and outline a planning process for the future. This baseline plan will begin to shift the VA system to a managed health care system.

The managed health care system would provide a full range of services available from networks of medical centers with different levels of specialization. Each eligible veteran would be assigned to a primary care provider/team responsible for ensuring continuity of care through the referral system. Patients will be provided inpatient primary care at all VA facilities with acute inpatient services; those requiring more specialized care would have it available at referral facilities (either VA or non-VA by contract or sharing agreement). The most complex levels of care would be provided in programs located at selected regional or national sites.

Future health service needs will be developed using veteran population and demographic characteristics, current disease prevalence and use rates among similar age cohorts. Comparison of existing facility capacities to the needed future capacity, within networks, will show the program changes required to meet future needs. Medical facilities in a network will then prepare for the needed changes. Program changes may call for increases or decreases in service levels. Each medical facility, based on assigned programs and projected service volumes, will decide if it has inherent capacity for the change and if not, whether sharing, contract services, leasing or construction is the most cost-efficient approach.

Mr. Chairman, the new VA leadership is actively involved in developing the President's health reform initiative and in developing a reform proposal for rules governing veterans eligibility for health care. In this context, the

new leadership is reviewing VA's planning mechanism and will initiate these processes in the near future.

FACILITY PLANNING PROCESS

The first step in the Facility Planning Process is the development of the Facility Development Plan (FDP) for each VA Medical Center. This plan is based on the approved mission and health programs for the medical center. The FDP is a comprehensive plan for the physical development of a VAMC over a long-range planning horizon, currently year 2005. It includes a selected facility development strategy and logical groupings of construction, leasing, sharing, or DoD joint venture activities to meet the needs and address the deficiencies identified for each VAMC. FDP's have been completed or are in progress at two-thirds of VA medical facilities. The FDP is used by the VAMCs to develop their specific projects in Five Year Facility Plans.

Each VA Medical Center maintains a five year plan listing intended facility improvements which will support the medical center's mission. The plan is based on the approved program plans and the FDP, if available. This is an implementation plan which depicts the magnitude of effort required to meet the facility's needs.

The National MEDICAL FACILITY DEVELOPMENT PLAN (MFDP), which must by law be submitted to the Congress by June 30 of each year, is developed from the highest priority projects from individual facility five year plans. These projects are prioritized using criteria such as workload, functionality, life safety, and building code requirements and are weighted for high priority health care programs such as outpatient or long-term care. Projects proposed for accomplishment in the plan (MFDP) are limited to funding constraints dictated by the Administration. The initial year of the plan lists projects submitted for funding in the President's Budget. The second and third years include projects under active advance planning. The fourth year usually contains projects which are just undergoing definition of requirements and refinement of scope. The fifth year contains projects which have been recently selected for preparation of a PROJECT SUBMISSION based on priority score and a very general scope concept.

PROGRAM AND PROCESS REORGANIZATION

In October of last year, after careful examination of our construction program, the Department implemented a number of process and organizational changes designed to improve the planning and construction of VA facilities. From the process perspective, these changes grew out of our desire to improve accountability and increase the role of the medical center in the development and management of projects; reduce the time required to plan, design and construct VA facilities; improve cost control and establish incentives for medical centers to develop less costly projects. We sought to achieve a balanced program beginning with planning from the bottom-up at the medical center; appropriate oversight; delegation of projects to medical centers where appropriate; and central management of the larger, more complicated projects using the best method available including design build, construction management, or conventional design and construction.

In addition to the process changes, at the Central Office level we reorganized those involved in the construction program. The VA's Office of Facilities which previously reported to the Assistant Secretary for Acquisition and Facilities is now a part of the Veterans Health Administration. For the first time those responsible for the construction of health care facilities serve within the same organization as those responsible for planning and managing the delivery of health care.

The office of the Deputy Assistant Secretary for Facilities Oversight will expand the technical oversight of facilities and projects in conjunction with the financial, budgetary, scope and needs oversight currently provided by the Deputy Assistant Secretary for Budget. The Department will continue to compare its methods and standards for facilities with those of other Federal departments and the private sector to ensure "competitiveness," and increase its technical oversight to ensure individual projects adhere to competitive methods and standards. In addition the reorganization created a Construction Policy and Oversight Board composed of the three administration heads, the assistant secretaries and chaired by the Deputy Secretary. That board will provide broad oversight on the planning, criteria and execution of the facilities programs.

We believe this organizational structure will better enable VA to effectively plan and develop its facilities to meet the future health care needs of the nation's veterans.

IMPROVED CONSTRUCTION MANAGEMENT

In addition to the process and organizational changes, the VA has implemented a number of initiatives to improve the effectiveness and timeliness of acquiring facilities. These include the use of alternative acquisition methods such as design build, use of construction management firms and public/private ventures; more intensive comparison with private sector standards; vigorous marketing of VA projects to elicit increased competition; and the use of partnering and alternative disputes resolution--two industry concepts intended to bring together the parties involved in projects to seek resolution of differences.

Design Build

In the design build approach to procurement, a single contract is awarded for both design and construction. It is advantageous when full funding is available early in the design process. We estimate that this method reduced the time to construct a new outpatient clinic in Martinez, California after the medical center there was closed, by 18 months. Other design build projects include the parking garage at Nashville, Tennessee and an imaging center at Palo Alto, California. This approach will continue to be used in future projects.

Construction Management

Several projects have been selected for support by non-VA construction management firms. These firms review projects for ease of construction, analyze the cost estimates provided by the Architect/Engineering firm, and supervise the construction activity itself.

Cost and Standards Task Force

VA is actively reviewing the construction standards we use to be sure that they are not excessive to our needs. Phase one of a two part study has been completed. This study has compared VA standards to those used in the private sector. For the most part, VA standards are comparable to those used in private hospital construction. In those areas where VA standards exceed those of the private sector, we will be carefully reviewing these to adjust them if appropriate. Part two of this study is being conducted by the National Institute of Building Sciences to validate the effort of the first phase and review other areas identified. Each of these studies examines private sector standards as used by several non-VA organizations. Phase two is utilizing the expertise of private sector experts from various sectors of the health care industry.

Enhanced-use Leasing

The Department is now in the process of testing the feasibility of an enhanced-use leasing program. This program allows the Department to use its unused or underused property as a means for obtaining facilities, services or monies for veteran programs that otherwise would be unavailable or unaffordable.

The first use of this authority was for the co-location of the Houston VAMC onto VA Medical Center land. The proposal selected will provide for the required VBA Regional Office and associated parking, and a 17,000 square foot non-VA retail center (drug store, fast food, bank, etc.). The Department will realize over \$6.0 million savings in the construction account \$300,000 a year savings in the VBA account, and will generate additional future revenues for the Nursing Home Revolving Account and the Houston VAMC's Medical Care account.

Several other enhanced use projects are under development for child care centers, parking structures, research laboratories, and training facilities. As the Houston project demonstrates, enhanced-use offers the Department a cost effective means of obtaining needed facilities.

Mr. Chairman, the reorganization of Construction functions and the implementation of process reforms was initiated in October 1992. Many of the process changes and new construction management initiatives are currently under development; however, we are confident that we will improve the responsiveness of the VA Construction program to the needs of veteran patients.

This concludes my formal testimony. We will be pleased to respond to any questions that the Committee may have.



PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
TERRY GRANDISON, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
MAJOR MEDICAL CONSTRUCTION
FOR THE
DEPARTMENT OF VETERANS AFFAIRS
MARCH 3, 1993

Mr. Chairman and Members of the Subcommittee, on behalf of the members of Paralyzed Veterans of America (PVA), I wish to thank you for inviting us to testify today concerning the Department of Veterans Affairs' (VA) medical construction program. I will focus my comments today on the VA's Facility Development Planning Program, Spinal Cord Injury (SCI) construction projects, and funding of VA construction programs.

Strategy 2000: VA Responsibility In Tomorrow's National Health Care System

In Spring 1992, PVA released its long awaited Strategy 2000, an intensive exploration of VA's role in health care for the 21st century. Strategy 2000 presents a series of scenarios the VA could play in the health care environment of the 21st century. PVA's Strategy 2000 articulates in fine detail VA's value to the nation and its veterans, particularly its spinal cord injured veterans. Strategy 2000's long-term analysis recognizes that any comprehensive reform of the nation's health care system would have a significant impact on the VA system. Its forward looking concepts attempt to identify the best strategy for VA to continue to discharge its missions in light of possible reforms in the larger health care system. This document provides a stark contrast to the Facility Development Planning Program (FDPP), a plan initially useful, but now mired in the past regarding major medical construction.

Facility Development Planning Program

The VA created the Facility Development Planning Program (FDPP) in FY 1987 to identify individual medical centers' current and projected facility needs. The implementation of this program was predicted to produce an accurate system-wide inventory of basic facility data. However, the FDPP has not generated reliable facility data. The FDPP approach does not yield accurate data in a format VA can analyze, model or update, as the system and the veteran population changes. VA posits that facility development plans actually provide an accurate system-wide inventory. The FY 1994 Independent Budget's assessment of the FDPP, however, does not show that it has achieved these objectives. In fact, the FDPP approach is costly and slow.

PVA and the Independent Budget co-authors recommend that an outside party evaluate FDPP and recommend a plan to implement a simple, efficient, and cost-effective process. Such a process should

profile each VA medical center's construction needs and reduce the cost and time required to develop individual facility development plans. VA management must act immediately to prevent further wasteful expenditures based upon the existing FDPP.

VA must also base its construction programs on an institutionalized analysis of its national construction needs. Unfortunately, VA has not developed a process to determine national priorities. Neither has VA documented each facility's current and projected needs. According to the Independent Budget, the absence of a sound basis for establishing national construction priorities is a major deficiency in VA planning, design, and construction. Therefore, it is not surprising that construction projects under VA take too long to complete. The typical time-line for major construction, from design through completion, is ten years. This results in facilities that are inadequate from the time they are activated.

The VA's selection of construction projects for funding and development is impractical. VA does not have a systematic approach to addressing long-term problems.

In 1985, Booz-Allen Hamilton completed a comprehensive study of the VA's organization and procedures for constructing health care facilities. While some of the report's recommendations have been followed, most of the systemic problems remain. An overly complicated and costly Facility Development Planning process has failed to provide cost effective and flexible planning tools to respond to today's fiscal crisis, and the changing demographics of veterans. The VA should again review the Booz-Allen Hamilton recommendations to correct system-wide problems in the offices overseeing the construction program. In addition, PVA urges a resumption of the quarterly VSO/VA Construction Forum so that we may appropriately monitor the progress of much needed improvements.

VA must develop and implement an efficient facility-planning design and construction process. This system must enable the VA to complete construction projects more rapidly. A reasonable and commercially practical completion time for most major construction projects is three years. VA can achieve the three-year time-line if Congress first authorizes design projects and then, in the following year, appropriates funding for "design-build" or "guaranteed maximum price" contracts for those projects.

Furthermore, the VA must select projects according to strategic priorities and a national assessment of construction requirements. In addition, VA must be cost-effective in planning, design, construction, and administration. Lastly, VA's system has to identify problems quickly, before they worsen, by monitoring departmental performance, quality, timeliness, and cost.

The above VA deficiencies can be cured by initiating a study which identifies veterans by their demographic areas. The study would provide the VA with a national assessment of the veteran population and makeup. More importantly, the VA could then plan, select, and design its construction projects based on the actual and identifiable needs of veterans throughout the country. PVA strongly urges the VA to follow this recommendation.

Spinal Cord Injury Centers

Spinal Cord Injury (SCI) is an example of catastrophic illness dependent upon not only multi-specialty medical care, but socioeconomic resources as well. VA, the creator of SCI Treatment Centers following World War II, has been in the vanguard of providing lifesaving and life-sustaining support for SCI victims. Since VA established that authority to oversee, coordinate, and establish uniformity of care, the system has grown to its current number and scope of 21 VA inpatient SCI centers with 1,460 beds. Those VA medical centers without SCI centers have coordinators

specifically designated to organize SCI patient care. Additionally 13 VA medical centers now have outpatient clinical staff specially trained to care for SCI patients.

The VA's reputation for high quality SCI services is now in jeopardy. The past decade has seen a progressive erosion of VA health care quality and, with it, a lessening of the Veteran Health Administration's (VHA) commitment to spinal cord injury services in particular. SCI centers are caught in that same degenerating spiral of annual budget shortfalls that are eroding the entire VA health care system.

PVA's membership is intimately affected by this degenerating decline in SCI care. PVA is quite aware that the modalities of health care delivery, along with the likely impact of national health care reform, will require future restructuring of VA health care programs and facilities, rendering some current construction plans obsolete. These facts make it difficult to assess, in all cases, where pending VA hospital construction will fit in the larger scheme of its role in tomorrow's health environment. However, because of the continuing high level of veteran health care demand, there is a clear exception among certain projected construction projects in the state of Florida, specifically the Tampa VAMC.

PVA is dedicated to the completion of the Tampa SCI construction project. PVA, for almost twenty-years, has discussed the need for modernization and enlargement of this center. A series of VA planning blunders have long delayed the construction of this much needed clinical wing containing the expanded SCI center. Although the design stage of the project is complete, the required funds needed to complete the project have not been approved. PVA strongly encourages the Congress to appropriate the necessary funds to complete the construction of this clinical addition and SCI center unit.

The task of quantifying and assessing the relationship between SCI veterans and SCI construction projects is difficult. Knowledge about SCI veterans' geographic distribution is limited. Data does exist on those veterans, including SCI veterans, who receive VA compensation or pensions and those SCI veterans who use the VA health care system, but there is no universal data base. PVA urges the VA to conduct a study that would ascertain accurate estimates of veterans with spinal cord dysfunction by geographic area and verify their health care use rates.

CONSTRUCTION FUNDING

The seventh annual Independent Budget recommends a \$788.7 million Major Construction appropriations for FY 1994. The Independent Budget basis for FY 1994 Major Construction funding projections is

VA's current Five-Year Plan, The Five Year Medical Facility Development Plan. The Independent Budget suggests that to receive less funding in FY 1994 would be catastrophic, given the extended replacement cycle for facilities, rapidly changing clinical requirements, and the existing plant's excessive age.

PVA recommends funding construction of nursing homes containing 960 beds in FY 1994. The aging veteran population necessitates this rate of nursing home construction through the 1990s. Moreover, PVA urges VA to abandon its use of outdated and poorly designed prototype nursing homes and pursue more creative options for constructing quality, cost effective facilities. Furthermore, we recommended that VA enter into two new enhanced use leases for nursing home beds. This effort, however, will alleviate only some of the actual need for nursing home beds. The Independent Budget advises the VA to adopt and implement its strategy for making nursing home beds available to veterans.

The VA's construction needs for maintenance and repair is representative of the desperate condition VA facilities are in today. The existing physical plant, much of which was constructed in the 1950s, is rapidly deteriorating. The VA must accelerate renovation, modernization and replacement of its infrastructure to meet the needs of its aging physical plant. The continued erosion in VA medical facilities severely restricts the quantity of care available and severely endangers the quality of medical services provided to the veteran community. The problems causing this erosion are basically dollar-driven and dollar restricted without regard to any proper long-term planning process.

We urge Congress to fully fund not only the Independent Budget's Major Construction recommendation, but also appropriate \$279.2 million for Minor Construction, which funds smaller facility construction projects. These appropriations would go a long way toward eliminating the VA's infrastructure deterioration.

Mr. Chairman, that concludes my testimony. I will be pleased to answer any questions you may have.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 3, 1993

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to offer comments on VA's medical construction program and its planning process.

Mr. Chairman, the VA's medical construction process recently experienced major reorganization. The Office of Facilities was integrated into the Veterans Health Administration (VHA). This realignment unites the operation of VA's capital facilities program with the design and construction programs. The Legion believes this reorganization will create a cohesive team concept, focusing on VA's prime mission of serving veterans.

The medical construction process today is divided into three major programs: construction management; planning and resource management; and operations. Each unit is responsible for separate performance oversight and program operations. The change created the Chief Medical Director's Construction Advisory Board composed of senior executives within VHA. This board will provide expertise on a wide range of issues at specific points in the VHA construction program. The board allows for representation from all VHA components with significant interests in the construction program.

The new board will address education and training priorities; planning criteria and standards for VA facilities; construction management; construction planning guidelines; project prioritization methodology; construction budget; major project delegation; minor/minor miscellaneous project lists; and

lease and/or build. VHA will continue to provide specialized contracting, technical consultation and project management services for the Veterans Benefits Administration and the National Cemetery System.

The former VA Office of Facilities construction program ran into some serious cost overrun problems in the 1980s due to the re-sizing of original hospital plans and to unbudgeted add-on items, coupled with the inability of VHA and the Office of Facilities to make timely decisions. The recent reorganization should help to monitor and contain project costs. Additionally, the overall economic climate of the construction industry has led to a recent trend of VA receiving competitive project bids.

This major change allows each medical center to play a primary role in the major construction program, throughout the design and construction process. We support the new concept as a positive development.

The construction program must be well-managed and flexible enough to undertake new direction to meet the changing needs of the veteran population, and adequately appropriated. Reorganization alone will not resolve VHA's construction needs.

Mr. Chairman, recent construction appropriations for major projects have not kept pace with existing demands. The American Legion maintains that major construction funding should be set at no less than \$600 million per year through the balance of this decade to permit VA to complete necessary renovation and/or modernization projects and undertake the construction of new facilities.

Historically, the VA construction program placed greater emphasis on inpatient procedures, while overlooking outpatient capabilities. Currently, VHA is developing a National Health

Care Plan to redefine each health care facility's mission, in terms of numbers of inpatient beds, outpatient workloads, individual programs and staffing levels. The American Legion and other veterans service organizations have urged Congress and the VA to revisit the issue of VA health care eligibility as the VA develops its plan. Once this plan is accepted and the VA's Facility Development Plan program is fully funded, a realistic priority construction schedule can be established.

The American Legion believes that should its **Health Care Eligibility Reform Proposal** become law, more veterans will seek VA services. If direct Medicare reimbursement can be made to VA and other innovative financing mechanisms accepted, more veterans will be eligible for quality health care and treatment at a substantial savings to the government.

We reject the premise put forth by the General Accounting Office in a June 1992 report, that expanding alternative health insurance options for veterans, under universal health care coverage, will reduce demand for VA care by up to 30 percent. We believe that, given proper financial incentives and greater access to VA medical facilities, more veterans will seek VA treatment. The Legion's plan calls for an expanded preventive health care element which would encourage outpatient checkups and other measures to treat veterans when they first become ill rather than waiting until some extensive inpatient care is required.

Over the past decade, both major and minor construction accounts were seriously under funded. Money appropriated for minor and minor miscellaneous construction projects was diverted within the Department to help pay for other priorities. Now these programs have a backlog of roughly 800 unfunded projects. The nonrecurring maintenance program has suffered a similar fate. We are pleased to see that the President's economic stimulus package has recognized these problems.

Congress and VHA must work together to reduce the tremendous backlog in minor/minor miscellaneous projects. The VA has an aging medical infrastructure and, without adequate construction funding, the system will continue to deteriorate and will not be able to support new program initiatives.

The Legion supports VHA's proposal to amend U.S.C. 38, Section 8104, and the minor construction appropriation language, which presently limits the cost of minor construction projects to \$3 million or less. That recommendation, to raise the limit to \$5 million, would provide for more efficient project management by having fewer contracts and more effective contract performance. All of the projects up to \$5 million would be delegated to the medical centers, providing more local control. Minor renovation projects could prove to be less time consuming and less costly if the proposal were enacted.

Mr. Chairman, over the past three years, VHA has been provided resources to convert up to 5,000 under-utilized acute care hospital beds to long-term care nursing care beds. In actuality, only about 3,000 such bed conversions have taken place. It is our understanding that VHA is currently evaluating a cost/benefit analysis of maintaining in-house nursing care capabilities versus contracting out such services. VHA maintains strict criteria for staffing nursing home care beds and is extremely stringent with regard to safety standards. The American Legion recommends a thorough review of long-term care within VHA.

Mr. Chairman, that concludes our statement.

211 Indian Spring Dr.
Silver Spring, MD., 20901
February 25, 1993

The Honorable J. Roy Rowland, Chairman
Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C., 20515

Dear Mr. Chairman,

Thank you for your recent letter requesting my views on the Department of Veterans' Affairs' Major Construction program, the planning process supporting that program, and related issues of timeliness and cost-effectiveness.

There should be several factors which guide the Committee's consideration of proposed major construction projects. These factors include:

1. The consistency of the project with a system-wide plan for the provision of medical care to veterans;
2. The balance of projects which meet critical needs such as seismic strengthening, expansion of long term and chronic care services and improvement of patient environment in smaller facilities, or other priorities;
3. The development of a policy on the appropriate construction methodologies and standards to assure that high quality facilities are built while restraining costs. In a period of tight budgets, stringent cost controls are the only way to assure an adequate level of construction to keep pace with the System's needs;
4. In considering the cost of construction, the Committee should consider the five year operating cost of the new facilities and force the Department to determine what programs will be reduced to fund the new operating costs if appropriations are not forthcoming;
5. Decentralization and streamlining are absolutely essential to reforming the major construction process. However, without adequate information on changes in scope, cost experience relative to projections, and timeliness meaningful oversight by VA central office or the Congress is impossible.

The Honorable J. Roy Rowland, Chairman
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THE PLANNING PROCESS

There seems to be a general recognition of the need for a system-wide plan for the provision of health care in the VA. This assumption underlies the findings of the "Mission Commission" and the development of the National Health Plan by the Veterans Health Administration. Such a plan would, among other things, define the missions of individual stations, provide guidance on the preparation of Facility Development Plans and set parameters on the scope of proposed construction projects. However, to date, no plan has been articulated or implemented. As a result, projects are still based on the existing Facility Development Plans. Since there is no meaningful national guidance as to mission, the station is free to plan based on local interests or desires. Often, there is no meaningful attempt to comply with system-wide needs or maximize sharing agreements for high cost equipment or services.

Therefore, the Committee must insist upon the development of an overall plan for the provision of medical care to veterans. Among other important issues, the plan must focus on the fact that for almost a decade, acute care workloads have been declining while chronic, long term and mental health workloads have increased. This plan must be used to determine the appropriateness of individual projects and, more importantly, the major programs and equipment proposed in each project. In addition, the Committee should require an exhaustive analysis of other programs and equipment--both VA and non-VA in the area that might be appropriate for sharing agreements.

PRIORITIES WITHIN THE PLAN

In each year, decisions must be made as to priorities within the overall construction plan. These priorities, in the past, have included seismic strengthening, increases in long term care facilities, patient environment projects, etc. The Committee must assure that a distribution of projects consistent with policy priorities is occurring within the Major Construction category. In addition, care must also be taken to assure that an appropriate level of funding for these or other priorities is being funded within the minor construction and NRM budgets and that planning funds are being allocated so that an adequate distribution of projects are "in the pipeline." Within the Minor Construction and NRM categories, this allocation does not entail approval of individual projects, rather it assures that a proper level of funding is being allocated to areas that have difficulty competing for funds within VHA.

The maximum limit of minor construction projects should be lifted to \$10 million.

The Honorable J. Roy Rowland, Chairman
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CONSTRUCTION METHODOLOGY

The Department of Veterans' Affairs undertakes very large and expensive major construction projects. While there have been efforts to reduce the scope and move away from the traditional VA building system, these have been ad hoc and project by project. There is no overall policy or incentive to keep costs of construction to a minimum. A thorough external review is needed to determine whether VA's traditional building methodology is appropriate to a world of constrained budgets.

FUNDING THE OPERATING COSTS OF NEW CONSTRUCTION

The Department of Veterans Affairs makes no attempt to determine the operating costs of new construction nor to emphasize that reduced operating costs is a goal of new construction. The FTE and activation costs must come "off the top" of each years' appropriation and the station receiving the funds has no incentive to keep the costs down. This problem is accentuated by the practice of using the new construction and activation funding as an opportunity to make up for past budget reductions.

As a result, each major construction project should include a five year operating budget that shows the cost increases (or decreases) resulting from the construction. The Department should be required to state not only costs, but to identify how the funds for the operation of the new facility would be generated if no increase in appropriations is forthcoming upon completion of the project.

DECENTRALIZED CONSTRUCTION

The Department of Veterans' Affairs recently undertook a reorganization of the Office of Facilities which entailed a massive decentralization of authority to the field and an accompanying reduction in central office oversight of projects. As a concept, I believe that this reform is valuable and will markedly reduce the time and frustration involved in managing a project from initial conceptualization to activation. However, in its final form, the proposal has a major flaw--once approved, information on the project scope (as it evolves) and problems in construction are given little emphasis. As a result of loose budgetary and financial control within VHA, programs and equipment can be added to projects after approval with a resultant significant scope change. Projects can run into construction difficulties along the way. With no steady stream of information and no funding being devoted to create such a stream, those offices charged with oversight and the Congress are left with precious little data to track projects.

The Honorable J. Roy Rowland, Chairman
Page 4.

The Committee should insist that decentralization and simplification of the construction process go forward. However, as a condition of funding, the Committee should require that an information system be developed to assure that modifications to the original project scope are consistent with the hospital's overall mission, that significant modifications are approved by proper authorities and that data to assure that projects are meeting time and budgetary milestones is systematically provided.

Since this data involves financial and program performance data and because its accuracy is essential to avoid after-the-fact scope changes and embarrassing delays or cost over-runs, I believe that the Department's Chief Financial Officer should define the critical data to be collected and assure its validity. This function is required by statute and provides an independent source to assure the accuracy, validity and relevance of data.

I hope that these observations will help the Committee in its responsibilities for authorizing major construction projects. Of course, If I can be of any further assistance to the Committee on this or any other matter, please feel free to contact me.

Sincerely,

S. Anthony McCann

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES
CHAIRMAN ROWLAND TO GENERAL ACCOUNTING OFFICE

Responses to Questions for the Record
For the March 3, 1993, Hearing On
VA Construction Held By the
Subcommittee on Hospitals and Health Care
House Committee on Veterans' Affairs

Question 1

You appeared to endorse in principle the concept of applying VA's prioritization methodology as a mechanism by which to limit funding of proposed major medical construction projects to those projects meeting a certain objectively measurable level of need. In doing so, however, you also appeared to suggest that "some improvements could be made" to that methodology. Was that the import of your testimony? If you see a need to revise the methodology, what specific changes are needed?

GAO Response

The prioritization methodology itself is, for the most part, reasonable. The method sets a numerical score based on established criteria for each project within a project category, such as new or replacement medical centers, outpatient improvements, cemetery projects, nursing homes, and correction of life safety and seismic deficiencies. Each category is assigned a program emphasis weight reflecting the relative importance of projects in that category. For example, projects to correct seismic deficiencies are assigned a higher weight than projects to build new regional offices. Program emphasis weights reflect policy decisions about which types of projects should have the highest priority for funding. While there may be concerns over whether the right weights are being assigned to various types of projects, the program emphasis weights are largely a reflection of the policy decisions of the Department. Changing the weights to emphasize outpatient care and nursing home care over hospital care would largely require a change in policy and not a change in the prioritization method itself.

While the methodology appears reasonable, it, like most such methods, is dependent on the quality of the input. This is where we identified some concerns. First, VA was not adequately considering socioeconomic characteristics of local veterans in developing plans. Similarly, VA does not always consider the availability of nursing home beds and hospital beds in community facilities and state veterans' homes when planning health facility construction projects. This could result in a project receiving too high a score because the data entered into the prioritization methodology understated the availability of alternative services. Finally, priority scores can be inflated if the potential for joint ventures with military facilities is overlooked.

Like many management systems, the prioritization methodology is also subject to "gaming." In other words, a medical center can obtain a higher numerical score--and thus a higher priority--for a project by changing the category under which the project is classified. For example, classifying a modernization project as a seismic improvement would increase the priority score.

Because there is no direct link between the prioritization methodology and the appropriation process, there is also a potential that projects not receiving high scores--or not considered at all--under the prioritization methodology may be added either by VA or the Congress.

Question 2

At the hearing, you stated that Medicare expenditures on veterans health care far exceed VA expenditures for veterans who are Medicare eligible. Did you adjust your data on the Medicare-user group so that it comprises only veterans who are either service-connected or have incomes below the VA means-test threshold, or do you have any data to suggest that significant numbers of those

veterans receiving care through Medicare are either service-connected or have incomes below that threshold?

GAO Response

The analyses we have completed so far do not break out Medicare expenditures on veterans' health care based on such factors as service-connection and income. Nor are we aware of data from other sources which specifically addresses Medicare usage by low-income and service-connected veterans. We are, however, exploring the possibility of conducting further data matches and analyses to develop such information.

One possibility is further analysis of data VA obtained through the 1987 Survey of Veterans. The Survey gathered data on VA usage by age, service-connection, and income category. This might enable us to determine what portion of veterans who are both (1) elderly and low-income or (2) elderly and service-connected have relied on the private sector for health care and have never used VA. It will not provide a direct link to Medicare usage. We will provide the Committee the results of any such analyses we perform.

Question 3

You state that Medicare expenditures on veterans health care exceed \$20 billion a year. How many veterans does this figure represent? Have you determined what level of income these veterans have?

GAO Response

Our preliminary data suggests that over 7 million veterans are Medicare-eligible. Approximately 70 percent of Medicare-eligible veterans used Medicare services during 1990, the year covered by our analyses. While we are still finalizing our analyses it appears that most Medicare-eligible veterans relied on Medicare rather than VA for their health care.

The data bases included in our analyses do not include income data. We are, however, planning to do a further match of our file against VA's compensation and pension file. While this file does not contain specific income data, it will enable us to further analyze VA and Medicare usage by low-income VA pension recipients. We will provide the Committee the results of these further analyses when they are complete.

Question 4

It is my belief that most veterans who rely on Medicare do so because current VA eligibility criteria restrict their access to the VA system or because VA facilities are located a considerable distance from their homes. Does any of your data refute this belief? If so, what does your data show?

GAO Response

Our analyses do not allow us to compare Medicare use by veterans living close to VA health care facilities to Medicare use by other veterans. Nor does it permit conclusions as to why veterans with dual eligibility choose Medicare over VA. We are, however, beginning studies to develop such data.

Question 5

At the hearing you stated that among those veterans choosing Medicare benefits over VA health benefits, some portion are lower income, nonservice-connected veterans. What specific data do you have to support this position?

GAO Response

VA's 1987 Survey of Veterans provides data showing that large proportions of both elderly veterans and low-income nonservice-

connected veterans have never used VA health care services. For example, over 63 percent of veterans with incomes under \$10,000 told VA they have never used a VA hospital. Similarly, 73 percent of veterans aged 65 to 69 had never used a VA hospital and over 75 percent of those from 70 to 74 years of age had never used a VA hospital. Of these two later groups, 15 percent and 28 percent, respectively, said that they had never used a VA facility because they used Medicare or Medicaid.

While the published tables VA prepared from the Survey of Veterans does not include the secondary analysis of veterans who are both elderly and low-income, we believe the data strongly suggests that such analyses would show that many low-income elderly veterans choose Medicare over VA services. We are beginning to conduct such analyses and will provide the results to the Subcommittee when they are complete.

Responses of David E. Lewis
Hearing of March 3, 1993

Would you explain your suggestion that increasing the minor construction threshold to \$5 million would be a valuable cost-containment step. If it is that good an idea, would you endorse the recommendation of the former VA Assistant Secretary for Finance that the limit should go up to \$10 million.

Increasing the minor construction threshold to \$5 million would be a valuable cost containment step primarily because it would hasten the construction process thereby lessening the impact of inflation and reducing Central Office costs.

A process in excess of \$3 million today is of course funded by the major construction appropriation which means that even a \$3,100,000 project lines up in the five year plan and competes with other major projects. Its inclusion in a particular budget year, while potentially satisfying political interests does not always mesh with VA's priorities.

The fact that major projects are often split funded -- design funding in one year and construction funding in a subsequent, not necessarily a succeeding year -- means that executing a major project in one year is impossible. Because of the split, the project may not be completed for several years thereby possibly incurring the cost of redesign and the impact of inflation.

By increasing the threshold to \$5 million, many ward renovations and conversions to nursing beds which may have cost \$3 million several years ago, but which now are more costly, can be achieved swiftly.

Without all the Central Office approvals and multiple reviews required of major projects, minor projects move through the system swiftly because of local interest in getting projects completed.

Expansion of the threshold to \$10 million borders on usurping Congressional authority because a \$10 million project is large enough to encompass new programs inviting Congressional review. However, such an increase could force many \$11 to \$15 million projects to be rethought so that they could fit into the minor category thereby effecting cost containment.

On balance, it would seem prudent to expand the threshold to \$5 million first, see how the hospital directors handle it -- \$10 million is a pretty big burden to place on local people -- and go on from there in subsequent years.

QUESTIONS FOR MISS MARJORIE R. QUANDT
from The Honorable G. V. (Sonny) Montgomery
for the Hearing of March 3, 1993

1. Would you elaborate on the concept of designing "multi-purpose" medical facilities mentioned in your testimony? Would you provide us with some examples?

"Multipurpose" medical facilities is an expansion of the principle of multipurpose rooms. The best example of the latter are those rooms which can be used for chapels, conferences, recreation activities, or an auditorium as the occasion necessitates. The Canadian Department of Veterans Affairs first purely chronic care hospital, St. Anne de Bellevue built in 1972, utilized the main entrance lobby as a family visiting room, dining area for ambulatory patients, or social/game room depending upon the hour of the day. Much of the entire facility has the capability of converting from a hospital to nursing home as the patients' needs change.

VAMC directors who voice a concern for multipurpose facilities are facing the problems of fitting patient needs into a structure design-built for 85-100 years. This type of construction is expensive and renders the building quite inflexible. A less costly physical plant with a 40-year life span can either be abandoned, or designed for flexibility with easily moved, temporary wall partitions that meet fire-safety code. This would facilitate conversion of wards from hospital care to nursing home care, to clinics or to adult day care centers. Meeting such needs for flexibility is another reason to unbundle elements of the continuum of care like administrative space, nursing home and clinics, as well as support services, from the hospital envelope in contrast to DVA's current method of construction.

Using a multipurpose or flexibility concept and a 40-year life span would also lower VA's modernization/remodelling costs.

The multipurpose facility concept should allow parts of VAMCs to be reconfigured with ease from intensive-acute care to lower level sustained or long-term care. VA's experience has actually been the reverse. Witness the expensive domiciliary construction which would allow these to become nursing homes in 25 years or the fate of the original Restoration Center at East Orange.

2. You made reference in your testimony to a data analysis undertaken last year on the so-called "snow-bird"/"northbird" phenomenon. Could you provide that analysis for the record?

I regret I do not have that material. I have contacted the Boston Development Center and requested similar data for FY 1992. The Center, however, is working on RPM applications, and I cannot be certain when it will supply the information. I will send the material under separate cover when received. I regret it will not come in time for inclusion in the Committee Report.

3. In responding to a question regarding applying VA's prioritization methodology as a mechanism by which to limit funding of proposed major medical construction projects to those meeting a certain objectively measurable level of need, you expressed the hope that methodology would be updated after decisions on hospital missions and on "the VA health program" are made. Would you explain the relationship between the soundness of the methodology and decisions on mission and program as it relates to when the prioritization criteria are updated. Other portions of your testimony appeared to suggest that the

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methodology is currently skewed in a manner giving insufficient weight to certain areas of need. If so, is there a reason to defer revising the methodology?

Although the prioritizing methodology for construction projects has been improved to give better weight to the infrastructure and now includes Veterans Benefit Administration (VBA) and National Cemetery Service (NCS) needs, there are weaknesses in the system. Both the Facility Development Plan (FDP) and the prioritizing methodology should be updated and corrected. As noted in my testimony only the first portion of the FDP is considered useful by facility directors. Frankly, I believe FDPs should be stopped until policy decisions are made. The prioritizing methodology either ignores or gives low value to needs in psychiatry and intermediate care in the process of some reviews.

At this point in time DVA is unclear what veteran population will be treated in the future (eligibility reform). Will it be all veterans, veterans needing specialty long-term services such as rehabilitation, spinal cord injury services, long-term psychiatry, or will it be veterans requiring nursing home care, extended long-term outpatient care such as adult day health care and home care. The needs of the population serviced make considerable difference in the siting and sizing of the necessary components of a vertically integrated veteran health care system (VHCS).

The decision of DVA's role in national health care reform is another factor. Will VHCS continue (1) as it is now, a fully integrated system with emphasis on acute bed care, or (2) will it be assigned a niche role of long-term care and rehabilitation with a small component of acute care to support the population serviced? Or, will the system be a combination of the above with the majority of veterans in urban-metropolitan areas receiving "niche care" in DVA as in option two with "standard" care in the private sector through national health care reform policies, while veterans and non-veterans in less urban and rural areas have access to a fully vertically integrated DVA system in option one. At the moment no one knows how many veterans will "walk" when national health care reform is operational. (DVA might gain some insight in this by tracking the shifts observed in veterans' care in Florida, Oregon, Minnesota or New York as these plans come on line.)

Until DVA knows the clientele to be served and what that service entails, any prioritizing methodology is moot. To use the current methodology in such an unknown environment could place the wrong capability in the wrong place.

When eligibility reform is enacted and the role in national health care reform defined, the prioritizing methodology should be kept up to date and revised perhaps every three years so that the methodology stays current with the changes in patient population and its health care needs. If DVA is to stay current with the health care industry and the manner in which care is provided, the methodology needs to favor community based and satellite clinics, greater use of all aspects of non-bed care, and to recognize honestly DVA's growing need for augmented geriatric services, long-term mental health and nursing home.

A Congressional staff member posited to me as late as April 23, 1993, that with national health care reform VHA will only need 16 teaching hospitals. Such a possibility would make the weights assigned various programs, new hospitals, hospital replacement-modernization and clinical improvements quite different values than those that currently exist.

The Encore of McLean
 Apartment 213
 1808 Old Meadow Road
 McLean, VA 22102-1826
 June 21, 1993

The Honorable G. V. (Sonny) Montgomery
 Chairman, Committee on Veterans' Affairs
 U. S. House of Representatives
 335 Cannon House Office Building
 Washington, DC 20515

Dear Chairman Montgomery:

One of the follow-up questions referred to me from the Subcommittee on Hospitals and Health Care Hearing of March 3, 1993, on the construction program dealt with where patients receive threathment in the VA. This is the famous "snowbird-northbird" issue. Specific interest at the hearing was expressed by subcommittee members for Arkansas and Florida. The information did not arrive by the reply deadline, and I am providing it now because of the rather startling findings for those two states.

The following table for Arkansas, Florida, Massachusetts, New York and Texas illustrates above all the mobility of veterans. It also reveals that contrary to customary belief, some veterans do not seek care in their state of residence. Several factors cause these results: personal travel, a catchement area that crosses state lines--the closeness of Memphis to Arkansas, lack of needed care in a state--Florida's dearth of psychiatric beds, or specialty care such as spinal cord injury.

Data is taken from the FY 92 Medical Care Appropriation file cost accounted to specific (individual) patients. There is a 96 per cent confidence rate on the file match. Figures do not add up to 100 per cent since the number of states below two per cent would make the table excessively long.

WHERE VHA MONIES ARE SPENT ON VETERANS FROM A KNOWN
 STATE OF RESIDENCE

VETs. ST. OF RESIDENCE	ST. WHERE CARE GIVEN	COST IN MILLIONS	PER CENT OF CARE RECEIVED
Arkansas	AR	\$89.4	52.5
	CA	13.5	7.9
	TN	9.4	5.5
	MO	6.9	4.1
	TX	6.7	3.9
	LA	5.9	3.1
	IL	4.3	2.5
	OK	3.7	2.2

The Honorable G. V. (Sonny) Montgomery 2

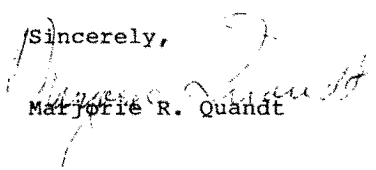
June 21, 1993

VETS. ST. OF RESIDENCE	ST. WHERE CARE GIVEN	COST IN MILLIONS	PER CENT OF CARE RECEIVED
Florida	FL	\$329.7	58.2
	NY	29.9	5.3
	CA	24.3	4.3
	AL	12.9	2.3
	MS	12.2	2.2
	GA	11.7	2.1
Massachusetts	MA	296.5	75.1
	RI	12.7	3.2
	CA	12.0	3.0
	FL	11.0	2.8
	NY	9.6	2.4
	CT	8.2	2.1
New York	NY	792.6	76.6
	CA	35.9	3.5
	FL	31.9	3.1
Texas	TX	537.2	68.1
	CA	57.2	7.3
	LA	25.2	3.2

The information suggests that the policy question of capitation management of the health care system cannot be ignored and delayed much longer by VHA. Congressional concerns about dollar expenditures for constituents would not be so compelling if the veterans living in Massachusetts, for example, had funds transferred through a "VHA plan bank" to the out-of-state hospital where he/she seeks treatment. This would allow the person to receive the care needed, and not rationed as is sometimes said to happen when veterans from New England are cared for in the South East.

The Department of Veterans Affairs must have a concern about the number of veterans who will continue to seek care in its system when health care reform is enacted. These data further highlight that question, since access to care through a reformed national system would not make it so imperative for Florida veterans to go to Alabama, Mississippi or Georgia for care. The same might be true for Arkansas veterans. The surprising thing about this table is the low per cent of veterans in Florida and Arkansas treated in their home state as compared to the other three.

Sincerely,



Marjorie R. Quandt

CHAIRMAN ROWLAND TO DEPARTMENT OF VETERANS AFFAIRS

POST-HEARING QUESTIONS
FROM THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING OF MARCH 3, 1993

QUESTION: TWO INDEPENDENT STUDIES, ONE BY THE PVA AND THE OTHER BY THE COMMISSION ON THE FUTURE STRUCTURE OF VA HEALTH CARE, HAVE CALLED FOR CHANGES IN THE VA HEALTH CARE SYSTEM THAT INCLUDE CHANGING THE MISSIONS OF NUMBERS OF VA HOSPITALS. IF THOSE RECOMMENDATIONS WERE ADOPTED IN PRINCIPLE, APPROXIMATELY HOW MANY HOSPITALS WOULD BE CANDIDATES FOR MISSION CHANGES?

ANSWER: A Mission/Program Review Subcommittee has been appointed to develop a process by which missions will be assigned to VHA medical facilities. Bearing in mind the Commission and PVA recommendations to provide a continuum of care within a geographic area, the results of the facility-specific mission assignments will be used to identify health care services within a specific network of VA medical centers. Until the classification and subsequent analyses have been completed it would be premature to predict how many facilities will be candidates for mission changes. Also, it should be noted that this is an ongoing process. Missions will be reviewed as part of each planning cycle and appropriate adjustments made.

QUESTION: WHAT EVIDENCE IS THERE TO BELIEVE THAT VA HOSPITAL DIRECTORS -- ON THEIR OWN -- WOULD PROPOSE ELIMINATING SUBSPECIALTY OR OTHER ACUTE CARE PROGRAMS IN ORDER TO PROVIDE MORE PRIMARY OR LONG-TERM CARE?

ANSWER: It should be noted that managed care/primary and long-term care have been identified by VA hospital management, as well as the private sector, as priority areas of focus. The VA has already instituted a number of primary care programs and is in the process of assessing where we are and how successful we are in the implementation of various primary care models. Through their own initiative, a number of medical center directors have instituted primary care models such as Sepulveda VAMC with their PACE program. VAMC Salem has also been cited as having an excellent primary care/ambulatory care model for adaptation throughout the system. Given that there is a national VHA Managed Care Committee, it is envisioned that this group will review what is currently being done and promote policies that will continue to encourage local initiatives.

With regard to long-term care, an example of local initiative is the conversion of hospital beds to nursing home care beds. To date, approximately 1000 beds have been converted nationwide, almost exclusively at the request of local facility management.

It should be recognized that both ambulatory care and long-term care have been identified as two areas to focus on in the regional planning submissions due this Fall. Plans for these programs are already being developed starting at the local level and continuing through networks and regional planning boards.

QUESTION: IN THE ABSENCE OF REVISED MISSIONS, AREN'T HOSPITAL DIRECTORS DEVELOPING CONSTRUCTION PROPOSALS BASED ON MISSIONS WHICH FROM A SYSTEMS-NEED BASIS MAY BE OBSOLETE?

ANSWER: All VA medical centers have mission statements approved by the Under Secretary for Health. Existing missions are the result of strategic planning processes which require review of gaps and duplication in services and which recognize the need to establish complementary missions for facilities in close geographic proximity or to insure patient referral and continuity of care within planning networks. All construction projects are vigorously screened against assigned missions at the network, region, and national level. If a project affects a clinical area for which a facility's mission requires clarification, a revalidation of the project's continuing need must occur before the construction project proceeds. In those rare instances when a mission might change after a construction award has been made or construction is in progress, subsequent modification of the space or realignment of beds to a bed service compatible with the revised mission might be required.

QUESTION: VA CONDUCTED A CAPITAL FACILITIES STUDY DURING THE 1980'S TO DETERMINE THE CONSTRUCTION NEEDS OF ITS OLDER FACILITIES. DOES THE DEPARTMENT HAVE A RELIABLE SYSTEMWIDE UPDATE ON THE BASIS OF WHICH TO PROVIDE A COMPARABLE, RELIABLE ASSESSMENT OF CURRENT TOTAL MAJOR CONSTRUCTION NEEDS?

ANSWER: Capital Facilities Studies (CFS) for 132 VA medical centers were completed in 1987. Because of funding constraints these studies included only buildings constructed prior to 1970. The capital facilities studies identified the technical requirements which were substandard and needed to be upgraded to continue providing the existing programmatic functions at that time. The data base is updated by the medical centers when they determine it is

appropriate. CFS did not evaluate costs required to make functional and programmatic improvements. More recently, the Department initiated the Facility Development Plan (FDP) initiative which does evaluate in a comprehensive manner the facility needs of each medical center. FDPs have been completed at 85 medical centers and 80 are either ongoing or in the contracting phase at the remaining medical centers. The CFS data is utilized in development of the FDP. Currently, data is available from the CFS studies, through the medical center's five year plan and where completed, the medical center's FDP. When all FDPs are completed, the existing data bases will be significantly improved.

QUESTION: SECRETARY BROWN IS COMMITTED TO ELIGIBILITY REFORM AND TO PROVIDING A COMPLETE CONTINUUM OF VA CARE. DOESN'T THIS MEAN THAT YOU NEED TO REDUCE ACUTE CARE BEDS SUBSTANTIALLY AND INCREASE LONG-TERM PSYCHIATRIC CARE AND OUTPATIENT CARE CAPACITY, FOR EXAMPLE?

ANSWER: Neither the exact components of the continuum of care nor the proposal for eligibility reform has yet been defined. Although it is difficult to foresee the effects before the scope of these is specified, we would certainly expect an increase in the number of outpatient visits and in long-term care, including psychogeriatric care. Under the status-quo, VA would reduce acute care and move toward more outpatient care; however, at this time, we do not anticipate the need to reduce acute beds should eligibility be simplified in the reform process because more veterans may choose to use the VA and the aging veteran population is likely to require more frequent hospitalizations than younger cohorts.

QUESTION: FROM THE PERSPECTIVE OF VA'S HOSPITAL DIRECTORS AND REGIONAL DIRECTORS WHO EFFECTIVELY DETERMINE WHAT FINDS ITS WAY INTO THE CONSTRUCTION PIPELINE WHAT PRIORITY DOES MAJOR CONSTRUCTION ON LONG-TERM PSYCHIATRIC FACILITIES HAVE?

ANSWER: Most of VA's long-term psychiatric units are in medical centers with specific missions to provide long term psychiatric care among other extended care modalities. These medical centers develop five year construction plans along with all other medical centers. Thus all projects, whether major or minor or non-recurring maintenance, completed or planned for these medical centers address the long-term psychiatric need. Many projects to upgrade environmental conditions are being completed through the minor program which provides the flexibility to maintain the same level of service during construction and complete jobs faster because of limited scope of work. Regarding the major

construction program, long-term psychiatric is covered under the category of patient environment/privacy which has high program emphasis and in line with outpatient, nursing home care and fire safety. Project scores for such projects may be lowered when medical centers include renovation of other, lower priority areas, such as administrative services for instance.

VA will be reviewing the prioritization methodology this year and will address program emphasis weights for long-term psychiatric care along with others.

QUESTION: HOW WOULD THE VA EXPLAIN DATA WHICH INDICATE THAT AT 15 OF VA'S AGING LONG-TERM PSYCHIATRIC HOSPITALS, THERE HAS BEEN NO MAJOR CONSTRUCTION ON PSYCHIATRIC BED BUILDINGS IN THE LAST 15-25 YEARS, AND IN SOME CASES NONE SINCE THE 1920'S AND 30'S?

ANSWER: Within the last three major construction budget requests, funds have been requested (FY'94) or appropriated (FY'93, FY'92) for long-term psychiatric facility improvements at Lyons, New Jersey; Leavenworth, Kansas; North Chicago, Illinois; Palo Alto Menlo Park, California; Marion, Indiana; and Tuscaloosa, Alabama.

In FY'92, long-term psychiatric projects represented approximately 50% of the request; in FY'93 roughly 30% and in FY'94 roughly 13%. Long-term psychiatric needs are also addressed with minor construction, renovating a ward at a time to avoid having to reduce services during construction. Long-term psychiatric construction is being provided under the fire safety and environmental improvements priorities in both programs. Long-term psychiatric facilities under the project prioritization process compete equally with other medical centers for funding.

QUESTION: VA'S POLICY FOR YEARS HAS BEEN TO BUILD NURSING HOME UNITS ON THE SAME SITE AS VA HOSPITALS, A PRACTICE THAT INCREASES COST (ONE STUDY FOUND VA SITE COSTS TO BE MORE THAN FOUR TIMES HIGHER THAN IN THE PRIVATE SECTOR). HAS THAT POLICY CHANGED, OR IS IT CHANGING?

ANSWER: VA policy is to build nursing homes where they are needed. Nursing home needs assessments are completed based on existing available beds including State owned and community nursing home beds compared to known need. In the past, the construction of nursing home beds has been limited to sites with existing VA hospitals. However, VA currently has plans for constructing nursing home beds co-located with Satellite Outpatient Clinics in Florida and California.

QUESTION: IS IT FEASIBLE, AS SOME HAVE SUGGESTED, FOR VA TO USE A SO-CALLED "DESIGN TO COST" APPROACH BY EMPLOYING NATIONAL CONSTRUCTION ESTIMATING GUIDES TO SET BENCHMARKS FOR PROJECT COSTS?

ANSWER: VA believes that it captures a "design to cost" approach in its improved process initiated in October 1992. Once a memorandum of agreement is signed, all parties expect to design to the defined program and the magnitude cost estimate. Market conditions however are unpredictable and some building conditions are discovered through A/E study during design or uncovered during construction. These factors must be dealt with in a manner that allows delivery of a fully functional facility. We do not believe it is possible or appropriate to define only a general project scope and maximum cost and allow the A/E or design-build firm to set criteria, materials, equipment and construction quality standards. VA loses control of the final product which we will run and maintain for many years.

QUESTION: PLEASE PROVIDE US SOME SENSE OF THE MAGNITUDE OF VA'S MAJOR CONSTRUCTION NEEDS, NOW AND IN THE FUTURE? ONE WITNESS ESTIMATED THAT UPDATING EXISTING BUILDINGS WOULD COST MORE THAN \$11 BILLION? IS THAT PROJECTION "IN THE BALLPARK?"

ANSWER: The five-year major construction inventory developed from the sum of VA medical center five-year construction plans estimates the need for major construction in the current five-year horizon to be approximately \$6.5 billion. Projects in this inventory are based on 1980 census and projections of workload for the year 2000, assuming current eligibility rules, current missions and current practice patterns. About \$2 billion of this inventory is reflected in VA's Medical Facility Development Plan covering the same five year horizon.

QUESTION: DO THE CONSTRUCTION PROJECTS CONTAINED IN THE FISCAL YEAR 1994 BUDGET SUBMISSION REPRESENT ONLY PROJECTS THAT RECEIVED THE HIGHEST SCORES UNDER VA'S PRIORITIZATION METHODOLOGY?

ANSWER: Projects contained in VA's FY 1994 construction budget request were selected from a pool of priority-ranked projects under development for which it is believed an award can be made during FY 1994 and which fell in rank order within the available budget target.

QUESTION: PLEASE PROVIDE THE COMMITTEE WITH A LIST OF ALL MAJOR CONSTRUCTION PROJECTS THAT HAVE RECEIVED DESIGN OR CONSTRUCTION FUNDING IN THE LAST FIVE YEARS THAT WOULD NOT HAVE BEEN CANDIDATES FOR FUNDING IF SUCH A DECISION WERE TO HAVE BEEN MADE SOLELY ON THE BASIS OF VA'S PRIORITIZATION METHODOLOGY?

ANSWER: The following is a list of major construction projects which have received design or construction funding in the last five years and would not have been candidates for funding if such a decision were to have been made solely on the basis of VA's prioritization methodology.

VAMC	PROJECT	FUNDING YEAR
Ann Arbor, MI	Clinical Addition/Research	91/92/93
Beckley, WV	Land Purchase	92
Madison, WI	Central A/C	89
Miami, FL	Parking Garage	91
Mountain Home, TN	Laundry/Warehouse	91
Saginaw, MI	Nursing Home Care	89
Tampa	SCI	90

QUESTION: SOME CRITICS CHARGE THAT VA PROJECTS FREQUENTLY EXCEED PROGRAM NEEDS, CONTAIN TOO MANY BEDS, TOO MUCH SPACE, OR DESIGNS THAT ARE TOO COSTLY. IS THERE A FOUNDATION TO THOSE CHARGES? WHAT CHECKS DOES VA CURRENTLY HAVE IN PLACE TO SAFEGUARD AGAINST SUCH PRACTICES?

ANSWER: Some replacement/modernization projects in the past have built more beds and consequently space than required at the time of activation. For a cost-effective design, the size/scope of a project must be defined clearly at the outset of development which occurs 7-8 years prior to activation. The scope and size is defined by the best estimate of need possible at that time based on population statistics and patient use of services and projecting these into a future year.

At present and continuing into the future, when projections vary significantly, the scope/size of a project will be adjusted as long as the savings of such changes exceed the cost of redesign and delay. Medical Centers and VA Central Office will sign a memorandum of agreement prior to any design which specifically sets the square feet to be constructed and the cost of the project. All parties are expected to abide by the terms of these agreements during design and construction. Oversight reviews will verify compliance with these agreements.

QUESTION: AT ITS MARCH 3RD HEARING, THE COMMITTEE HEARD FROM A WITNESS WHO EXPRESSED THE BELIEF THAT ALTHOUGH THE PRIORITIZATION METHODOLOGY WAS REVISED IN 1990, AND, AMONG OTHER CHANGES, ACUTE CARE WEIGHTS WERE "LOWERED SLIGHTLY, SO THAT INFRASTRUCTURE, PATIENT SAFETY, PATIENT COMFORT WOULD HAVE A HIGHER RATE", "THE VALUES ARE STILL SUCH THAT THE MAJORITY OF FUNDS GOES TO ACUTE CARE." PLEASE ADVISE THE COMMITTEE WHETHER THIS PERCEPTION IS AN ACCURATE ONE.

ANSWER: Patient safety, comfort and infrastructure are of concern to VA whether the patient is in need of acute or long-term, medical/surgical or psychiatric care. Other high VA priorities are long-term and outpatient care. In the budgets developed since 1990 requests by % of dollars requested were:

- 31% for nursing home and long-term care
(Marion, In, Tuscaloosa, Palo Alto Menlo Park, No. Chicago, Salisbury, Bonham (Dom and NHCU), Asheville, Leavenworth Baltimore Loch Raven , Tuskegee, Lyons)
- 25% for replacing seismically unsafe patient/clin buildings
(Palo Alto, Memphis (D= design), Martinez (D))
- 17% for clinical improvements to acute facilities
(Dallas Clin and SCI, Tampa Clin (D))
- 14% for outpatient care
(Northport, Brooklyn, Marion, Il, Wilmington)
- 9% for environmental improvement to medical surgical beds
(Muskogee, Temple)
- 2% to improve access to care (Honolulu (D), Anchorage)
- 2% for other infra structure (kitchen, laundry) Brooklyn, Knoxville

QUESTION: VIEWED HISTORICALLY, HAS CONSTRUCTION FUNDING DECISIONMAKING WITHIN THE DEPARTMENT REFLECTED A BIAS TOWARD ACUTE INPATIENT CARE? IF SO, TO WHAT EXTENT HAS SUCH BIAS BEEN FED BY THE FOLLOWING FACTORS (IDENTIFIED BY SOME WITNESSES): AFFILIATED MEDICAL SCHOOL INTERESTS, A "CULTURE" WITHIN VA WHICH AT LEAST IMPLICITLY ASSIGNS HIGHER VALUE TO TERTIARY CARE OVER LONG-TERM CARE, AND THE RESOURCE ALLOCATION MODEL?

ANSWER: Acute inpatient care including tertiary care has in the past enjoyed higher priority. This was largely due to the pressure to provide state-of-the art technology for diagnostic and therapeutic modalities and is essential to being perceived as having the capability to provide high quality care. This movement was industry-wide and not unique to VA medical care. Resource allocation models have not affected construction requests as far as we know.

QUESTION: UNDER EXISTING POLICY, CAN THE COMMITTEE EXPECT TO SEE ANY CHANGE IN THE RELATIVE LEVEL OF FUNDING DEVOTED TO LONG-TERM CARE CONSTRUCTION? IF SO, WHEN AND BY VIRTUE OF WHAT POLICY(IES)?

ANSWER: Requests for long-term care will fluctuate from year-to-year depending on ability to make an award and priority rank of projects. Long-term care needs are also being addressed by the minor construction program with about \$63 million dollars set aside in the last two years for this purpose. Furthermore, the Department is examining the prioritization methodology and program emphasis weights this year and will make appropriate adjustments.

QUESTION: AT THE MARCH 3RD HEARING, THE COMMITTEE WAS TOLD THAT ALTHOUGH VA POLICY CALLS FOR FACTORING COMMUNITY RESOURCES INTO CONSTRUCTION PLANNING, FACILITY DIRECTORS OFTEN FAIL TO DO SO AND ARE NOT HELD RESPONSIBLE FOR CARRYING OUT THAT REQUIREMENT. IS THAT CHARGE ACCURATE, AND IF NOT, PLEASE DOCUMENT THE BASIS FOR YOUR RESPONSE.

ANSWER: No. Where there is a requirement, Directors are held accountable. Availability of community resources as an alternative to VA construction is mandated when proposing projects to meet the long-term care needs of veterans. Current policy requires that medical centers complete a community nursing home assessment when they are developing a construction project for new VA nursing home beds. There is not a similar requirement for other VA programs.

Failure to comply with the policy on nursing home construction would place a proposed project at risk of disapproval.