

**THE DENVER REPLACEMENT MEDICAL CENTER:  
LIGHT AT THE END OF THE TUNNEL?**

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**HEARING**

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES**

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## **THE DENVER REPLACEMENT MEDICAL CENTER: LIGHT AT THE END OF THE TUNNEL?**

**Wednesday, January 17, 2018**

COMMITTEE ON VETERANS' AFFAIRS,  
U. S. HOUSE OF REPRESENTATIVES,  
*Washington, D.C.*

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Bilirakis, Coffman, Wenstrup, Radewagen, Bost, Poliquin, Arrington, Higgins, Bergman, Gonzalez-Colon, Walz, Takano, Brownley, Kuster, Rice, Sablan, Esty, and Peters.

### **OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN**

The CHAIRMAN. Good morning and welcome to the one-half inch Washington blizzard this morning. Everybody trudged through the one-half inch of snow to get here this morning. The meeting will come to order. I want to welcome everyone to today's hearing, which is the seventh this Committee has held examining the construction of the new Rocky Mountain Regional Medical Center in Aurora, Colorado.

The road to completing this hospital has been extremely long and bumpy. The groundbreaking ceremony was held in 2009. All told, the price tag is at least \$2 billion. This situation must never happen again. But the finish line is near. Mr. Coffman, Mr. Congressman Perlmutter, and myself toured the medical center last week to see personally about this. Today we are here to discuss how near and take a close look at the facility that has been produced.

The construction debacle changed the way VA builds hospitals. In 2015 Congress mandated that another expert agency take over management of all VA super construction projects, which is everything over \$100 million. That agency is the Army Corps of Engineers. All available evidence suggests this was the right decision. In just over two years, the Army Corps has guided the project from less than 60 percent complete and mired in contractor disputes to 98 percent complete. VA has accepted all but one of the buildings, the diagnostic and treatment center. But the end of construction is merely the beginning of VA's activation effort.

Activation is never easy and unfortunately in this hospital's activation the team must continue to correct design and construction errors. The design of this facility began over ten years ago. It has already been well established how architectural novel and extravagance drove up this construction cost. In addition to that, so much

time has elapsed that the practice of medicine, building codes, and intended uses for the spaces have changed. It is deeply troubling that this new Aurora Medical Center doubles the square footage of the existing Denver Medical Center, but includes the same number of beds and actually reduces primary care capacity.

There are also hundreds of errors individually but small which add up to a significant problem that must be corrected. Things like sink in an operating room, surfaces that can't be cleaned, inadequate air conditioning systems, voltage problems, and an entire data center that must be rearranged. There are also mistakes to be fixed at the end of the construction job, but I have to wonder whether the clinicians who will treat veterans in this facility have ever scrutinized its specifications.

Even after the new medical center opens, VA must continue operating the old medical center because presently some of the primary care doctors and the PTSD residential rehabilitation facility have nowhere else to go. When Congress authorized this project and continued to authorize it through all its struggles, having two major VA hospitals six miles apart was never part of the deal. The local leadership expressed their commitment to closing down the old facility as soon as possible and recouping as much money for the taxpayers from the assets as they can. This Committee is going to make sure that that happens.

H.R. 4243, the VA Asset and Infrastructure Review Act, which we reported out of Committee in November, would give the VA the tools it needs to expedite building a new PTSD rehab facility on the Aurora campus and cut through bureaucratic hurdles to dispose of the Denver campus. And I can tell you after visiting out there last week, this particular facility is a poster child for why we need VA asset review. If any of you all had any doubt about that, please make the trip to Denver and look. And it will absolutely reassure, it will make, give you peace, it did me, to know that we need to do this.

Now is the time to add up what has been gained and lost in this experience. VA added a state of the art spinal cord injury treatment center. And I do want to mention, this truly is a state of the art. That was one of the most impressive parts of my trip, was this new spinal cord treatment center. It is going, there could not be a better one, I think, in the world maybe. And I know that the PVA, the Disabled Veterans, looked at this, helped design it, which I thought was really smart. And I want to commend the VA for this. And I think once it is implemented it will be really a state of the art facility for our injured veterans.

Also the new imaging capabilities, amenities for patients, and a modern facility for the burgeoning veteran population's decades into the future.

On the other side of the ledger, VA lost a significant amount of primary care space and must continue correcting defects potentially up to the day the doors open. And of course, successive groups of VA managers have spent a mind-boggling amount of taxpayer money. That being said, I now yield to Ranking Member Walz for his opening comments.

**OPENING STATEMENT OF TIMOTHY J. WALZ, RANKING  
MEMBER**

Mr. WALZ. Well thank you, Chairman Roe, and thank you all for being with us. We were just discussing earlier that I am entering my twelfth year in Congress and have the most amount of time here along with Chairman Roe. This project was approved before we got here. It has been here my entire congressional career. I mentioned it is older than my son Gus, who is 11. So again, with all due seriousness on this, we know, and again knowing what went wrong here, and the number of hearings we held here, some of them in prime time, over this issue, our responsibility of those of us sitting here now is about the lessons learned. And I would argue under Chairman Roe's leadership, and Mr. Coffman, and others, the way we have approached this has changed. The hand of Congress exercising its oversight authority has been much more present. It has been much more forceful. And for that, Mr. Chairman, I thank you. This is about fixing problems, not just complaining that they were there. And so I am grateful.

We have been waiting over 15 years for this replacement hospital. Now it finally appears Colorado veterans will have the state of the art facility that they deserve. We are all intimately familiar, as I said, with the history of project schedule overruns. It is important we apply these lessons we have learned from this project and apply them to the Army Corps' model for project management to future VA super construction projects.

Now that the facility will be turned over to VA this month for activation, VA needs to ensure it is able to adhere to the activation schedule so veterans can start receiving care at their new facility later this summer. Today I hope we get assurances from VA that the staff and resources are there to open on time. I want VA to ensure it is working closely with the Army Corps to complete construction. My greatest concern is whether VA has the infrastructure in place to meet the needs of veterans in Colorado and its neighboring states. We know the veterans receiving their care at the Denver Medical Center experience some of the longest wait times in the country. Due to the significant cost overruns for this project, the much needed PTS residential treatment facility was not constructed and additional funds will be needed to build this facility on the Aurora campus. Seven primary care teams will continue to operate out of the existing Denver facility, along with the community living center for the next three years.

Solutions are needed to address these significant infrastructure and capacity needs so that veterans do not continue to wait for their care. I hope the VA has come to be prepared to discuss solutions today, prepared to work with Congress, the State of Colorado, and the City of Denver to address those needs.

Thank you, Chairman Roe, for your leadership, and I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Now I would like to welcome our panel who are seated at the witness table. On our panel we have Ms. Stella Fiotes, Acting Principal Executive Director of the VA Office of Acquisition, Logistics, and Construction. She is accompanied today by Mr. Dennis Milsten, Director of Operations for the VA Office of Construction and Facilities Management. Ms. Fiotes is also accompanied by Mr. Ralph Gigliotti. And

I would like to mention that when I picked up my rental car in Denver, this young man who rented me my car said, "I think you are going to see my dad tomorrow." That would be Mr. Gigliotti, which tells you it is a very small world, Director of Veterans Integrated Service Network 19, which covers Colorado and neighboring states. We also have Mr. Lloyd Caldwell, the Director of Military Programs for the United States Army Corps of Engineers, and thank you for being here. And finally we have Mr. Andrew Von Ah, Director of Physical Infrastructure for the Government Accountability Office. I will ask your witnesses to raise your right hand.

[Witnesses sworn.]

The CHAIRMAN. Thank you. And let the record reflect that all witnesses have answered in the affirmative. Ms. Fiotes, you are recognized now for five minutes for your testimony.

#### **STATEMENT OF STELLA FIOTES**

Ms. FIOTES. Thank you. Good morning, Mr. Chairman, and Members of the Committee. Thank you for the opportunity to update this Committee on the status of the construction of the new Rocky Mountain Regional VA Medical Center in Aurora. I am accompanied today by Mr. Dennis Milsten and Mr. Ralph Gigliotti.

We are pleased that this facility will enable us to serve over 390,000 Colorado veterans and their families as we work to ensure that local veterans receive the VA services that they have earned and deserve. Upon opening, the Rocky Mountain Regional VA Medical Center will provide the same robust range of tertiary health care services that currently are available at the Denver VA Medical Center, with the addition of mammography and PET CT to its imaging services. The exception is the Post Traumatic Stress Disorder residential rehabilitation treatment program and seven patient aligned care teams that are currently slated to remain in the old facility. We are working, however, on options that will allow their relocation off the existing campus as quickly as possible to allow for ultimate closure and disposition of the old facility.

The Rocky Mountain facility is also proud to be the latest spinal cord injury and disorder center within the VA system. This center will serve populations in Colorado, Utah, Wyoming, and parts of Nebraska and South Dakota. The SCI center will include both an outpatient clinic and inpatient unit, offering comprehensive multidisciplinary care for patients with spinal cord injury, multiple sclerosis, and amyotrophic lateral sclerosis.

Lastly, the new facility will provide a much more up to date and positive veteran and family experience. This includes private rooms for patients with their bathrooms as well as space for family members to stay overnight, an intensive care unit with an 800-square foot waiting room suite, and all interventional services such as surgery and radiology to be located adjacent to pre-operative and post-operative beds to improve the coordination of care and efficiency of service delivery.

I am pleased to tell you that the construction contract with Kiewit-Turner is 98 percent complete and 11 of the 12 structures have been turned over for activation. VA and the United States Army Corps of Engineers are currently working through contract completion items and actively working with the contractor to bring



this contract to an end as swiftly as possible. Activation activities are ongoing and the facility will open to serve local veterans in August 2018.

The current activation schedule has the majority of installation, calibration, and testing of newly procured equipment being completed in May. This will enable the Denver Medical Center staff to complete over 40,000 staff hours of education, training, and orientation in late July. VA's current activation budget of \$341 million provides sufficient funding to service the opening of this facility.

During the Corps' construction management of the project, the contractor proposed to concentrate labor on completing and turning over the campus to VA building by building rather than a longer process of delivering it in full by the contract completion date of January 2018, which saved a substantial amount in KT overhead costs. KT is the contractor. Additionally, the Corps will not incur the estimated staffing costs they budgeted for the project and will be returning approximately \$10 million of unused funds to VA.

VA has worked diligently to improve the management and oversight of our major construction program by partnering with the Corps and incorporating lessons learned to ensure that the challenges faced on this project will not happen again. I'm here to tell you that VA today is doing business very differently than in the past. We are rethinking everything about how we will modernize our infrastructure to find ways to deliver much needed facilities smarter, faster, and at significantly less cost. Just one example is a recent project in Omaha, Nebraska where we have partnered with private donors and entities to deliver an ambulatory care center for our veterans in half the time and 30 percent cheaper than our traditional way of doing business. We are also looking at the next major projects to see how we can find smarter solutions, speed their delivery for veterans' use, and lessen the cost to taxpayers.

In closing, VA is thankful for the work this and other Congressional Committees have done to help VA navigate the challenges this project has posed and for securing the funding necessary for its planned completion. VA remains committed to ensuring the project provides a facility where veterans will receive the best 21st Century health care in a manner where the department, Congress, veteran's service organizations, and local stakeholders work together for the benefit of our Nation's veterans.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify before the Committee. My colleagues and I would be pleased to answer questions from you and Members of the Committee.

[THE PREPARED STATEMENT OF STELLA FIOTES APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you for your testimony. Mr. Caldwell, you are now recognized for five minutes.

#### **STATEMENT OF LLOYD CALDWELL**

Mr. CALDWELL. Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you on behalf of Lieutenant General Todd Semonite, the Chief of Engineers. I provide leadership for the execution of the U.S. Army Corps of Engi-

neers engineering and construction programs in support of the Department of Defense and other agencies of the Federal government.

Today we have been asked by the Committee to testify on the subject of the Denver replacement medical center in Aurora, including the Corps' accounting of construction costs known to date and ancillary construction activities. In addition, I will provide information pertaining to the Corps' lessons learned.

While the Corps has the lead in construction execution of the Denver hospital, the VA remains responsible for project requirements, resourcing, and facility transition to full operations. In December of 2014, the VA and the Corps entered into an Economy Act agreement to allow the Corps to assess the Denver hospital project. Subsequent modifications to that agreement and a new agreement provided the Corps the funding and the authority to transition the project's construction agent responsibility to the Corps. During construction the Corps and the VA have collaborated well, and have collaborated with the staff of the House Veterans Affairs Committee to provide transparency of the completion status, ongoing activities, changes, and expenditures associated with the project. Additionally, VA and the Corps have provided quarterly briefings to the Committee staff on the project's completion status.

Our contract provided a target value for completion of the project of \$570.75 million, including in addition to that, we have a contingency for unforeseen conditions which we held in the amount of a little over \$14 million, for a total estimated construction value of \$585 million. With the construction now 98 percent complete, our current estimate anticipates that upon final completion we will have expended about \$555 million for the construction, resulting in about \$30 million being returned to the VA. Additionally we anticipate returning \$10 million from the government and contract oversight and audit costs that we had estimated. This will result in a total of approximately \$40 million being returned to the VA from the original \$625 million which was provided to the Corps for the project. The construction is on schedule for substantial completion of all buildings this month.

There will remain ancillary construction activities for the project which fall in two categories. One is punch list items and the other is modifications to address current medical facility requirements. Punch list requirements are routine with any construction requirement. They involve typically minor work remaining for construction or completion that the contractor must finalize to be in full compliance with the contract. These punch list items should not delay the occupancy and use of the facility.

The second category typically involves emergent requirements which are necessary to ensure the new facility complies with current codes and practices that may have evolved over the course of construction. These emergent requirements will be a contract action separate from the Kiewit-Turner contract. We anticipate completing these requirements using the same government team currently on the project but with a new contract. We are currently targeting to have this work completed by the summer of 2018. We made the decision to address these emergent medical requirements by a new contract since this course of action requires clarity and transparency to completion of the project and ensures finality in

completion of the larger contract. The decision allows the current contract to concentrate on completing their contract requirements.

As part of our process, we review our project execution to identify lessons learned. While this project is not complete we have been recording lessons learned. One significant lesson learned is the value of consistent senior executive review of the project. The senior executive review group for this project is comprised of senior leaders from the VA, the contractor, and the Corps. This group met regularly on the project to provide guidance. This commitment at the senior levels of all stakeholders helped to ensure that the entire team remained focused on the success of the project and achieving our collective goals. At the completion of the project the final package of lessons learned will be formally documented and published.

We are pleased to be nearing completion of the project and believe that the completion of the hospital will be a great source of value to the veterans in the region. Mr. Chairman, this concludes my statement. Thank you for allowing me to be here today to discuss the work and I'll be happy to answer any questions.

[THE PREPARED STATEMENT OF LLOYD CALDWELL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Caldwell. Mr. Von Ah, you are now recognized for five minutes.

#### STATEMENT OF ANDREW VON AH

Mr. VON AH. Chairman Roe, Ranking Member Walz, and Members of the Committee, thank you for the opportunity to discuss our March 2017 report on VA major construction projects which reviewed the Denver Medical Center project among others. We have previously reported and testified on VA's struggles in managing the Denver project. The project's substantial cost increases and schedule delays are well known to this Committee and the audience here today.

While the Army Corps of Engineers has an agreement with VA to oversee completion of major construction of the Denver project, which is scheduled to finish this month, VA is responsible for activation, which is the process of bringing a facility into full operation. Activation is scheduled to continue through this summer. My remarks today are based on our 2017 report, which highlighted several opportunities for improvement in VA's management of these projects, particularly with respect to activation, and follow up on our recommendations from July 2017 to January of 2018.

In our 2017 report we made two recommendations related to activation of the VA facility, rather the Denver facility, that VA, one, deliver a reliable activation cost estimate for the Denver project; and two, clarify policies on integrating construction and activation activities. VA agreed with these recommendations and has been taking steps to implement them.

First with respect to activation cost estimates, we found in 2017 that VA had minimal documentation supporting its estimate of the cost of activation for the Denver project, which we therefore found to be unreliable. The most recent estimate we received for the Denver facility is \$341 million. With minimal documentation, we recommended that VA develop and document an activation cost esti-

mate for the project that is reliable and conforms to best practices as described in GAO's Cost Estimating and Assessment Guide. The lack of a reliable estimate can make it difficult for VA to manage its budget and also poses difficulties for Congress which relies on it to make appropriations decisions.

In July 2017 VA provided us with new documentation on its estimate. We analyzed this information and found that it did not meet best practices. Of the four characteristics of a reliable cost estimate, Denver's activation estimate partially met two and only minimally met two others. Specifically we found that it's unclear how VA is developing a good picture of the estimate's sensitivity to risk. A sensitivity analysis is important so decision-makers have an idea of how close to the point estimate they can expect the project to be. VA has provided comments on our assessment concurring with some of it and identifying additional information for us to consider. While VA has made improvements in its documentation of the estimate since our report, such as documenting discussions with management and including more detailed information, we still cannot find that the current estimate meets the characteristics of a reliable estimate. VA officials also indicated they are taking steps, such as developing training and providing GAO's Cost Estimating Guide to staff in an effort to improve activation estimates going forward.

With respect to the activation schedule, we found in 2017 that VA's policies were not clear or consistent on how to link construction and activation schedules to form an integrated master schedule for the entire project. For the Denver project, in part because of the lack of clarity and consistency in policy, we found that certain activities and milestones in these schedules were not aligned with each other. For example, we found three different dates for the same milestone in the existing schedules in March of 2017.

In response to our recommendation VA has clarified its policy documents, which we have reviewed and verified, and reinforced that all projects develop and maintain an integrated master schedule that includes and links all construction and activation activities. Moreover, VA officials indicated that they have worked with the Corps to resolve inconsistencies in linking construction and activation activities for the Denver Medical Center. This and other actions VA is taking with respect to cost estimating, as well as tracking change orders, if fully implemented should improve VA's ability to manage its projects going forward.

Mr. Chairman, this concludes my oral statement. I'd be happy to address any questions you or Members of the Committee may have. Thank you.

[THE PREPARED STATEMENT OF ANDREW VON AH APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you for your testimony. And I will now recognize myself to begin the questioning. And I want to start by saying that I think there is a dedicated group of, there are a dedicated group of people in Denver, Colorado who are mission focused on getting this hospital open and providing this incredible new facility for our veterans out there. We met with, Mr. Coffman and I met with, and Mr. Perlmutter, with the Chief of Staff, with the

Chief of Nursing, with the VISN Director, with the Chief of Surgery, Chief of Nursing. And just to give you an idea of how these folks are already thinking, this building is laid out a little different than any hospital I have ever seen. It is 1,100 feet long. So I would recommend, Mr. Coffman, that you donate some Nikes, or New Balance, I am sorry, from your district for people to walk in. And just to give you an idea that the Chief of Nursing and the physicians and the nurses had already started thinking, we are going to have to use, our Code Blue is going to have to be different because it is so far to get from one end of it to another. They will have to have a different way to do Code Blue. So they are already thinking ahead about how they provide quality care for our veterans.

When you look at the facility, and I just want to go over this very quickly before I ask any questions, when this facility was laid out, what we got was this, a facility that is 1.2 million square feet as opposed to 600,000 square feet of the previous facility. We got four more ICU beds. We got less, nine less medical beds, the same rehab beds, less psychiatric beds, of which we need more of and a facility, a psychiatric facility that is going to have to be modified because of design errors that are there. They did add the spinal cord injury, which I have already talked about. PTSD, which we know is a critical part of the VA's mission, was not even included in this. The VA had to buy an additional building for administrative offices. In this 1.2 million square feet there were no administrative offices, or at least none that I saw. And primary care rooms, where we examine patients, went from 60 to 34. So we actually lost primary care, which is where our care is being given. It actually may be and our PAC teams are going to have to stay at the old facility, with an aging boiler. So we are going to have to keep the facility open. It will not be three years. It will be more like five years, I can tell you, before you can design and build other facilities. That is the minimum amount of time you are going to have to keep it open. And if it does stay open, there is an estimate that there would be \$350 million worth of work that would have to be done to a campus that you are going to get rid of. Now that, none of this makes a lot of sense.

So I bring that up just to sort of give you a CliffsNotes version of where we are. And Ms. Fiotes, I appreciate you and Mr. Milsten coming out to Colorado to tour the new medical center with us. And how do you assess what is good and what is problematic about the Aurora facility's design? And what do you attribute, and to what do you attribute the problems?

Ms. FIOTES. Thank you for the question, Congressman. I think that the design, we can all agree, was probably more complex than it needed to be. The design was prepared a long time ago. Requirements have evolved over time and that probably is part of the reason that the capacities are smaller right now, including in the primary care, patient aligned care teams, which were not in existence when the building was originally designed. They were introduced later and because of the additional space that they take have actually reduced the capacity of the new clinical space in comparison to the old facility.

So going forward we have learned much from this design that we would not replicate in any future designs. I believe a more compact

design would have resulted in a more efficient, functional hospital and probably at a lesser cost.

The CHAIRMAN. Thank you. Mr. Gigliotti, does the new facility meet all of your needs and your employees' needs?

Mr. GIGLIOTTI. The new facility is short, as you stated, on primary care space. So there will be seven primary care teams that will be left behind at the current facility. We are actively identifying, working with a brand new Loveland, Colorado community based outpatient clinic that opens up this April. We're looking at expanding the footprint in Aurora for a community based outpatient clinic that we already have there. And then we're looking at adding another community based outpatient clinic in the metro area. We're also working closely with the Veterans Benefits Office. We have comp and pen in our CBOCs in Colorado Springs and Golden, and we're looking to work with them to take comp and pen out of those clinics so that we can have more room for PAC teams so that those seven teams can go into the community and that we could dispose of the building quickly.

The CHAIRMAN. Well my time is expired. But I do, would like to say that if we do the asset review, you will be able to take those assets, and there are, they are going to be a lot when you add that VA property, and reinvest that back into VA. I think that makes a lot of sense. Mr. Walz, you are recognized.

Mr. WALZ. Well, thank you. And I would like to reiterate, I agree with the Chairman on the asset review piece and I think it does give us opportunities. There's obviously some differences of how we get there. But this is a highlight of why that should be.

I would say, Mr. Caldwell, to you, we were looking back, as early as 2010 I think Chairman Miller, myself, and some of us who were here at that time, Chairman Roe, were advocating that your involvement was needed. That you are construction people as opposed to VA. So I am grateful you are there. But once your original construction with K-T is complete, as we heard there is final contracts with another contractor to, just those remaining items such as code upgrades. Will this impact the cost of construction and the schedule for opening the facility?

Mr. CALDWELL. So there is obviously a cost associated with that new contract. I can, we are in the process of developing that cost estimate. I can tell you we think it's in the order of, let's say, between \$5 million and \$10 million for that contract. But it will not delay the opening of the facility. The plan is to have that contract awarded within the next couple of months, have them working in April, and have them completing by the end of June or early July. So we believe it will support the opening of the hospital.

Mr. WALZ. Very good. Thank you. And I would like to take a minute now, I am going to ask the next question based on some things in the Denver Post. If any of us needs a reminder of the importance of a free and professional press in this country, the service that was done to our veterans and to taxpayers of Colorado, and to this country, by the folks at the Denver Post, I would like to highlight Daniel Brenner and Mark Matthews' work in that. We followed that here, and those are things that came up, and the partnership in helping us get that has been incredibly important. And this week they indicated trying to, and they are right to ask

these questions, the hiring of staff at the medical center, and do you have sufficient staff for the medical center to open? Are there challenges with the tight labor market? And give us the timeframe on that of making sure that those FTEs are in place when we go?

Mr. GIGLIOTTI. So we are on target for the opening this summer. We have 421 FTE to be hired for the new project. We've already hired 257. 118 positions still to be hired support the spinal cord injury center that was referenced earlier. That will not open until 180 to 200 days after the opening of the facility and that's in concert with the PVA. They want to make sure the hospital is up and running and seamless and working well and then we will open up the spinal cord injury center approximately six months after that.

So Denver is a difficult labor market. Unemployment rates are around three percent, which is very low. But we are making excellent progress. We are confident that we will be able to meet the staffing needs. But if for any, anything arises that we are not able to, we have other tools available, contracts and other types of staffing, until we're able to actually hire. But we are confident we'll meet the staffing needs to open up by August.

Mr. WALZ. We have had a lot of hearings in here and talked about some of the burdens to be being able to quickly hire folks, some of the problems that are there. Are you experiencing just the usual bureaucratic hurdles, if you will?

Mr. GIGLIOTTI. I would summarize it that way, yes sir.

Mr. WALZ. Maybe when we are done with this those are maybe some lessons learned on what we can do here with what you are doing to help us with that. This to Mr. Von Ah, what progress has VA made in addressing GAO's recommendation on activation cost estimates? Because if there is anything here, we are pretty brow-beat by projected estimates and then coming back to us over and over and over. And I just want to make sure that it appears like there could be some pitfalls here that get us into that same thing.

Mr. VON AH. Absolutely. Thank you for the question, Congressman. VA has taken a number of steps. I would characterize it as early steps in the process of building the capacity to do good cost estimation for activation. There's training that's been talked about. They've provided the Cost Estimating Guide that GAO has developed to their staff in an effort to get people up to speed on how to do good cost estimation for activation. So I would say that they are definitely taking steps in that direction.

As far as the current Denver activation estimate, that's something that is already done and complete and we don't have any concerns at this point of whether they're going to not meet the schedule and costs that they've put forth. But we still look back at that estimate and say that that wasn't a reliable estimate from our perspective, based on the lack of a risk and uncertainty analysis.

Mr. WALZ. Thank you. I would like to thank all of you, though. Over the last 12 to 18 months the communication and the transparency of helping us get this has really been great and I am grateful for that. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. I now to Mr. Coffman for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman. Mr. Von Ah, when you look at the activation plan of the VA, I think it was found to be

inadequate by your analysis. And so we have, I led the fight to strip the VA of their construction management authority. I wanted \$10 million. VA put out \$250 million. The number that we settled down, settled on, was \$100 million. I think that is unfortunate. I think it needs to go down further. But that is only for the construction management phase. That number, \$100 million, does not include activation.

Mr. VON AH. Right.

Mr. COFFMAN. So it seems like we have the same sort of mismanagement problems when it comes to activation that we had for construction management under VA supervision. Is there any precedent, I mean, does the Army Corps of Engineers or does GSA or anybody else do activation as part of the construction management for an agency, in an agency relationship?

Mr. VON AH. Right. The scope of our work didn't cover that. I'm not—

Mr. COFFMAN. Sure.

Mr. VON AH [continued]. —sure if that's the case or not. So we could look into that and get back to you, Mr. Coffman.

Mr. COFFMAN. Let me go to the Army Corps of Engineers, does anybody else, when you do other hospitals for other agencies, like for the Department of Defense, do you do the activation? Or does the United States Army or the Air Force or whoever you are doing it for do the activation?

Mr. CALDWELL. Mr. Coffman, Congressman Coffman, that function is typically handled by the medical departments and we restrict ourselves to that area that we have expertise, which is really in the design and construction. We do on occasion assist with the initial outfitting—

Mr. COFFMAN. Mm-hmm.

Mr. CALDWELL [continued]. —and transition of the facility because that may involve purchasing equipment, furniture, and other kinds of supplies. So we do assist the activation in that regard.

One of the things that we and the VA are working together on for the other hospitals that we expect to assist them on, and are assisting, will be an activation plan. So that we can, early in the life of those projects, can identify what the requirements are, what the respective parties and stakeholders will bring to that plan to ensure that it comes together effectively.

Mr. COFFMAN. I just want to say the fact that Ms. Fiotes is here today, and some of the other players, that have their fingerprints all over this \$1 billion in cost overruns, is a signal to me that the VA has not changed. And so whatever we can do to strip their authorities in terms of construction management, in terms of activation, I think is necessary. I mean, Ms. Fiotes, you said that, I am not clear on what your explanation is in having gone, in the planning process of having 34 primary care examining rooms when the existing facility has 60 and cannot accommodate seven PAC teams, seven primary care teams in the new facility requiring us to keep part of the old facility open. Can you really explain how that number, 34, was devised?

Ms. FIOTES. I will try, Congressman, although the PAC teams and the 34 and 60 were not in existence when the project was designed, which was what I tried to explain. When the design was



developed, 2009, 2010, there were no PAC teams. At the time, the medical center and the construction entities believed that the project was sized to accommodate the necessary primary care clinics. As time evolved, the patient aligned care teams came into existence. They take up more space than the regular clinics do. And that has resulted in—

Mr. COFFMAN. Well that is still not an explanation. I mean, the fact is that you have X number of primary care personnel, no matter how they are arranged. You had that much capability in terms of exam rooms. And you have almost half the number here.

Ms. FIOTES. Again, we are talking about a design that was developed many years before the construction was completed.

Mr. COFFMAN. So then we are in, in 2009 and 2010 we are a Nation at war in Afghanistan and Iraq and you all cannot amend that plan?

Ms. FIOTES. I cannot answer that, sir. I wasn't there.

Mr. COFFMAN. Well you—so then and why was PTSD not included in the initial project?

Ms. FIOTES. I believe PTSD was taken out of the scope of the project before the final appropriation authorization.

Mr. COFFMAN. Do you know why?

Ms. FIOTES. I do not recall exactly.

Mr. COFFMAN. I just do not know how you cannot have answers to these questions and be in the position that you are in. I mean, that absolutely makes no sense.

Ms. FIOTES. Again, Congressman, I am going by what I have heard, not what I experienced. I believe the PTSD was removed at the time of the authorization appropriation to bring the cost down.

Mr. COFFMAN. Well how about this—

The CHAIRMAN. The gentleman's time has expired.

Mr. COFFMAN. Oh, I am sorry.

The CHAIRMAN. We are going to have a second round. Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Well I just want to mention for the record that two and a half to three years ago, this Committee authorized additional funds to complete the replacement facility. And at that time this Committee, and by a quick count of nine of us who were here on the Committee at that time, this Committee decided to reduce the scope of the facility by not funding the PTSD inpatient or the assisted living facilities. So to act shocked that part of the old facility will still need to be used moving forward is ridiculous. We knew what we were doing, and now we decide do we invest the money so we can move everything to the new campus? Or do we keep the status quo and continue to use it as a political pawn? That being said, what are the plans for expanding the Aurora facility to include these services?

Mr. GIGLIOTTI. So the PTSD is, Deputy Secretary Gibson in one of his last acts as Deputy Secretary notified four corners that because this is a replacement hospital, it's the first true replacement hospital to move since Detroit in the 1990s. And because it's a replacement hospital he made the determination in coordination with general counsel that PTSD should move over to the new site and notified four corners and there was no objections. We went out for a minor project. Unfortunately when the bids came in for that it

was over the minor threshold. It came in about \$3 million over the \$10 million threshold. So we have our process for trying to get it into a major. So that is one thing.

The second piece is the community living center. Currently the veterans that were in our community living center are being seen in the community. We follow them. The care is going very well. That is also in our SCIP process for a long term solution of building a community living center on the campus at Fitzsimmons.

Mr. TAKANO. Well my question is in order to complete a PTS residential treatment facility and community living center that were deleted from the project, what are the plans for the VA to expand the Aurora facility and include these PTSD treatment? Are they priority projects? What is the estimated cost of each of these future projects?

Mr. GIGLIOTTI. So we were hopeful that the cost for the PTSD would be below the \$10 million threshold. It came in higher. It is a priority. The care will be rendered at the existing medical center site now. If we have to go into an emergency lease scenario while we're awaiting funding for the PTSD if we're able to excise the current, we will do that.

Mr. TAKANO. So it is above \$10 million, you are saying?

Mr. GIGLIOTTI. It came in above \$10 million.

Mr. TAKANO. So \$10 million, \$11 million? Around there?

Mr. GIGLIOTTI. Thirteen million.

Mr. TAKANO. Thirteen million. So that is what we need to find in order to fund, because the Committee made its previous decision. So are other plans or solutions being developed to ensure facilities available for PTS residential treatment, are available for PTSD residential treatment, eight primary care teams, and the community living center beyond the next three to five years?

Mr. GIGLIOTTI. Yes. So the, all of those will be being given at the current site and that was the three-year time period that was referenced. If we are able to divest ourselves of the hospital, which is our intent, then we will find space in the community to offer those services while we look for a permanent solution.

Mr. TAKANO. And will some facilities continue to be located in the current Denver Medical Center campus? Or will additional construction take place on the Aurora campus?

Mr. GIGLIOTTI. Initially it will be on, PTSD, CLC will be done on the, and the seven PAC teams will be done on the current campus and we will be looking for solutions in the metro Denver area for community based outpatient clinics and on the current campus PTSD and CLC will ultimately end up there.

Mr. TAKANO. Well, thank you. Will the opening of the new Aurora VMAC decrease wait times for veterans in the community and at what rate?

Mr. GIGLIOTTI. So because of the PAC model we're looking for efficiencies of through put to be able to get more veterans in. We have PAC at the current facility but the physical constraints don't let us operate PAC as the model was intended. The current design will allow that. So we anticipate some efficiencies but it would be hard to state exactly because the metro area continues to see growth and we have to address the seven PAC teams.

Mr. TAKANO. Thank you. I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding. It is difficult to argue that this Congress did not provide the money when this is over \$1 billion over budget. And by the way, passage of Asset Review raises that \$10 million to \$20 million. You would be able to go right ahead with it. So that is another reason we need to do this. Mr. Bost, you are recognized.

Mr. BOST. Thank you, Mr. Chairman. And I was going to ask a question. I am going to go ahead and send my question just in writing concerning some personnel hiring practices and things like that. With that, I would like to yield my time to Representative Coffman.

Mr. COFFMAN. I thank the gentleman. First of all, Mr. Takano, what our conversation was about was that PTSD was not included in the initial plan for the hospital. So it was after the fact that a stand-alone building was added for Post-Traumatic Stress Disorder. And in the negotiations to get the \$1 billion for those cost overruns, there were two buildings that had not broken ground yet. One was the CLC, the community living center, and the other one was for PTSD. As part of the negotiations to get the \$1 billion, those had to be scrapped and now we are going to get them put back in. So my question was, as an Iraq War veteran, how is it in 2009 and 2010 that we broke ground for a project without PTSD? Without a plan for it? And that is certainly the case.

The, Ms. Fiotes, under your leadership the new Rocky Mountain Regional VA Medical Center construction project has been plagued with excessive cost overruns, a four-year schedule delay, and overall mismanagement of the project. When did you become aware of the variances in the project's scope, schedule, or cost that put the project at risk of completion as originally planned? In other words, when did you in working on this project realize that it was getting out of control? That it was not going to be on time? That it was not going to be on budget?

Ms. FIOTES. Congressman, I joined the VA in January of 2013 and over the next few months became familiar with the project, visited the site, talked with the contractor, of course talked with our teams. I heard varying versions of cost increases and schedule delays. And at the time that we were looking for ways to move the project forward and keep progress on the construction going. The contractor filed a claim with the Civilian Board of Contract Appeals. And from that point on we were in a position where the VA had taken the stance, with advice from general counsel, its then general counsel that the contractor was obligated to deliver the facility for \$610 million based on a supplemental agreement they signed in 2011. That was the VA's position. That was the position that I was relaying to you as well.

Mr. COFFMAN. But you knew that was not correct, that the project at that time, given all the change orders, could not be built for that amount.

Ms. FIOTES. That, that is not accurate, sir.

Mr. COFFMAN. Well I, I disagree with that. The—so what is the total number, who can answer this question, so the total number of personnel is now going to be in the new hospital, is now going to be 3208? Am I correct in that?

Mr. GIGLIOTTI. That sounds correct, sir.

Mr. COFFMAN. Okay. So we have an increase in personnel, a dramatic increase in personnel. We have got double the square footage. But in effect we have less capability. I mean, there are some things that are added, like spinal cord. But in terms of the primary care outpatient, obviously a tremendous reduced capacity in that. Am I correct in that?

Mr. GIGLIOTTI. It is less PAC teams than we currently have functioning now, yes.

Mr. COFFMAN. Okay. And so what is, so essentially right now until you get these new CBOCs built, these new outpatient clinics built, the Aurora one I think the lease is coming up, am I correct in that?

Mr. GIGLIOTTI. That's correct.

Mr. COFFMAN. And so you're going, is it a plan to build a new facility or lease a new facility?

Mr. GIGLIOTTI. So the plan would be, we would go out for bid and see which of those would occur. What's available in the marketplace, there would be a market study, either use an existing or do some kind of build. And that would be in the Aurora and then also in the southern part of the metro area.

Mr. COFFMAN. So in the southern part, and so that could be a lease or that could be built as well?

Mr. GIGLIOTTI. Correct.

Mr. COFFMAN. So how long do you think this entire process will take? And will that have to, would that require a new appropriation? I suspect if the \$20 million figure is approved in terms of redefining major construction management projects, then I suspect that you could go ahead then, I mean, based on our appropriation, correct?

Mr. GIGLIOTTI. Right. And it would be part of our SCIP process and it gets competed against other clinic designs and desires across the country.

Mr. COFFMAN. And how, so you need those to, so the Aurora facility you would expand and have additional PAC teams there. And then you would have, and then obviously this in the southern metropolitan area, this new outpatient clinic, would then absorb the remainder of the PAC teams?

Mr. GIGLIOTTI. That would be the intent. And then also, as I stated earlier, working with VBA to move comp and pen to another location would free us to be able to put a couple more PAC teams in both Colorado Springs as well as Golden.

The CHAIRMAN. The gentleman's time is expired. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. I had just a more global question, I guess, in terms of things that still need to be done. We have talked about a lot of them. We have talked about the movement of the old facility and when that is going to happen, the PTSD facility, etcetera. So I am just, I am wondering if is there a timeline by which you are following to get to, you know, certain dates. And if there is, is that something that is out there and published that is, all of us can see?

Mr. GIGLIOTTI. We are looking to do a movement of the outpatient services from the existing facility to the new facility on July 28th. We are looking to remove the remaining inpatients from the

current facility to the new facility August 4th. So those are the timelines that we are working—

Ms. BROWNLEY. Understood. That timeline, I understand, because it is in print and I can read it.

Mr. GIGLIOTTI. Okay.

Ms. BROWNLEY. What I am looking for is beyond the August opening date in terms of closing the old hospital, when the PTSD facility is going to get done, is there a printed timeline that VA has agreed upon, all of its contractors have agreed upon, that can be shared with the Committee? So that clearly on this project accountability has been an issue. And moving forward now we want to have the tools to, for you to hold yourself accountable and for us to hold you accountable.

Mr. GIGLIOTTI. Right. So we're looking after approximately 18 months and then—

Ms. BROWNLEY. Is it a printed timeline?

Mr. GIGLIOTTI. I'm not—

Ms. BROWNLEY. Or is it one that you are, you know, you think that is what it is going to be, and that is what you are planning on, but is there an agreed upon that everybody is working towards?

Ms. FIOTES. Congresswoman, I think that because of some of the unknowns, including the minor threshold and the ability to construct the new PTSD, the timelines are somewhat estimates at this point. That's why the number of three to five years has been put out there. I can tell you that we are collectively looking for solutions to allow us to do it sooner rather than later. We do want to get out of this facility but it does take some time, not knowing when we're going to be able to build the new PTSD, not knowing exactly when we're going to get the new clinic space in our existing clinics.

Ms. BROWNLEY. Can you give me a timeline when you might be able to have completed those to know with certainty when things can get done?

Ms. FIOTES. I don't think we can give you a timeline with certainty right now.

Ms. BROWNLEY. Can you give me a timeline to get to certainty now? Is it going to take you a year? Is it going to take you three years? Is it going to take you five years? That is all I am asking.

Ms. FIOTES. No, it is not going to take us five years to get to a timeline.

Ms. BROWNLEY. Not five years. Will it take you one year?

Ms. FIOTES. I anticipate we will have a much better understanding of the timeline in the next six to 12 months.

Ms. BROWNLEY. Thank you. I want to yield the balance of my time to Mr. Takano.

Mr. TAKANO. Thank you, Representative Brownley. For the VA and the GAO, my understanding is that the PTS residential treatment facility was part of the original design prior to 2010. Is that correct? It was part of the original design prior to 2010?

Ms. FIOTES. I am not sure that it was part of the original design. I know that at some point before 2009–10, there had been an effort to minimize the size and scope of the facility and at that point I think the PTSD was initially not included in the design. At what point it got reinserted, I will be honest with you I don't know.

Mr. TAKANO. Could I hear from—

Mr. MILSTEN. I know when it was reinserted and that's when we came back with the estimate—oh. Sorry. That's, we—

Mr. TAKANO [continued]. —When was it reinserted?

Mr. MILSTEN. It was reinserted when we came back to the Congress looking for the authority to continue and the money for the overrun for bringing in the (indiscernible) and completing it. We put it in the estimate at that time. That's what drove us to the estimate that I delivered to you that was \$1.73 billion at one point. And in consequence, in subsequent negotiations that and the CLC, along with a couple of other minor things, were taken out of that number that got us down—

Mr. TAKANO. Okay. So I would ask if you could go back and reexamine the history and my understanding is that it was originally part of the scope prior to 2010, and then it was descoped from the contract from when we, when they were trying to get the costs down. So it was a matter of money, not necessary planning, that has left us without a PTS residential treatment center.

Ms. FIOTES. We will provide that. We will take that back for the record.

Mr. TAKANO. Thank you. I appreciate it.

The CHAIRMAN. I thank the gentleman for yielding. Vice Chair Mr. Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it so much. And thank you for your testimony today as well. I have one question and then I am going to yield the rest of my time, submit my questions and yield the rest of my time to Mr. Coffman. But again, to follow up on what Ranking Member Walz said, that asked this particular question of Mr. Gigliotti, with regard to the staff positions, I understand you said that over 250 were filled out of the 421. My question is, do those numbers include vacancies that already exist at the current facility?

Mr. GIGLIOTTI. They do not, sir.

Mr. BILIRAKIS. They do not. How many vacancies exist in the current facility?

Mr. GIGLIOTTI. I do not have the exact number but I think the vacancy rate, not counting the 421, is approximately ten percent.

Mr. BILIRAKIS. Okay. Next question, why are we having trouble filling these vacancies? I know you answered the question but be more specific. And which vacancies are we having trouble filling? I mean, you know, this, I know Colorado is not Florida but it is pretty darn nice to live in. And so in any case if you could answer that, I would appreciate it.

Mr. GIGLIOTTI. Sure. So there is a multitude of reasons. One is the three percent unemployment rate in the metro Denver area. That is basically there is no unemployment. Individuals can go work wherever they want. It is a growing health care market, so health care professionals have choices all over metro Denver without having to move. They can just go from job to job. So it's very important for us to use the tools we have available, not only to recruit but to retain the staff. The mission attracts a lot of our workforce. So the one area that we've made major improvement in was nurse pay. Our nurse pay lagged in Denver and then we have been very aggressive in the last two years with nurse salary rates, mak-

ing sure they are comparable to the community's rates. So we've been able to recruit and retain more. But that is still an area that we are looking to hire more. In, of the 421, some of the positions we're still recruiting for are nurses. We've hired about 20. We still have 20 more to go for new nurses for the new facility. So that's a key area of concentration for us.

Mr. BILIRAKIS. Very good. If you need any more tools, do not hesitate to contact us. Because I think it is pretty desirable to work for the VA. I will yield the rest of my time to Mr. Coffman. Thank you.

Mr. COFFMAN. All right. I thank the gentleman. Is it not true that you also lack an HR director? Is that true to facilitate the hiring?

Mr. GIGLIOTTI. We, no, we have a—

Mr. COFFMAN. You have it?

Mr. GIGLIOTTI. Yes, we have a new—

Mr. COFFMAN. Because I think there was, I thought there was in the GAO report?

Mr. GIGLIOTTI. It could have been—

Mr. COFFMAN. Let me refer to Mr. Ah.

Mr. VON AH. That may have been at the time but I am not sure of the current status of that.

Mr. COFFMAN. And when did you, when is that person been on board?

Mr. GIGLIOTTI. Fairly recently, within the last six months.

Mr. COFFMAN. Within the last six months. Okay. The, just still, I am just stunned that just in terms of the knowledge of the history of the project, is either intentionally lacking or that you actually do not know these answers. As to the design questions, it seems like anybody who would go on this project from a managerial standpoint would have the situational awareness in terms of what the evolution of this project was and where the pitfalls were in this project. So I am very surprised. But I can certainly remember the controversy on the PTSD issue, that in fact the, it was not included in the initial design. It might have been taken out early. But when they broke ground there was not a PTSD facility within it. And I can remember being called by the media, they said what do you, as a Member of Congress, what do you think about this issue? And so I think it was the combination of congressional pressure along with the VSOs that got the stand alone facility that was later unfortunately deleted when we had to get the \$1 billion in cost overruns done. And when do you anticipate having the PTSD, that stand alone building, or I understand there might be an emergency lease to get them out of Building 38 in the old hospital? Where are we at with the PTSD residential?

Mr. GIGLIOTTI. So, currently it is in Building 38. Until we know what we are going to do from disposal of the existing hospital, it will stay there. If we are not able to get the approximately \$13 million, you know, through the major project in time, currently, now, that would be a major—if we are not able to get that in time when the current building is excised, we will have to enter into an emergency lease space for the PTSD program until we are able to go onto the campus with PTSD, which is our desire.

Mr. COFFMAN. So when do you anticipate the—I'm sorry, when do you anticipate the stand-alone PTSD facility or is that in the planning process now?

Mr. GIGLIOTTI. I think a lot of it is contingent on when we devolve ourselves from the current facility and that I don't know the timeline yet.

Mr. COFFMAN. Okay.

The CHAIRMAN. The time is expired.

Ms. Kuster, you are recognized for 5 minutes.

Ms. KUSTER. Thank you very much, and thanks for being with us.

I think you can tell, this is painful for all of us. And as I said several years ago in the hearing, I remember an exchange with my colleague Mr. Coffman that, although I do care a great deal about veterans in the Denver, Colorado area, my veterans in New Hampshire and particularly, right

now, Manchester, New Hampshire have a significant problem with the facility that serves the veterans in New Hampshire. And all of us also represent the taxpayers. So we are constantly making decisions on serving veterans with the highest level of care at a price that our taxpayers can afford, frankly.

So we are shocked and we continue to be how these decisions got made to go from over 60 units for serving primary care down to 34. I don't understand what the plan was from the very beginning.

So I want to try to zero in here on the questions about what your plan is now to make sure that after the taxpayers have spent \$1.6 billion that veterans in Colorado won't have longer wait times. Frankly, it sounds to me as though they will. So can you walk us through—and I have read the report in the Denver newspaper and I am trying to understand the response that was given to the minority staff—it seems to me that the plan is to move primary care outside of this facility, that it is not intention that it goes into the new, \$1.6 billion facility, but in fact it gets moved to other areas outside of the Denver metropolitan area, because apparently this facility has been built that is not adequate for the needs of Denver veterans, Colorado veterans. Can you walk us through precisely what the plans are and where you will need additional facilities, whether rented or otherwise, to serve veterans in Colorado?

Mr. GIGLIOTTI. Sure. Thank you.

There will be 12 primary care teams in the new hospital. There will be—

Ms. KUSTER. Twelve, I'm sorry to interrupt, but as compared to—

Mr. GIGLIOTTI [continued]. —Twenty now in the old.

Ms. KUSTER. Okay. So, clearly, I am just doing basic math, you will not be able to serve as many veterans in the new facility as were served in the old facility?

Mr. GIGLIOTTI. Right.

Ms. KUSTER. Can we just get that for the record straight?

Mr. GIGLIOTTI. That would be correct.

Ms. KUSTER. Okay. Where will they be served and what will you be asking the Congress to fund in addition to the \$1.6 billion facility?

Mr. GIGLIOTTI. So the remaining teams will stay at the current hospital in Building 38—



Ms. KUSTER. Indefinitely?

Mr. GIGLIOTTI. Not indefinitely, until the decision is made on what to do with the current facility. Our desire is to get out of that facility.

Ms. KUSTER. In the meantime, we will have to pay for both facilities, everything will be doubled in cost?

Mr. GIGLIOTTI. We believe we can take away the clinic—or, excuse me, part of the physical plant and have it independently run. So the whole facility, the 600,000 square feet, will not be operational. It will just be focused on Building 38, one building.

Then we have a desire to increase the primary care capacity at Aurora. We have a primary care clinic now. As Congressman Coffman stated, that lease is due to expire; we are looking to go into a larger one.

Ms. KUSTER. So this is separate from the brand new facility? This is—

Mr. GIGLIOTTI. It is separate from the brand new facility.

Ms. KUSTER [continued]. —a separate lease that would be required?

Mr. GIGLIOTTI. Right. We already have an approved lease, a new community-based outpatient clinic in Loveland, Colorado, which is north of the northern suburbs, and that is scheduled to open in April. And we believe that will have some of our patients wanting to go there and not have to drive through Denver traffic. Then we have in Colorado Springs and in Golden, we are working with VBA to move comp-and-pen out of those two areas. If that occurs, that will allow us to place some of those primary care teams that are left behind at the old site into those existing sites.

And because our market is growing, Denver is still growing at a phenomenal rate and trying to stay ahead of that growth, we are looking at our high-concentration areas of veterans and an area that we need to get a clinic in is in the Southern Denver metro area.

Ms. KUSTER. Well, my time is up. Can I just say, for the lessons learned, that the next time we decide to build a facility we take into account when we are at war in two different countries with veterans that we have learned have significantly complex medical, including mental health and physical health, et cetera. So I would just like that added to the lessons learned as we spend the taxpayers' dollars and try to serve the veterans.

I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

In the South, we have a saying, "A blind pig finds an acorn every once in a while," and I think that is what happened here. Through no design or plan whatsoever, the VA has less capacity on this huge campus, but it is going to force them to go ahead and put the CBOCs out—a very expensive way to do it, I might add, but the CBOCs need to be—and they showed us, actually, the last briefing we had was the demographics of the Denver area and where the veterans are. And so I think putting those clinics where the veterans are makes a lot of sense and not having everybody coming on that big, huge campus. You can't believe how far it is from the parking lot to where they have got to go.

So we have said this, and I have heard Ms. Brownley say it and others on the Committee, many times about we need to—and myself—put the care where the veterans are, not make them come, like he said, through the Aurora traffic and Denver traffic to get there. So, all in all, it may actually work out as a positive.

Mr. Poliquin, you are recognized.

Mr. POLIQUIN. Thank you, Mr. Chairman.

Ms. Fiotes, when you have any kind of construction process, I understand that you will have disputes with subcontractors. How many judgments and settlements has the VA paid to subcontractors for this project?

Ms. FIOTES. I would have to take that question for the record, sir. I don't have that number.

Mr. POLIQUIN. What do you mean, you don't know?

Ms. FIOTES. I don't have that number available.

Mr. POLIQUIN. Has the VA finalized all of its settlements with its contractors?

Mr. MILSTEN. Yes, sir. The original contract, all of the settlements have been made with the prime contractor. On the interim contract that we had that spanned—

Mr. POLIQUIN. Okay, they have all been settled?

Mr. MILSTEN. They have all been settled.

Mr. POLIQUIN. Okay, but we don't know how much this is total, correct?

Mr. MILSTEN. I don't recall the—

Mr. POLIQUIN. Okay. My staff—

Mr. MILSTEN [continued]. —exact number and the—

Mr. POLIQUIN [continued]. —will be in touch with Ms. Fiotes after this hearing to get that number from you.

Does the VA have any management reserve or contingency funds, Ms. Fiotes, remaining for this project?

Mr. MILSTEN. Yes.

Ms. FIOTES. I will let Mr. Milsten answer that.

Mr. POLIQUIN. This is not a tough question.

Mr. MILSTEN. Yes, yes, sir, we do.

Mr. POLIQUIN. You do have contingency funds?

Mr. MILSTEN. Yes, sir.

Mr. POLIQUIN. How much?

Mr. MILSTEN. We have got about 6 and a half million dollars of that. That is the 5 and a half million dollars that we are using to fund the completion items that have been identified earlier.

Mr. POLIQUIN. Thank you.

Mr. Caldwell, do you over at the Army Corps have a contingency fund remaining for the completion of this project?

Mr. CALDWELL. Sir, we do have funds remaining from the funds that were set up for the original construction.

Mr. POLIQUIN. Do you have a contingency fund remaining?

Mr. CALDWELL. Those can be used as contingency funds.

Mr. POLIQUIN. So you do. How much is it?

Mr. CALDWELL. Sir, we expect that there is going to be about \$40 million available.

Mr. POLIQUIN. Okay. Mr. Von Ah—thank you—Mr. Von Ah, in 2016, the VA told Congress that there was \$55 million in recurring costs and \$341 million in one-time costs to activate the facility, and

today we are hearing the activation cost is 341 million. What the heck happened to the 55 million?

Mr. VON AH. Yeah, the 55 million, it turns out, is not part of the activation costs.

Mr. POLIQUIN. Where is it?

Mr. VON AH. Those are the—that was at the time the estimate for the incremental additional staff salaries and services provided at the new facility over and above what is moving over from the old facility.

Mr. POLIQUIN. Thank you.

Mr. Chairman, I am going to yield the rest of my time to Mr. Coffman, whose district encompasses this facility.

Mr. COFFMAN. I thank the gentleman.

Mr. Von Ah, to what extent did the fact that the VA did not use professional, I think they call it, medical equipment planners in the process, to what extent did that drive cost?

Mr. VON AH. The focus of our 2017 report was not exactly on that question but, again, I think from our perspective we looked at exactly what sorts of processes they have in place for estimating costs and certainly didn't meet the criteria that we have in place.

Mr. COFFMAN. Mr. Caldwell, how significant is—I believe that the Army Corps of Engineers utilizes medical equipment planners when it builds a facility from the start. Obviously, you took this over very late, but could you comment on that?

Mr. CALDWELL. Sir, we do have medical equipment planners, we do that in conjunction with the medical departments where their expertise resides.

I will tell you that, in this business of medical facilities, the technology is constantly evolving. So one of the constant challenges that we have on virtually every major medical facility is the fact that, by the time we have gone from design through construction, there have been technological changes that have to be accommodated.

Mr. COFFMAN. So the fact that this construction project has been 4 years behind schedule, how much did that delay drive additional cost in terms of what we have been discussing?

Mr. CALDWELL. Sir, I can't give you a number on how that affected it, but it is likely that whether it would have been 4 years after the project would have been completed or 4 years after the start of construction, in either case there would have had to have been changes made to upgrade to current medical equipment at that point.

Mr. COFFMAN. So the problem is rooms are configured that no longer comports with the technology in the lapse of time, codes have changed, and those factors are going to drive cost?

Mr. CALDWELL. Yes, sir, there is an added cost associated with that typically.

Mr. COFFMAN. Okay. Oh, on the question about your HR director, isn't that person just an acting HR director and there is a question about qualifications?

Mr. GIGLIOTTI. I will have to look into that, sir.

Mr. COFFMAN. Well, is it or not? I mean, is that person the acting HR director and does not fit the qualifications of an HR director?

Mr. GIGLIOTTI. My impression was that that individual—that the Denver facility has a permanent HR chief. Let me take a look—

Mr. COFFMAN. I yield back.

Mr. GIGLIOTTI [continued]. —and we will get it for the record.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Sablan, you are recognized for 5 minutes.

Mr. SABLAN. Thank you, Mr. Chairman. I actually had no intention to speak. But say in the past 20 years, maybe one of the witnesses could answer, in the past 20 years, how many facilities did the Department build, open and operate? New ones, new ones.

Ms. FIOTES. To my knowledge, the VA has built four major hospitals in that timeframe: the Las Vegas, Denver, Aurora, Orlando, and New Orleans. And numerous other specialty facilities, such as poly-trauma facilities and others.

Mr. SABLAN. CBOCs?

Ms. FIOTES. CBOCs are typically done as leases, not as our own construction, but yes.

Mr. SABLAN. And how many of those four major facilities were done on time, according to schedule, and consistent with the estimate?

Ms. FIOTES. I believe that they all had schedule delays.

Mr. SABLAN. And the cost overruns or—

Ms. FIOTES. I am looking to my colleague for Las Vegas, because that was finished before I arrived. For the other three, yes, they did.

Mr. SABLAN. Okay.

Mr. MILSTEN. And the Las Vegas did not have a cost increase. There were increases to the contract, but within the appropriated and authorized funds that were provided, not after we came back for additional funds.

Mr. SABLAN. All right. Thank you very much.

I yield back my time.

The CHAIRMAN. Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman.

I am not sure who may want to answer this, but has there been any attempt in the existing facility to try and sell some of the buildings that may be scheduled for demolition rather than demolishing them? Has there been an outreach attempt? I hear the economy is good in the area, you know, unemployment is low. So is there any attempt to sell the existing buildings?

Ms. FIOTES. Congressman, we have just engaged with the General Services Administration to conduct what they call a target asset review. That is the first phase, if you will, of a real estate due diligence that we must follow in the Federal Government before we can take any action on existing Federal property.

The target asset review identifies the property boundaries, identifies value constraints due to environmental liabilities or historic encumbrances, it identifies also potential interest from private or public entities in use of the facility. And, ultimately, it begins to shape an informed decision about the highest and best use of the property.

This target asset review has just been completed, is my understanding from GSA, and it will be followed by an appraisal by a professional of the property value, and at that point in time we will

be able to consider options for disposal, exchange, or other disposition.

Mr. WENSTRUP. And I am also curious too, you know, it is a pretty active market, are people reaching out and inquiring? I mean, it is not necessarily—real estate isn't necessarily a one-way street, you know, people look for potential. So has there been any outreach to take a look at these facilities and have they had the ability to take a look at them?

Ms. FIOTES. There may be outreach. We have to follow certain processes within the Federal Government—

Mr. WENSTRUP. I think that would be—

Ms. FIOTES [continued]. —and I think that this is the first phase in—

Mr. WENSTRUP [continued]. That doesn't mean people can't inquire, regardless of what the process—

Ms. FIOTES [continued]. I am not—

Mr. WENSTRUP [continued]. —of the Federal Government—

Ms. FIOTES [continued]. —personally—I am not—

Mr. WENSTRUP [continued]. —and that is really my question.

Ms. FIOTES. —personally aware of any inquiries.

Mr. WENSTRUP. And also when it comes to the CBOCs and community outreach, has there been a market assessment? Because that is kind of key, you know, are we going necessarily where we need to be and, at the same time, do we necessarily have to build a new facility, a new CBOC, et cetera, if there is some former clinic or something in the area that could be used.

Mr. GIGLIOTTI. So, as far as a market assessment goes, we do know where the veterans live in the metro Denver area with higher concentrations. So that is what we are looking at and then both of those would be on the table, which would be most cost-effective, either an existing building or have to build one.

Mr. WENSTRUP. Thank you.

I yield my time to Mr. Coffman.

Mr. COFFMAN. I thank the gentleman for yielding.

Who can answer this question, how long have you known—I mean, literally, you have had to have known for years, let me just put it that way, that you didn't have the capacity in the new hospital to fit all of the primary care capability from the old hospital, and yet you are testifying today that you have no definitive plan as to how to address that issue. And can anybody explain to me—well, first of all, can you tell me when you knew that the plan for the new hospital didn't support the plan for the new hospital didn't support the plan for the old hospital in terms of outpatient capability?

Mr. GIGLIOTTI. So I became Network Director in 2012 and was made aware that the design was set and that our plan to deal with that, as we have articulated, was if we added the Golden clinic, we added an expanded Colorado Springs clinic, we got approval and are activating a Loveland, Colorado clinic, we opened up an Aurora clinic, and so that was the plan was to offset that by those clinics.

The population growth in Denver, coupled with the PACT model, compromised our, you know, ability to successfully meet that total issue. So that is why we are looking at expanding Aurora and then looking at Southern Denver.

Mr. COFFMAN. How many PACT teams—I have seen two numbers, I have seen 17 and I have seen 20—how many PACT teams, again, do you have right now?

Mr. GIGLIOTTI. So we have, it would be 20, seven or eight remaining and twelve going over.

Mr. COFFMAN. And how long have you had 20 PACT teams?

Mr. GIGLIOTTI. We have added PACT teams probably less than a year. A PACT team is 1200 veterans and the growth in the Denver area has been more than 1200 veterans a year.

Mr. COFFMAN. Well, how is it they are just bringing this to public light now? I mean, Friday was the first time I have been briefed on having to keep primary care capability at the old hospital, and why is it just coming to light now?

Mr. GIGLIOTTI. Well, like I said, I got there in 2012, the plan was in place with what I stated, it is a challenge. I thought we have been transparent on the issue of the challenges with the PACT team capacity at the new facility. I will have to look into that, sir, if we haven't been transparent, but my assumption was we were with all the briefings we have done with Congressional Representatives and with the United Veterans Coalition.

Mr. COFFMAN. It was certainly clear on the PTSD issue, but not on the PACT team issue, and I am just surprised that there is no definitive plan in the works, because it is going to be very, very expensive to keep this old hospital open. I mean, it is really beyond its service life and so that is going to be an extraordinary cost. And even if you—and so you are going to have to maintain now the first floor of the old hospital from 3 to 5 years, is the estimate that I have from you—

The CHAIRMAN. The time is expired.

Ms. Esty, you are recognized for 5 minutes.

Ms. ESTY. Thank you, Mr. Chairman. I want to thank the Chairman and Ranking Member for holding today's important hearing, and I want to thank our witnesses for joining us.

As you are hearing from all of us, we are deeply concerned about the time this has taken and the cost overruns, because these funds are to go to serve our veterans. So now we are looking at a facility that is over cost, way late, and we are going to have two facilities open.

So there are two issues I would like to address with you, one has to do with the customer service for the veterans who are now going to have to figure out which of two facilities they go to and if you have figured out how you are going to deal with that. You are talking about World War II veterans, you are talking about Korea veterans, who now are going to have to figure out where their appointments are. I see massive opportunity for confusion. So that is one and just a brief answer on that.

With the other—and I apologize for having been out, but I am also vice Ranking Member of the Transportation and Infrastructure Committee, I serve on the Water Resources Subcommittee, and so we deal with the Corps all the time. So I have questions about what have we learned from this in specific about how are we going to do delivery of projects faster? Because if we take so long, that is how we wind up in part with the project being completed not meeting the needs that we then have. If it takes 15 years to do a

project, at the beginning you have a certain set of needs you are trying to meet, at the end of it you aren't even meeting those needs.

And so the delivery time is incredibly important. So I was in fact just in a Subcommittee, you know, powwow about that issue, what we can do on streamlining.

And so I want more specifics, both from you, Ms. Fiotes, and from you, Mr. Caldwell, about specific lessons that we have learned from this that will be implemented with Corps involvement on supervision and construction of VA facilities, because I heard general remarks, but not specifics like these are three things other than that executives ought to be involved. Well, yes, executives ought to be overseeing projects and holding people's feet to the fire, but that is construction 101. And I say this as the daughter and granddaughter of civil engineers who worked on Army Corps projects.

So, first, it looks like we have you ready to T up on the customer service.

Mr. GIGLIOTTI. Sure. We have 60 activation teams of employees working on all the logistics and that issue you raised about notifying and working with our veterans, that will be with the remaining PACT teams, that is part of what they are doing. So they will be communicated with, they will know that they will be remaining back at the current site, and they will be kept abreast throughout the entire process.

Ms. FIOTES. Thank you for that question, Congresswoman. And let me just state for the record, I share those concerns. This is a project that none of us want to have happen ever again and so we have many lessons learned. The causes have been analyzed and we have taken those reviews and assessments to heart, and we have put in place new policies, new procedures at the VA to make sure that we don't make these mistakes, and just very briefly let me summarize.

So, clear definition of the requirements up front. One of the issues found with this project was that it took way too long to nail down what kind of project it was going to be, it took years of back and forth. So, clear definition of the scope and the requirements.

And then clear control of the scope and of changes. And we have put processes in place not just within the Office of Construction and Facilities Management, but at a higher level within the VA to ensure that any scope changes receive the appropriate review and approval and budgetary consideration. And where there are issues of non-agreement, that the issues are raised to the Deputy Secretary.

Risk-informed acquisition strategies. Clearly, the acquisition strategy on this project was not the appropriate one and that cost us dearly. We have now put in place a very structured and disciplined way of making decisions about our acquisition strategy.

Disciplined governance, and that part of it is what Mr. Caldwell mentioned before about engagement about the senior executives, but also, importantly, roles and responsibilities and clear lines of decision authority for the projects.

And, finally, adequate resources. Clearly, we were found to be understaffed and under-resourced in the execution of this project from the beginning, and that is a lesson we have learned. We have

developed a staffing model, so for the projects that we will continue to execute we have the appropriate staff, both contracting and engineering, to see the project to fruition.

Mr. CALDWELL. Madam, thank you. There are so many places you could go with your question about how to expedite projects and let me touch on just a few.

And I have got to say, the point I made earlier about senior level involvement is not a throw-away idea. That is something that is critically important to ensure that both the contractor and the other stakeholders are unified in their objectives as opposed to getting cross with each other in nonproductive ways. So it does help us cut through issues if things are working well.

From a construction agent's standpoint, when we are doing work for the Department of Veterans Affairs or doing work for another defense agency, early involvement by the construction agent is critically important to define the scope of the project and to determine how that project will be executed. And in that process determining what are the mission critical-requirement dates that have to be met, so that you can set up an acquisition strategy that will help you achieve those.

Another thing is funding. And when you talk about civil works, although I am not in my current job responsible for civil works, I can tell you that one of the chronic problems that we have in civil works projects has to do with the continuity of funding to take that job to conclusion. The concept applies—

The CHAIRMAN. Mr. Caldwell, could you wrap this up? We have other Members and she has exceeded her time significantly.

Mr. CALDWELL. It applies as well to other projects as well.

The CHAIRMAN. I thank the gentlelady for yielding.

Mr. Higgins, you are recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

We have shared from both sides of the aisle on this Committee great concerns regarding this project. This is a bipartisan Committee. I thank the Chairman and the Ranking Member for their leadership, and I thank the panel for appearing today.

The Department of Veterans Affairs is making a concerted effort to modernize the VA methods of care and to transition to an outpatient model. We need fewer in-patient beds in distant facilities and more accessible health care services closer to where the veterans reside, yet we hear today that the Eastern Colorado Health Care System will be in the unique and undesirable position of operating both the new Aurora Medical Center and the Denver Medical Center it is supposed to be replacing.

How long after the opening of the Aurora Medical Center can we expect the Denver Medical Center to close?

Ms. FIOTES. As we mentioned earlier, Congressman, we really don't know that specifically. We are targeting sooner rather than later, but some of it will depend on the opportunities that exist for disposal of the old facility, as well as the opportunities to provide those services that will be left behind at other locations.

Mr. HIGGINS. I represent the district in the southernmost part of Louisiana. So, like my colleague Ms. Esty, I also have a great deal of interaction and experience with the Corps.



So my question for the Corps, sir, much of the difficulty of the VA that has been encountered regarding construction can be attributed to the complex and expansive design that no longer reflects modern standards of care, how would you recommend allowing for future flexibility in blueprints and plans? Is there a way that the VA can better manage the construction of a project, as my colleague suggested, that takes many years and requires regular updates to keep up with nationwide trends? How can the Corps help us streamline future projects, so that we don't encounter this type of gross mismanagement again?

Mr. CALDWELL. Congressman, I think that the Corps and the VA have already reached a milestone, and I will say it was in conjunction with guidance from this Committee and other Congressional Staff Members, to assist us in ensuring that we understood what the scope of projects are. It is critically important when a construction project is being designed and constructed that we understand with some precision what Congress has authorized and how that entire project will come together, especially if it is being executed in multiple phases.

So one of the things that together we have done, is determine that on these future projects that we are working together on, that we are going to have a clear definition of what the scope is, a clear understanding, we believe, with the Congress about what that scope is, so that we can work together effectively to achieve that.

Mr. HIGGINS. That is an encouraging answer. If my colleague Mr. Coffman would like, I would certainly yield the balance of my time, Mr. Chairman.

Mr. COFFMAN. I thank the gentleman.

Mr. Gigliotti, you stated that you have been transparent in this entire process, and I want to argue that you haven't been transparent and that the VA hasn't been transparent, because of the fact that in all the hearings we had the issue of keeping the old hospital open to house primary care outpatient services was never discussed, was never brought forward by the VA. So this whole notion that you have been transparent is absolutely false and because you all have known for years. But I think the embarrassment of having these incredible cost overruns and having to come back to Congress with that was not going to be complicated by another issue, so I think it was intentionally kept away from the Congress.

And let me just say that, thank God—I think Ms. Esty had questions about how do we do better next time—let me tell you, the VA, by the wisdom of Congress, will never build another hospital again on its own, it has been stripped of that authority, and I think it needs to be stripped of more authority.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

Good morning, folks. Thanks for being here.

There are two ways to make the above-the-fold in the newspaper, you know, and I didn't really know what the above-the-fold in the newspaper meant until about a year ago, but I do now, and the point is usually it is the negative that gets the first chance to be above the fold. You know, backwards congratulations to this

project—not anyone in particular, but this project for being above the fold for much too long a time.

In the spirit of the timing of the season here, we are towards the end of the professional football season and today we are looking at game films of this weekend's games, so we can tell exactly what occurred at what point that caused an outcome.

Now, I am going to ask a question rhetorically, there is no need to answer this: do you know the difference between a lesson learned and a lesson observed? Pure and simple. You didn't learn anything if you just observed it.

So, having said that, in the military we are very, very big on lessons learned, so that we do not repeat in any way, shape, or form the mistakes. What is the plan to collate the data, because I have heard a couple of different people say we are doing this, we are doing that, what is the plan, the overall plan to collate the data of this entire experience in such a way that anyone, whether it is someone within the VA, someone within the Army Corps, someone within GAO, someone within Congress, someone anywhere can view the game films, if you will, as it relates to the Denver VA project? Is there an overall game plan right now to put all of this together, so that it does not repeat itself in the future?

Mr. CALDWELL. Sir, speaking for the Corps of Engineers and from the point in time that we became involved, we have been collecting lessons learned. We have held a number of workshops, we have brought in a number of people, including from the DVA, Department of Veterans Affairs, as well as from across the Corps, people that will be involved in the future VA contracts to learn what we can from this project. So those have been workshops and at the same time we have been recording the lessons learned.

At a point in time when we are completed with this project and that point in time will be—it is imminent and it will be a few months beyond—we will refine those lessons and we will publish them, so that they are available both within the VA, within the Corps, as well as to the Committee or anyone else that would have an interest to have those.

I can't speak to how far we go back. I am speaking from the point in time that the Corps of Engineers became involved. But I think that, as we work together, it is likely that what we will do is to identify some of the lessons that caused this project to get into the circumstance that it was in when we became involved, we will work with our colleagues to do that.

Mr. BERGMAN. So just to make sure I understood what I thought I heard you say, the Army Corps has accepted responsibility for overall lessons learned on this project, whether it is construction, whether it is design, whether it is placement, whether it is consideration of clinical outcomes based upon old hospital, new hospital, veterans' waits, et cetera, et cetera. So did I hear that the Army Corps has got the dot?

Mr. CALDWELL. Sir, I did not intend to say that. What I intended to say is that we will take—

Mr. BERGMAN. So you are going to take your part or a certain part. I guess what I am asking you collectively, as a group and I don't care, plan a meeting time, and then tell one member a dif-

ferent meeting time, they miss the meeting, you elect them and they got it. There is a little humor in there.

Okay. The point is, don't segment this out to the point where someone doing something future, especially here in Veterans' Affairs where we are trying to figure out all the pieces and parts and what went wrong. One last analogy, and I know my time has expired. As a pilot, whenever there is an aviation incident, think about how airplanes are pulled out of the depths of the ocean and reassembled, that is what we are talking about, that is what we need to do going forward.

And, I'm sorry, I yield back, sir.

The CHAIRMAN. I thank the gentleman for yielding.

Let's see, Miss Gonzalez-Colon, you are recognized.

Miss GONZALEZ-COLON. Thank you, Mr. Chairman.

I know the Aurora facility has undergone multiple budget changes and completion dates, plus most of the staff has changed throughout this process, has transitioned out of the VA. How will you say that, will this be one of the problems, the transition of those employees, the turnover staff will be one of the problems or not?

Ms. FIOTES. I am not sure I understood your question, Congresswoman. The transition of which staff?

Miss GONZALEZ-COLON. Most of the staff has changed and has transitioned out of the VA during all that process; that is correct or not?

Ms. FIOTES. Yes. Do you mean—

Miss GONZALEZ-COLON. Yes.

Ms. FIOTES [continued]. —the VA staff—

Miss GONZALEZ-COLON. Yes.

Ms. FIOTES [continued]. —on the project? Yes.

Miss GONZALEZ-COLON. Did that affect the whole process, yes or no?

Ms. FIOTES. I don't believe so.

Miss GONZALEZ-COLON. Okay, you don't believe so. So you don't understand that the VA have staff turnover on the facilities?

Ms. FIOTES. The staff turnover on the project team was not that significant. I thought you were talking about the turnover to the Army Corps of Engineers, that transition. I am not sure, that's why I asked for a clarification.

Within the VA, the project team was fairly consistent for a length of time.

Miss GONZALEZ-COLON. So staff turnover was never a problem?

Ms. FIOTES. I did not say that staffing was never a problem, but turnover in particular was not the issue. I think this lack of sufficient staffing and some of the project leadership was not adequate for that project.

Miss GONZALEZ-COLON. Thank you.

With that, I will yield the rest of my time to Mr. Coffman.

Mr. COFFMAN. I thank the gentlelady.

Mr. Von Ah, in a 2017 GAO report, it cites on page 8, "In our March 2017 report, we found VA's policies were not clear or consistent in the way that they require VA to link construction and activation schedules to form an integrated master schedule."

Could you elaborate on that and your concerns or GAO's concerns about VA's ability to execute an activation plan?

Mr. VON AH. Sure. Our concerns at that time were, we found when we looked at—the integrated master schedule at the time, as well as the construction schedule and the activation schedule—as we looked at all three of them, many of the dates didn't match up where they should have matched up, so they were misaligned. We didn't have a huge amount of documentation regarding the activation schedule at that time, but just the fact that those dates misaligned was the basis for our recommendation.

When we looked back at VA's policies regarding that, it was not clear what should have been aligned or how these schedules should work together.

Since then, VA has changed their policies, so that they do clarify exactly what they mean by this delivery date or this delivery date, and have worked with the Army Corps to put that together in an integrated master schedule. So, at this time, we don't have significant concerns about their ability to do that going forward.

Mr. COFFMAN. Ms. Fiotes, when can you have a copy of your activation plan to this Committee and to my office?

Ms. FIOTES. Congressman, I would have to ask my colleagues to answer that. I don't have the activation plan.

Mr. COFFMAN. Have you read the activation plan, Ms. Fiotes?

Ms. FIOTES. I have not.

Mr. COFFMAN. Who can respond to that?

Mr. GIGLIOTTI. Sir, yes, we do have an activation plan, we can share that with the Committee.

Mr. COFFMAN. When can you share it with the Committee?

Mr. GIGLIOTTI. This week. We have it, so—

Mr. COFFMAN. Okay.

Mr. GIGLIOTTI. And, Congressman, on that earlier comment, if I could, on the human resource director, I misspoke. The individual is coming on in February, we believe, I believe from what I have been told, the current acting is qualified.

Mr. COFFMAN. Mr. Von Ah, is that an issue that you all looked at?

Mr. VON AH. I'm sorry, what was the question?

Mr. COFFMAN. Concerning the qualifications of the current acting human relations—I mean human resource person?

Mr. VON AH. The qualifications was not something we looked at, no.

Mr. COFFMAN. Okay. Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. I too want to welcome the panel.

I have a question for Ms. Fiotes. How was the allocation of beds and floor space in the new facility determined?

Ms. FIOTES. I can't answer that question, Congresswoman. The design predates my arrival at the VA.

Mrs. RADEWAGEN. Mr. Gigliotti, I have the same question for you: how was the allocation of beds and floor space in the new facility determined?

Mr. GIGLIOTTI. I'm sorry, I don't know that either. The project was designed before I got to my position.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. I yield back my time to Mr. Coffman.

Mr. COFFMAN. Thank you.

Ms. Fiotes, when did you start working, directly or indirectly, on this particular construction project?

Ms. FIOTES. January of 2013.

Mr. COFFMAN. January of 2013. And when were you given essentially a promotion, albeit acting?

Ms. FIOTES. I was asked to be acting and have been Acting Principal Executive Director since April of 2017.

Mr. COFFMAN. And whose place did you take in that position?

Ms. FIOTES. Mr. Greg Giddens.

Mr. COFFMAN. Okay. I am just—how can you, as a professional—I mean, you have either not answered or evaded a number of questions today that are very basic to this particular construction project, and so I am just absolutely amazed at your lack of professionalism in not understanding the origins of this project and how you could assume leadership over something that you seem to go out of your way not to understand. Could you answer that?

Ms. FIOTES. What was the question?

Mr. COFFMAN. Well, just tell me, I am just stunned at your lack of knowledge on this project, that anything that occurred the day before you got there somehow you don't know. It is the difference between your saying I am not responsible for and I don't know, but there seems to be an awful lot you just don't know. So I guess I can understand how this project got in the condition that it is. I mean, if none of you seem to know, have any real understanding of why it was designed the way it was, you know, it is just stunning.

I guess you are right, there is no explanation on your part for your answers or your lack of answers today to the questions that have been presented to you.

So, for the record, I would like an explanation on how we got to going from 60 beds to 34 beds. For the record, I want to know why PTSD was taken out of the initial plan of the hospital; not the standalone, but the initial plan of the hospital. For the record, I want to know when you all became aware that PACT teams would have to be left at the old hospital. And, for the record, I want to know when you brief Congress on all these facts.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

I think everyone has had an opportunity. I am going to have a second round, because of the importance of this. We are going to limit the second round to a couple of minutes and I will yield myself now 2 minutes of time.

Let me just summarize what I think I have learned in this. Number one, the initial design build is a bad idea. I think design, bid, build, and include the people who are going to be working in that building and in that facility, because I think you would have had a much different facility if you had done that, instead of start designing it as you are building it. This was a train wreck. So I would do that and I would include the people who are going to be working there every day.

Secretary Shulkin said this past year when he was testifying here that his primary goal this year was to reduce veteran suicide. And so what did we do? Mr. Coffman and I attended in that Building 38—and you all, some of you all were there—we had a town hall for those veterans in that PTSD facility and they had nothing but great things to say. And Dr. Wahlberg, who is in charge of that facility, apparently has one of the best outcomes of any in the country in that facility, and to have sort of left that out when that is a primary goal of VA.

And I think the other, when we look at the construction cost of this, I looked at a hospital that we built, it has been about 8 or 9 years ago in my hometown, so about \$1 million a bed, so we have about \$120 million in a 120-bed hospital. In this facility—and it is a more complex facility, this was a community hospital—it looked like it is about 13 million per bed, is what we have in this facility, if you look at 150 beds and \$2 billion. So an enormous cost and we just cannot afford that.

So one question, very quickly, that I want to get answered on the record—two things, very quickly.

One, Ms. Fiotes, do you believe that the Committee's legislation, H.R. 4243, the VA Asset and Infrastructure Review Act, would help you vacate the Clermont campus?

Ms. FIOTES. It would help in terms of raising the threshold for the minor construction, yes, it would.

The CHAIRMAN. And what about reinvesting the money back in the VA, not to the general fund?

Ms. FIOTES. Absolutely, Mr. Chairman.

The CHAIRMAN. Thank you.

And, Mr. Caldwell, very quickly, why do we have a second contractor who doesn't know anything about the building that is going to come into the building to finish up all these 300-plus minor things or minimal things that have to be done and we don't have a contractor yet? And we know the unemployment rate is very low in Denver and we also know that the building trades have moved in these areas, for instance, Texas. And we are finding problems just getting sheet rock where we are at home now and the cost has gone up for all this, I know the sheet rock is up 25 percent in our town and we can't find anybody to put it up.

So why are we not using the original contractor who knows all about this building, where every plug is, getting a second contractor we don't have and expect it to be done by August?

Mr. CALDWELL. Sir, there were several reasons that we made that decision. One is, we thought it was important that we ensure the prime contractor, Kiewit-Turner, focus on completing the work that they were responsible for. We did not want to distract them with beginning to add things to the job.

In addition to that, the things that—

The CHAIRMAN. Let me interrupt you there. Isn't that what their job was to do this, like the contractors laid out? I mean, maybe I am confused—

Mr. CALDWELL. Well, not the added things. We are talking now about adding things to them.

And the other factor was the cost associated with using that very large contractor and the general conditions costs that we are incur-

ring on a daily basis for having that contractor on the project site. So the longer that we add—the more we add work to them and the longer we extend them on the job, the Government would be responsible for those general conditions, which are going to be or would have been much larger than they would be with this smaller contractor.

The CHAIRMAN. Well, are you confident that we can get somebody in here to do all this? Because you cannot open that building at 98 percent—

Mr. CALDWELL. Yes, sir.

The CHAIRMAN [continued]. —it has got to be 100 percent.

Mr. CALDWELL. Yes, sir. We have good confidence that we can do this. We are using an 8A, a small business firm, as our acquisition strategy permits us to go to a firm that has a proven track record that we can depend upon. And so we are confident that we can pull this together.

The CHAIRMAN. Thank you.

I now yield to Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

I think, first of all, that all the last four projects, to include this one, major construction hospital projects, the VA in each project has been hundreds of millions of dollars over budget and years behind schedule. This just happens to be the worst and, unfortunately, it is in my community.

This project I think is an affront to the veterans who have made tremendous sacrifices in defense of our country in not getting the kind of state-of-the-art care, given the fact that this hospital is so late in terms of its schedule, and it is an affront to the taxpayers of the United States that have had to pay for this.

And I can tell you, I am very disappointed, you know, President Trump ran on the fact that he was going to clean up the Veterans Administration. I think he has certainly made progress, but this is an area that is very critical and I see no change, I see absolutely no change. It is the same—those that have their fingerprints on this hospital, I mean, it is virtually the same bureaucratic incompetence and culture of corruption.

And so I will ask Dr. Shulkin and ask the President to clean house, and that is what he should have done from day one and it hasn't been done.

I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

General Bergman, you are recognized.

Mr. BERGMAN. Thank you, Mr. Chairman.

And I am just going to reiterate, we have got a chance here to not repeat history and the only way we are going to do that is if we are not laying blame here, we are looking objectively at what occurred and what we do, all of the stakeholders—and someone does have to have the lead, by the way, whether it is the Army Corps or somebody else—someone, I would suggest, do that should be within the VA. Okay? It is your business, it is your business. So, please take for action the fact that this situation needs to be objectively looked at, totally in such a way that those who would potentially in the future not have any clue what happened here can read about it, study it, and not repeat it.

I yield back, Mr. Chairman.

Mr. MILSTEN. Sir, I would add that we are taking the lead. We are the one that is going to consolidate them, but beyond consolidating them, to get back to the point that you made, one of the processes that were put in place is that at all of our stage gates on these projects, when we sit down with the Corps and do the reviews, that we positively review the lessons learned and record for the record how they are accomplished on this project, on the project of the future.

So it is not we are going to learn, we are looking at that process that says, if this is what we learned here, how are we applying it on this project, and my project teams will record positively how they have evaluated that lessons learned in that future project.

Mr. BERGMAN. So then we will at some point, as Members of Congress or anyone else for that matter, be able to review what you all created.

Mr. MILSTEN. Yes, sir, you will.

Mr. BERGMAN. Very good. Thank you.

Mr. VON AH. Mr. Bergman, I would also just add that GAO is following up on all of our recommendations regarding this project and others that we have made over the years, and we have ongoing projects that also look at other aspects of VA's construction.

Mr. BERGMAN. Well, this is an opportunity for us to excel. I mean, truly, this is bad, but we can make it good for the second time.

Thank you, sir.

The CHAIRMAN. I thank the gentleman for yielding back.

And I want to thank our panel for being here today and I want to thank you for touring us through the facility last week. It was very informative to me.

And, with that, I will yield to Mr. Walz for any closing comments that he may have.

Mr. WALZ. Again, well, thank you all for being here, and thanks to the Chairman.

And maybe segueing from General Bergman, I think that starting several years ago under the leadership of then Chairman Miller and transitioning to Chairman Roe, the ownership of this Committee had started to change at asking for things. I remember in 2015, we sat in this room and that is when I was asking, quite unrealistically, but out of frustration that every change order should come to here and we should sign off on it, because we have ownership in it and I was getting tired of being blamed for things that were outside of our ability to provide that oversight. So I think what the General is bringing up is a good point.

I would also like to say and recognize the leadership of Mr. Coffman. It is undeniable, he is a friend and champion of veterans; his frustration is justified and understandable. I mentioned earlier, we have been getting a little more feedback, but he is absolutely right, we had no idea on these PACT teams staying over there; that took us blind-sided, it was unacceptable. That should be a lesson learned and that frustration is real and I thank him for continuing to hold all of us accountable on that piece.

So if we can get this thing through, the bottom line is improved care and access for our veterans. We can't let it go. It is a con-



tinuing journey, not a destination. We are scheduled, I believe, for August 11th.

I would again use General Bergman's references looking at game field and, as a Vikings fan, there is a hopefulness of what can happen, but there is a flip side to that coin: there are Saints fans out there that everything seemed certain and it was not certain.

So I would caution all of you and I know you will not raise those toasts to what has to be done. This system was broken, there is much more work to be done. Our focus in the short term is getting that facility up, functioning, and getting quality care for our veterans. So I encourage all of you to continue on with that. You can rest assured that this Committee, certainly under the leadership of Chairman Roe and the doggedness of Mr. Coffman, isn't turning away on any of this.

And, with that, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

And, in closing, I think you can sense from Members up here a great frustration. And I think what humanizes it, when Mr. Coffman and I sat down with those veterans in the PTSD unit and listened to their stories, I then left and went to Castle Rock with Mr. Buck and spoke to over 200, a standing-room-only crowd of veterans who were there, who had served this country from Iraq and Afghanistan all the way through Vietnam, and some even Korean War veterans that were there, and when you look at those men and women that have served this country, you understand why we are doing this and why it is.

And sometimes I think in these kind of projects we forget who we are doing this for and it is for the patients who have served this country. And I don't want us to lose sight of that and I think that is why there is some frustration, because we as Representatives, Mr. Walz, all of us, go home and meet people whose needs are not being met and I think that is—I think I am correct there and that there is light, I think, at the end of the tunnel, hopefully in August of this year. After planning this facility since the 1990s, we now have an end in sight, and it is a concrete goal and I appreciate VA's willingness to set this goal.

Transparency has not always been the operative principle, I think we have heard that over and over today. And, as we have discussed this morning, many challenges persist and meeting this activation schedule will in no means be easy, but the veterans have waited long enough. And this Committee will keep a close eye on the activation process throughout the year.

And I will also say that that move, I have gone from an old hospital to a new medical center, I have made that transition where you move patients, and that will require a tremendous amount of planning on the hospital staff's part. I do not believe there was ever a time in the Government or in the private sector when a 10-year \$1 billion hospitals were a workable model, much less a 10-year \$2 billion hospital. And the size of the capital need of the VA is enormous, I think it is \$50 billion, and if we double it on everything it will be \$100 billion. While Congress and this Committee specifically have repeatedly demonstrated a willingness to allocate resources, we will never be able to solve the problem if we are not able to get value for the dollars we invest.

Modern medicine is also increasingly agile, and flexibility and adaptability are more important than ever, and I am afraid VA's experience with this hospital design has demonstrated the risks of obsolescence. At the end of the day, I hope that all involved have learned lessons from the mistakes that were made and will carry those forward.

Without a doubt, putting the Army Corps of Engineers in charge was the right response to the problem that confronted us in 2015. I am encouraged by what the VA and the Corps have achieved working together. Taking over a construction project when it hit rock bottom is significantly different from managing it from the outset and preventing problems before they develop; those are different challenges. It seems the Army Corps' involvement is necessary, but not sufficient for its success.

And we have heard some good testimony today about how we prevent these problems that have occurred in the past repeating themselves. A repeatable model incorporating the lessons learned must be developed and carried forward on future projects.

Finally, we must all focus as much attention on stewardship of the property VA already has as on flashy, new construction.

I want to again thank you all for being here. And I will probably make, as Mr. Coffman will, another trip to Denver to see how this process is going, and hopefully get it on schedule and get it there, and open it up and hand the keys to the medical people in August of this year.

I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks.

Without objection, so ordered.

The meeting is adjourned.

[Whereupon, at 12:03 p.m., the Committee was adjourned.]

## A P P E N D I X

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### Prepared Statement of Stella Fiotes

Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to update the Committee on the status of the construction of the new Rocky Mountain Regional VA Medical Center in Aurora. I am accompanied today by Mr. Dennis Milsten, Director of Operations, of the VA Office of Construction and Facilities Management; and Mr. Ralph Gigliotti, Veterans Integrated Service Network 19 Director.

We are pleased that this facility will enable us to serve over 390,000 Colorado Veterans and their families, as we work to ensure that local Veterans receive the VA services that they have earned and deserve. The Denver VA Medical Center currently provides a robust range of tertiary health care services and the replacement campus will provide all of these same services upon opening. The only exception to this is the relocation of the Post Traumatic Stress Disorder (PTSD) Residential Rehabilitation Treatment Program, which will remain at the Denver facility until such time as its replacement structure can be built. In addition, the new campus will add mammography and PET/CT to its imaging services.

The Rocky Mountain Regional VA Medical Center is also proud to be the latest Spinal Cord Injury and Disorders (SCI/D) Center within the VA system. This center will serve Veteran populations in Colorado, Utah, Wyoming, and parts of Nebraska and South Dakota. The SCI/D Center will include both an Outpatient Clinic and Inpatient Unit, offering comprehensive, multi-disciplinary care for patients with SCI, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS). The SCI Center will offer a full range of inpatient and outpatient services, including Physical Therapy, Occupational Therapy, Psychology, Social Work, Nutrition, Assistive Technology, Therapeutic Recreation, Pool Therapy, and Urology assessment. The facility will be able to accommodate ventilator-dependent patients, and have separate indoor and outdoor space for recreation, community re-entry, and training.

Lastly, the new facility will provide a much more up-to-date and positive Veteran and family experience, as illustrated below. The following is a summary of some of these significant improvements to the delivery of health care to our Veterans:

- Patients will now have private rooms, which include their own bathrooms, as well as space for family members to stay overnight.
- All interventional services, such as surgery, bronchoscopy, and interventional radiology, will be located on the same floor of the Diagnostics and Treatment building. These complex services are also adjacent to the pre-operative and post-operative beds, which will improve the coordination of care and efficiency of service delivery.
- The new operating rooms will also have Operating Room integration.
- There is a sky bridge that connects the operating rooms to the Intensive Care Unit, which will allow for ease of movement for those patients requiring an overnight stay following a procedure.
- The intensive care unit will also have an 800-square-foot waiting room suite, which will emphasize family support.

The construction contract with Kiewit-Turner (KT) at the new location is 98 percent complete and 11 of 12 structures have been turned over for activation. VA and the United States Army Corps of Engineers (USACE) are currently working through contract completion items and actively working with our contracting partners to bring this contract to completion as swiftly as possible. Activation activities are ongoing and the facility will open to serve our local Veterans in August 2018.

The current activation schedule has the majority of installation, calibration, and testing of newly procured equipment being completed in May 2018. This will enable the Denver Medical Center staff to complete over 40,000 staff hours of education, training, and orientation in July 2018. We are currently on schedule to complete relocation of the existing patient services by August 2018. We will be monitoring the

remaining construction activities as we coordinate the ongoing activation process with facility completion.

VA's current activation budget for this project is \$341 million, which covers activity from 2013 to 2020. This budget includes \$2.6 million to serve as contingency fund. The activation budget has been adjusted annually based upon current needs for respective fiscal year (FY) obligation plans. However, the overall activation budget is still on track with the planned \$341 million, per the data table below. Project obligations and planning are summarized as follows:

- To date, we have spent 53 percent of the total amount, with 2.75 years remaining in the plan. All High Tech-High Cost equipment for the new facility was procured in prior years.
- FY 2017 costs included the procurement of furniture, equipment, and low voltage systems (\$45 million).
- FY 2018 costs will involve equipment leases and service contracts (\$20 million).
- Recurring (staffing) expenditures have occurred in each year since FY 2013 and have been increasing yearly, as hiring ramps up to staff the new facility.

The subsequent years of the plan will involve operating and recurring staffing costs, which will support the new operations and pave the way for the Medical Center's budget to undergo annual programming as part of VA operations.

During the USACE construction management activities for the project, VA minimized all user-requested design, equipment, and functionality changes. This provided an opportunity for KT to propose to USACE that labor would concentrate on completing and turning over the facility to VA building-by-building, rather than a longer process of delivering it in full at a later date, which saved a substantial amount in KT overhead costs. Additionally, USACE has not incurred the staffing costs that USACE budgeted for the project, and will be returning approximately \$10 million of unused staffing funds to VA. We also note that about \$6 million in settlements were saved with subcontractors from the original contract and the interim contract.

Based on the decision to turn over building-by-building, VA is now in the process of working with USACE to let a "completion contract," to address code requirements, necessary equipment changes and process modifications that have changed throughout this project, at a lower overhead cost. It is common on complex projects like this one, to defer items that can be more cost effectively and efficiently handled through a follow-on contractor. This completion contract is estimated to cost about \$10 million and will be funded from savings realized on the project. USACE will coordinate with VA as it contracts for and manages the completion contract. The overall goal under that contract will be to reach project completion as soon as possible.

In August 2017, VA initiated a Targeted Asset Review with the U.S. General Services Administration (GSA) to assess the existing property, and also initiated a market survey in December 2017. VA currently expects to receive the results for the Targeted Asset Review in early February. The objective is to leverage the property to maximize benefits to VA, Veterans, and our Nation's taxpayers.

VA plans to keep the existing hospital in service until the PTSD building can be completed at the new campus. VA is currently reviewing options to expand this capability at the new replacement facility. Additionally, seven Patient Aligned Care Teams (PACT) will remain at the current facility to serve Veterans until VA conducts further analysis on how to optimize their impact for local area care based on where those PACT teams can continue to function. There will also be limited support service such as police, food service, and facility maintenance at the current hospital, until all services are relocated.

In closing, VA is thankful for the work this and other Congressional Committees have done to help VA navigate the challenges this project has posed and to secure the funding necessary for its planned completion. And despite those challenges, VA remains committed to ensuring the project provides a facility where Veterans will receive convenient 21st Century health care in a manner where the Department, Congress, Veterans Service Organizations, and local stakeholders work together for the benefit of our Nation's Veterans.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify before the Committee today. My colleagues and I would be pleased to respond to questions from you and other Members of the Committee.

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**Prepared Statement of Lloyd C. Caldwell, P.E.**

**DENVER REPLACEMENT MEDICAL CENTER CONSTRUCTION PROJECT,  
AURORA COLORADO**

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you on behalf of Lieutenant General Todd Semonite, the Chief of Engineers. I provide leadership for execution of the U.S. Army Corps of Engineers (Corps) engineering and construction programs in support of the Department of Defense (DOD) and other agencies of the Federal Government.

The Corps fully recognizes the importance of the service of members of the armed forces and the service of our veterans in sustaining the strength of our nation. The Corps has significant capabilities and experience delivering medical facilities for our service members and veterans. We understand the link between the technical capabilities we provide to enable vital health care for our veterans.

DOD's construction program utilizes designated Construction Agents, of which the Corps is one, that procure and execute design and construction of projects to deliver the Department's infrastructure requirements authorized by law. The Corps is also known for the Civil Works mission we execute for the Nation, and the Corps' capabilities are uniquely developed to deliver both defense and non-defense infrastructure. Interagency collaboration is an important element of the Corps' work, and the Corps provides interagency support as a part of its service to the nation. The Economy Act (31 USC 1535) provides the necessary authority for the Corps to assist other federal agencies, to include the Department of Veterans Affairs (VA), with any design and construction requirements.

Today, we have been asked by the Committee to testify on the subject of the Denver Replacement Medical Center in Aurora, Colorado (Denver Hospital), including the Corps' accounting of the total construction costs known to date and any ancillary construction activities. In addition, I will provide information pertaining to the Corps' lessons learned as related to the Denver Hospital.

While the Corps has the lead role in the construction execution of the Denver Hospital, VA, as the project proponent, remains responsible for project requirements, resourcing and facility transition to full operations, as well as the activation budget and timeline and planning for the existing medical center's continued use or decommissioning.

In December 2014, the VA and the Corps entered into an Economy Act agreement to allow the Corps to assess the Denver Hospital construction project. Subsequent modifications to this agreement and a new agreement provided the Corps the necessary funding and authority to transition the project's construction agent responsibility to the Corps.

Upon completion of the initial Corps assessment, we identified a preferred course for procurement as a Fixed Price - Incentive Firm Target contract. This contract was awarded on October 30, 2015, after lengthy negotiations with the contractor, and it has demonstrated effectiveness in cost and time savings, due to numerous factors, not the least of which has been a dedicated team consisting of the Corps, VA, and the Contractor working towards the goal of timely, cost effective delivery of a quality facility.

During construction, the Corps and VA have collaborated with each other, and staff from the House Veterans Affairs Committee to provide transparency of the completion status, ongoing activities, changes and expenditures associated with the project. Additionally VA and the Corps provided quarterly briefings to Committee staff on the project's completion status.

Our contract provided a target value for completing this project of \$570.75 million, with contingency for unforeseen conditions held in the amount of \$14.25 million, for a total estimated construction value of \$585 million. With the construction now 98 percent complete, our current estimate anticipates that upon final completion, we will have expended approximately \$555 million for construction resulting in approximately \$30 million being returned to VA. Additionally, we anticipate returning \$10 million from the government and contract oversight and audit costs. This will result in a total of approximately \$40 million being returned to VA from the original \$625 million provided to the Corps via Interagency Agreement. Construction remains on schedule for substantial completion of all buildings this month.

Upon completion of the new facilities, there will remain ancillary construction activities for the Denver Hospital, which fall into two categories; punch list items and modifications to address current medical facility requirements. Punch list requirements are routine with any construction project, and involve minor work remaining for correction or completion that the contractor must finalize to be in full compliance with the contract. These punch list items will not delay project occupancy and use.

The second category typically involves emergent requirements necessary to assure the new facility complies with current codes and practices that may have evolved during the course of the construction. These are relatively minor as compared to the total project requirements.

These emergent requirements were identified and validated by VA, and will be a separate contract action from the contract with Kiewit Turner. We anticipate completing these requirements using the same government team currently on the project but with a new contract. The time required to complete this contract action is still under review but we are currently targeting to have this remaining work completed by the summer of 2018. It is normal that medical facilities require modifications to address emergent requirements. The Corps and VA made the decision to address these emergent medical requirements via a new contract. This course of action provides clarity and transparency to completion of the project and assures finality in completion of the larger contract. This decision also allows the current contractor to concentrate on completing their contract requirements.

As part of our process the Corps reviews our project execution at various stages and identifies lessons learned. The lessons learned help to determine if quality objectives have been met, enable us to identify root cause(s) for quality objectives not met, and help us to formulate strategies to improve performance during ongoing execution of current or future projects. While this project is not yet complete, lessons learned are being continuously recorded.

For example, one significant lesson learned is the value of consistent Senior Executive Review of the project. The Senior Executive Review Group for this project was comprised of senior leaders from VA, the Contractor's organization, and the Corps. This group met regularly to receive project updates from the team on the project and to provide guidance. This commitment at the senior levels of the organizations of all stakeholders helped to ensure that the entire team remained focused on the success of the project and achieving our collective goals. At the completion of the project, a final package of lessons learned will be formally developed and documented.

Finally, while we are pleased to be nearing completion of this important project, we are also keenly aware of the trust the Committee has placed in the Corps. We appreciate the partnership that has developed during this project between the Corps and VA. We believe that the completion of the Denver Hospital will be a source of great value to the veterans in the region, and will validate the trust that you have placed in the Corps and the VA to bring it to completion. We are committed to working with VA for final completion of the Denver Hospital, and to continue this partnership and collaboration on future VA major construction projects.

Mr. Chairman, this concludes my statement. Thank you for allowing me to be here today to discuss the Corps' capabilities and our work to assist VA. I would be happy to answer any questions.

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### **Prepared Statement of Andrew Von Ah**

#### **VA CONSTRUCTION**

#### **Actions Taken to Improve Denver Medical Center and Other Large Projects' Cost Estimates and Schedules**

Chairman Roe, Ranking Member Walz, and Members of the Committee:

I am pleased to be here today to discuss the Department of Veterans' Affairs (VA) management of medical facility construction projects costing \$100 million or more, particularly the Denver VA Medical Center,<sup>1</sup> and other matters.

As you know, VA has pressing infrastructure needs and has struggled to make progress addressing them. VA operates one of the largest health care systems in the country with 1,376 sites in 2017. However, many facilities were built decades ago and were designed for an inpatient-driven health care system that does not align with VA's current wellness approach, which emphasizes outpatient and specialized care that, according to VA, served 6.26 million of the 9-million enrolled veterans in 2016. VA has endeavored to design and construct new facilities to replace its aging infrastructure with the intent of improving veterans' health care. However, we found substantial cost increases and schedule delays for VA's largest medical-facility construction projects in 2013, finding that four of the largest had experienced a total

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<sup>1</sup>VA's Denver VA Medical Center is actually located in Aurora, Colorado, near Denver.

cost increase of nearly \$1.5 billion.<sup>2</sup> These overruns included the Denver VA Medical Center, which, at the time, had experienced a 144 percent project cost increase. As a result of these cost increases and schedule delays, Congress mandated that VA outsource management of certain projects costing \$100 million or more. As a result of these mandates,<sup>3</sup> VA contracted with the U.S. Army Corps of Engineers (USACE) to manage construction of the Denver project as well as the others that Congress specified. Nevertheless, VA continues to manage other projects costing \$100 million or more that Congress has not specified should be outsourced. While cost increases and schedule delays at VA's medical-facility construction projects can occur for many reasons, such as unforeseen site conditions, management issues also play a part.

This testimony (1) provides an update on VA's Denver project and selected other projects reviewed in our March 2017 report and (2) discusses VA's progress toward addressing the recommendations in that report.<sup>4</sup>

To address these objectives, we reviewed our March 2017 report and obtained and reviewed documentation and interviewed VA officials on the status of the Denver project and our selected projects at VA's major medical-facilities, as of January 2018, and the steps VA has taken to address recommendations in our March 2017 report. We did not assess the extent to which USACE or VA is following best practices for cost estimates or schedules on projects initiated since our 2017 report. Detailed information on the scope and methodology used in our issued reports and testimony statements can be found in those products. We conducted the work for this statement in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

### Background

We have previously reported on significant cost overruns on VA's major medical-facility projects, as well as VA's weaknesses in managing these projects. Specifically, in our 2013 report,<sup>5</sup> we made three recommendations to improve VA's management of its major construction projects, and VA took actions to address those recommendations as described below:<sup>6</sup>

1. Integrate medical equipment planners in the design and construction of medical facilities to better integrate medical needs with the design of the facilities: In response, VA issued a policy memo providing guidance that medical equipment planners be assigned to medical-construction projects costing \$10 million or more to better integrate medical needs with design and construction of facilities.<sup>7</sup> During our 2017 work, VA officials at project site locations indicated that this had improved VA's capabilities for medical facilities' planning, including equipment planning.

2. Improve VA's communication with contractors to clarify roles and responsibilities, especially for change orders:<sup>8</sup> In response, VA implemented procedures to address our finding that a lack of clear communication with contractors contributed to project delays and cost increases. During our 2017 work, contractors at the three selected projects we reviewed that VA managed told us they had established good working agreements with VA's Office of Construction and Facility Management.

<sup>2</sup>GAO, VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects, GAO 13 302 (Washington, D.C.: Apr. 4, 2013).

<sup>3</sup>Provisions related to three laws enacted in 2015 collectively require VA to contract with other federal entities to provide full project management services for the design and construction of certain then ongoing construction projects with a total estimated cost of \$100 million or more as well as such construction projects Congress authorizes in the future. See, Pub. L. No. 114-58, § 502, 129 Stat. 530, 537-38; Pub. L. No. 114-92, 129 Stat. 726, 1020 (2015); and Pub. L. No. 114-113, 129 Stat. 2242, 2691-92 (2015). The explanatory statement accompanying Public Law 114-113 specified seven ongoing projects for which VA was directed to outsource design and construction management. These seven projects are in Alameda, CA; American Lake, WA; Livermore, CA; Long Beach, CA; Louisville, KY; San Francisco, CA; and West Los Angeles, CA.

<sup>4</sup>GAO, VA Construction: Improved Processes Needed to Monitor Contract Modifications, Develop Schedules, and Estimate Costs, GAO 17 70 (Washington, D.C.: Mar. 7, 2017). VA concurred with the recommendations we made our report.

<sup>5</sup>GAO 13 302.

<sup>6</sup>"Major construction projects" are those estimated to cost more than \$10 million. Of VA's 25 major construction projects, 22 are estimated to cost \$100 million or more.

<sup>7</sup>Department of Veterans Affairs, Office of Construction & Facilities Management, Architectural Design Manual (Aug. 1, 2014).

<sup>8</sup>Change orders are used to process changes to a project's design.

3. Issue and take steps to implement guidance on streamlining the change-order process based on the findings and recommendations of the Construction Review Council:<sup>9</sup> In response, VA took steps to streamline its change-order approval process including establishing processing time frames for change orders on construction projects and authorizing more people to approve change orders. However, our 2017 work found further room for improvement with regard to VA's tracking of change orders, as I will discuss later in this testimony.

**Cost Increases and Schedule Delays Persist at Major Medical-Facility Projects; However, USACE Expects to Finish Constructing the Denver Facility Within Its Estimated Costs and Meet the Project's Construction Schedule**

While VA had taken steps to improve its management of major construction projects, some VA major medical-facility projects we reviewed for our March 2017 report continued to experience cost increases and schedule delays. For example, in 2017 we found that the Denver project's costs increased another 100 percent over the estimated cost of the project since our previous report. See table 1 for the most recent available information on five projects we examined for our March 2017 report. These five projects, among the most costly projects, are in different phases of construction and represent a mix of projects managed by USACE and VA; thus, this information cannot be generalized to sites agency-wide.

Table 1: Changes in Costs and Completion Time Frames between November 2012 and December 2017 for Selected Department of Veterans Affairs' (VA) Medical-Facility Construction Projects

- (a) *The Louisville project did not have estimated completion dates available in November 2012 or December 2017.*
- (b) *VA expects the cost estimate for the Palo Alto project to increase.*
- (c) *The St. Louis project did not have an estimated completion date available in November 2012.*

| Project location        | Estimated cost, Nov. 2012 (dollars in thousands) | Estimated cost, Dec. 2017 (dollars in thousands) | Percentage (%) change | Estimated completion timeframe, Nov. 2012 | Estimated completion timeframe, Dec. 2017 | Number of months difference |
|-------------------------|--|--|-----------------------|---|---|-----------------------------|
| Denver                  | \$800,000  | \$1,675,000                                      | 109.4%                | April 2015                                | Jan. 2018                                 | 33                          |
| Louisville <sup>a</sup> | 900,000  | 925,000  | 2.8                   | NA  | NA  | NA                          |
| New Orleans             | 995,000  | 1,084,500  | 9.0                   | Feb. 2016                                 | Apr. 2018                                 | 26                          |
| Palo Alto <sup>b</sup>  | 716,600  | 716,600  | 0                     | Dec. 2017                                 | June 2022                                 | 54                          |
| St. Louis <sup>c</sup>  | 366,500  | 366,500  | 0                     | NA  | Mar. 2021                                 | NA                          |

Legend: NA=Not available  
Source: GAO analysis of VA data. | GAO-18-329T

When USACE took over the Denver the project in August 2015, it estimated that completing construction would cost \$585 million. We found that the cost estimate substantially met the characteristics of reliable cost estimates identified in the GAO Cost Estimating and Assessment Guide.<sup>10</sup> According to USACE, it currently expects to complete the Denver project at a cost of less than the \$585 million estimate.

Further, according to VA officials, they expect construction of the Denver project to be complete in January 2018.<sup>11</sup> While in our March 2017 report we found that the USACE construction schedule to complete the Denver project in January 2018 was not reliable, USACE decided not to revise it because doing so would have been

<sup>9</sup>In April 2012, the Secretary of Veterans Affairs established the Construction Review Council to serve as the single point of oversight and performance accountability for the planning, budgeting, execution, and delivery of the VA's real property capital-asset program.

<sup>10</sup>GAO, GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs (Supersedes GAO 07 1134P) GAO 09 3SP (Washington, D.C.: Mar. 2, 2009). Specifically, on a scale from "fully meets" to "does not meet," for four characteristics of a cost estimate, we found the USACE estimate to substantially meet all characteristics. The estimate was comprehensive, well-documented, accurate and credible. See GAO 17 70 p. 20–21 for further information on these characteristics.

<sup>11</sup>We did not independently verify the remaining construction schedule to confirm this completion date. While the VA expects the bulk of the construction to be complete by January 2018, VA officials stated that certain construction activities will continue beyond January under a new contract that USACE will award and manage. USACE and VA expect that the cost of this work will still result in keeping the overall project within USACE's total \$585 million cost estimate.



costly and disrupt progress on the project. USACE officials explained they would have followed best practices if they had initiated the project. However, they stated that the Denver project presented a unique situation because USACE began managing the project when it was about 50 percent complete.

**VA is Working on Improving its Management of Change Orders and Estimated Project Costs and Schedules**

**VA Has Improved Data Collection of Timeframes for Change Orders, but it Is Unclear How VA Will Use this Information to Improve Project Management**

In our March 2017 report, we found the following limitations related to change orders, or changes to a project design:

1. VA did not collect the necessary information to determine whether efforts to streamline the change order process have in fact been successful.
2. VA did not collect sufficient information to categorize and monitor the reasons change orders occur.
3. It was unclear how VA plans to use this information to monitor whether change orders are approved within VA guidelines.

For example, three of the five VA sites we selected for our 2017 report kept some information on processing time frames, but it was incomplete and inconsistent. Further, the monitoring process was done manually by the regions, according to VA officials. We thus recommended that the VA establish a mechanism to monitor the extent that major facilities' projects are following guidelines on change orders' time frames and design changes.

Since then, VA has implemented changes to its system that captures information on time frames for approving changes and, according to VA, the reasons for the changes. This improvement should allow VA to track change orders that are still open and how long it takes to close them, and the extent to which VA's guidelines for these timelines are being adhered to. It should further allow VA to identify and track the reasons why changes occurred, such as whether a change resulted from a design oversight, an unforeseen condition discovered during construction, or some other reason. VA officials also stated that they have developed guidance that discusses how to track and report change-order time frames and the reasons for the change orders, and how this information will be used going forward. While VA has yet to provide documentation, if fully implemented, these mechanisms should improve VA's accountability and allow for more informed decision-making by Congress and VA.<sup>12</sup>

**VA is Improving its Activation Processes; However, it Has Not Produced a Reliable Estimate for the Denver Facility**

In our March 2017 report, we found that VA had minimal supporting documentation for its estimate for the cost to "activate"-the process of bringing a facility into full operation-the Denver Medical Center, and as such determined that the activation estimate was unreliable.<sup>13</sup> While the USACE is under contract with VA to manage the construction of the Denver project, VA is responsible for activating the Denver facility and has estimated that this process will cost \$341 million.<sup>14</sup> With minimal supporting documentation of this estimate, we recommended that VA develop an activation cost estimate for the Denver project that is reliable and conforms to best practices, as described in the GAO Cost Estimating and Assessment Guide. Without a reliable estimate, it is difficult for VA to make funding decisions for activating various facilities. Further, the lack of a reliable estimate poses difficulties for Congress, which relies on this estimate to make annual appropriations decisions.

In July 2017, VA provided us with additional documentation on its activation cost estimate. We analyzed this information and found that the estimate did not meet best practices. Specifically, the VA Denver hospital's activation cost estimate partially met two (comprehensive and credible) and minimally met two (well documented and accurate) of the four characteristics of a reliable cost estimate as described in the GAO Cost Estimating and Assessment Guide. In December 2017, VA provided comments on our analysis, concurring with some of GAO's assessments

<sup>12</sup>These mechanisms do not apply to change orders for the Denver project, since it's being managed by USACE, which has its own change order process.

<sup>13</sup>Activation includes activities such as purchasing and installing furniture and medical equipment and hiring new staff for the facility.

<sup>14</sup>VA continues to expect activation to cost \$341 million.

and identifying additional information for us to consider. While we cannot find that the current estimate meets or substantially meets all of the characteristics of a reliable estimate, VA has made improvements in the documentation of the estimate since our report. VA officials also indicated they are taking steps such as developing training and going forward will be providing staff GAO's Cost Estimating and Assessment Guide to improve activation estimates.

**VA Has Taken Steps to Clarify Its Policies on Linking Construction and Activation Activities with the Integrated Master Schedule**

In our March 2017 report, we found VA's policies were not clear or consistent in the way that they require VA to link construction and activation schedules to form an integrated master schedule. The integrated master schedule is an important element for ensuring the successful and timely completion of these projects. Although VA and USACE officials at the Denver project provided a construction schedule, an activation schedule, and an integrated master schedule, we found that certain activities and milestones in these schedules were not aligned with each other across the three schedules. This lack of alignment may be because, although VA required an integrated master schedule, many of its policies on developing an integrated master schedule were not clear or consistent. For example, VA's policies used conflicting and undefined terms to describe the activities an integrated master schedule should cover. Without a fully integrated master schedule, VA could have encountered additional delays in completing the project. We thus recommended that VA clarify policies on integrating schedules.

In response to our recommendation in our March 2017 report, VA clarified various policy documents in June 2017 and reinforced that all projects develop and maintain an integrated master schedule that includes and links all construction and activation activities. VA also has updated its policy to require USACE to comply with the requirements related to integrated master schedules. VA provided documentation of these changes which we reviewed and found that the clarifications addressed our recommendation. Moreover, VA officials indicated that they have worked with USACE to develop an integrated master schedule linking construction and activation activities for the Denver Medical Center and agreed to provide documentation. These actions should help VA avoid schedule delays and better manage its major construction projects.

Chairman Roe, Ranking Member Walz, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

**GAO Contact and Staff Acknowledgments**

If you or your staff have any questions about this testimony, please contact Andrew Von Ah, Director, Physical Infrastructure team at 213-830-1011 or vonaha@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Cathy Colwell (Assistant Director), Brian Bothwell, Antoine Clark, Lynn Filla-Clark, George Depaoli, Geoff Hamilton, Jason Lee, Nitin Rao, and Malika Rice.

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### **SUPPLEMENT TO ANDREW VON AH STATEMENT**

#### **Why GAO Did This Study**

VA and USACE are nearing completion of the Denver Medical Center, which is intended to improve health care to veterans in that region. This project has suffered from substantial cost increases and delays resulting not only from unforeseen circumstances but also from mismanagement. In response, Congress mandated that VA outsource management of certain projects costing \$100 million or more. VA contracted with USACE to manage construction of the Denver project, among others. VA continues to manage other major construction projects.

In March 2017, GAO reported on opportunities to improve the management of Denver and other VA construction projects. Specifically, GAO recommended that VA: (1) establish a mechanism to monitor change orders; (2) develop a reliable activation cost estimate for the Denver project, and (3) clarify policies on integrating schedules. VA concurred with our recommendations. This statement discusses, among other objectives, VA’s actions to address these recommendations.

The statement is based on GAO’s March 2017 report (GAO–17–70), additional documentation VA provided to address GAO’s recommendations, and selected updates on the Denver Medical Center as well as other major VA projects.

#### **VA CONSTRUCTION**

##### **Actions Taken to Improve Denver Medical Center and Other Large Projects’ Cost Estimates and Schedules**

##### **What GAO Found**

The Department of Veterans Affairs (VA) is taking actions to implement GAO’s 2017 recommendations related to project management, as described below. However, in some cases VA has yet to fully implement these actions.

Change orders: In 2017, GAO found that VA did not track: (1) how long it took for change orders-changes in a project’s design-to be approved and whether that

amount of time met VA's guidelines, or (2) the reasons for those changes. Since then, however, VA has started tracking the time frames. Additionally, VA told GAO it is tracking the reasons for those changes as well as developing guidance on how to use this information and agreed to provide documentation. This step does not affect change orders for the Denver project (see photograph), which is managed by the U.S. Army Corps of Engineers (USACE) but, if fully implemented should improve VA's management of other projects.

**Cost Estimate for Activating Facility:** In 2017, GAO found that the most recent cost estimate of \$341 million for activating, or bringing the Denver Medical Center into full operation, had minimal supporting documentation. Although VA is improving its cost estimation process for activation in response to our recommendation, the Denver estimate does not yet meet or substantially meet the characteristics of a reliable activation cost estimate.

**Integrated Master Schedule:** In 2017, GAO found that certain activities and milestones from Denver's construction and activation schedule were not aligned with its integrated master schedule—the schedule intended to link construction and activation activities. Without a fully integrated master schedule, VA could have encountered additional delays in completing the project. GAO recommended VA clarify its guidance on linking schedules. VA said it has since aligned its construction and activation schedules for the Denver project and agreed to provide GAO documentation. VA has clarified its guidance and is working with USACE to ensure this clarification occurs on other projects.

One picture here

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## Statements For The Record

**PATRICK MURRAY**

WITH RESPECT TO

“The Denver Replacement Medical Center: Light at the End of the Tunnel?”

Chairman Roe, Ranking Member Walz and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I want to thank you for the opportunity to present the VFW's views on the Denver Medical Replacement Center.

The Denver Replacement Medical Center in Aurora, Colorado, has been an embarrassment for the Department of Veterans Affairs (VA) for years, and its completion date does not mean the end of the struggle for this project. Overdue and over budget is simply not enough to describe how badly this project was mismanaged. Without the voices of local veterans and their representatives in Congress, this hospital project would still be floundering.

Major construction on the hospital is set to be completed this month, with the majority of the building work coming to an end. This does not mean the project is complete by any means, there is still millions of dollars' worth of work to be done. The major construction milestone can sound misleading as some may think the work is done, but there are still months ahead of this project before they can start operating fully.

In the next six months, VA has to fully stock the hospital with furniture and medical equipment which will cost hundreds of millions of dollars. Even though substantial completion will be reached this month, the building will still not be ready to receive significant numbers of patients until this summer.

Activation and startup costs are typical for every project, but every additional dollar spent on the Aurora hospital continues to erode public trust for an already extremely expensive project. Supplying the hospital with equipment, testing and approving the equipment, and staffing the facility are all part of typical startup costs. Transparency in all the additional time and money needed for the actual completion of the project is one important step in regaining the public's trust in how tax dollars are spent.

The Aurora hospital project was mismanaged from the start and is a clear indication that the VA construction division is not up to speed with innovative and progressive construction practices. Many have stated that the leadership of this project lied to Congress and the public about the progress and costs associated with the hospital from the beginning. It took the U.S. Army Corps of Engineers to take over control of the project for any significant headway to be made toward completion. VA and Congress must make certain this is not allowed to occur again and that those responsible are held accountable.

For future VA major construction projects to succeed, the personnel within VA managing those projects need to be empowered to be decision makers on the ground and be given the authority to make changes to stay ahead of schedule and under budget. The VFW has been an advocate for VA construction to fully embrace the Integrated Design-Bid-Build (IDBB) process for all projects. Until they do so, construction projects like Aurora will continue to hit unnecessary pitfalls like they have in the past.

IDBB allows contractors, designers and owners representatives to come together in the early stages of the entire project in order to avoid conflicts during the building process. By integrating the early phases of the project, designers and the contractors building the hospital can easily navigate conflicts and changes that would typically stall progress during key phases of the project. Avoiding having to redo work that does not fit for the staff using the facility saves costs to the tax payer.

Small issues like electrical outlets needing to be replaced in Aurora due to incompatibility with the types of patients being seen in certain clinics, could have been avoided if the end users had input from the beginning. Having to go back and redo work-in-place only adds to the already staggering cost of the facility. The IDBB process helps reduce overall time and cost of any project by overlapping early phases of the project and bringing all stakeholders to the table in order to get the work done right the first time.

Projects like Aurora should never have reached the level of mismanagement that it did, but once the waste and abuse of government money was fully brought to light, Congress stepped in and demanded change. A shining example of Congress getting it right is Representative Mike Coffman who was one of the leaders in demanding change and accountability for the Aurora project. The VFW shares Mr. Coffman's frustrations with the project, and are happy to see members of Congress taking the right approach to correcting the problems associated with it.

Another key voice in calling out the problems associated with this project are the local veterans themselves. Nobody knows their own communities better than the people living in them. Whenever issues that involve honesty and transparency arise it is important to listen to the voices most affected by them. The VFW's local leadership has been extremely vocal about this project since the beginning. With such a large veteran community surrounding the hospital, there are thousands of local area veterans that will benefit once the hospital obtains fully operational status. That is why the combination of local leadership, with that in Congress are so integral in making future projects a success.

The VFW has called on VA to reform its construction process so facilities can be delivered on time and on budget. Previous errors must be corrected to ensure the issues in Aurora, Colorado, never occur again. However, Congress and the Administration must not ignore the growing capital infrastructure needs of the VA's health care system. When VA asked its Veteran Integrated Service Networks to evaluate what they need to improve its facilities to meet the increased outpatient demand, VA determined that "improving the condition of VA's facilities through major construction projects (96) accounted for the largest resource need."<sup>1</sup> Yet the Administration's major construction request for the Veterans Health Administration is 36 percent less than FY 2017 and 85 percent less than actual expenditures in FY 2016. Aurora must not deter Congress and VA from continuing to invest in major projects like this in the future in order to continue providing world class care to our veterans.

Another area of major concern for the VFW is the lack of a comprehensive replacement plan for the existing services offered at the original Denver hospital. The new Aurora facility has less primary care services offered and substantially less PTSD services. The original hospital will need to remain open for years to keep serving primary care patients, and there is currently no plan to have a replacement PTSD facility built on the new Aurora campus. VA needs to provide an accurate and transparent plan for making sure the new facility offers better support for veterans, and does not represent a step backward. It is unacceptable for VA to invest almost two billion dollars in a new facility that does not offer the same measure of care as the hospital it is meant to replace. New VA hospitals should be expected to meet current demands, and have the capacity to address future needs as well.

While the Aurora hospital project will remain in the memory of those associated with it for years to come, we hope it also serves as a reminder of why getting it right the first time is the best case scenario. Transparency is an absolute must in all future projects in VA construction, and bringing in all key stakeholders as early

<sup>1</sup>Department of Veterans Affairs 2018 Budget and 2019 Advance Appropriations Requests, Volume IV: Construction, Long Range Capital Plan and Appendix. Long Range Capital Plan, page 8.3-8.

as possible will help mitigate unnecessary cost overruns and ensure the timely completion of future projects.

