

STATEMENT OF
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VETERANS OF FOREIGN WARS OF THE UNITED STATES
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO

VA's CONSTRUCTION BUDGET FOR FISCAL YEAR 2005

WASHINGTON, D.C.

FEBRUARY 4, 2004

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.7 million men and women of the Veterans of Foreign Wars of the U.S. and our Ladies Auxiliary, I would express our deep appreciation for being included in today's important legislative hearing to discuss the budget for the Department of Veterans Affairs (VA). As a constituent member of the Independent Budget for VA, the VFW is responsible for the Construction portion of the VA budget so I will limit today's testimony to that area.

The Department of Veterans Affairs construction budget includes major construction, minor construction, grants for construction of state extended care facilities, grants for state veterans' cemeteries, and the parking garage revolving fund.

A historical overview of VA Major and Minor Construction clearly shows that since 1993 VA's construction budget and annual appropriations for both major and minor projects continue to drop sharply to the current low level.

While at the time of this writing we have not been provided with a copy of the President's FY 2005 budget VA recommendation for review, information available to us indicates that along with gross funding deficiencies in practically every VA account, VA construction is to be dramatically and most detrimentally short-changed as well. We look forward to working with the members of this Committee and indeed the entire congress to correct this disgraceful administration funding package for our nation's sick and disabled veterans in need.

Most unfortunately, VA construction funding has been in steady decline. The FY 1993 combined total was \$600 million; however, by FY 2003, the total had decreased to only about \$300 million. VA's history of low construction budgets the last 12 years is an explicit indication of poor stewardship of the system's facility capital assets. It also flies in the face of moral as well as statutory mandates to provide for the short and long-term care needs of our most seriously service connected veterans. It is our understanding that the administration will once again propose counting State Nursing Home Beds as part of its own long-term capacity. We view this as a disgraceful attempt to circumvent both the letter and intent of the law with a number of our most deserving and vulnerable veterans suffering as a consequence.

In a study completed in 1998, Price Waterhouse was asked to determine the spending level required to ensure that VHA's investment in facility assets would be adequately protected against adverse deterioration and to keep the average condition of facilities at an appropriate level. Price Waterhouse concluded that the VHA was significantly underfunding its construction spending, and based on their observations across the industry, appropriate annual spending should be between 2% and 4% of the plant replacement value (PRV) on reinvestment to replace aging facilities. Price Waterhouse considered reinvestment to be improvements funded from the major and minor construction appropriations. PRV for the VHA is

approximately \$35 billion. The 2%–4% range would therefore equate to annual funding of \$700 million to \$1.4 billion

There continues to be major resistance to fund an adequate construction budget before the Capital Asset Realignment for Enhanced Services (CARES) process has been completed. We have been supportive of the CARES process from the beginning, as long as the primary emphasis is on the “ES”—enhanced services; however, we believe that it is poor policy to defer all VA construction needs until CARES is complete.

Currently, most VA medical centers, with an average age of 54 years, are in critical need of repair. Sadly, the prospect of systemwide capital asset realignment through the CARES process has been used as an excuse to hold all construction projects hostage. These projects are essential to patient safety; moreover, they will eventually pay for themselves through future savings as a result of modernization. The ongoing reconfiguration of the system through CARES must not distract VA from its obligation to protect its current assets by postponing needed funding for the construction, maintenance, and renovations of VA facilities.

While we still believe the CARES process should proceed, we perceive a need for further data to support various recommendations that would close or change missions of certain VA long-term care and small size facilities. These data should include such items as a cost analysis associated with these changes to include the costs of transferring patients and staff; the cost associated with contracting for care in the community; the cost related to shutting down and disposing of property to include asbestos removal; the cost to build or lease new facilities like community-based clinics and patient bed towers to include associated site elements to make the building functional, such as equipment, relocation, and activation costs; and updating facility infrastructures to handle additional patient workloads while maintaining privacy and safety requirements.

We acknowledge that the VA Office of Facilities Management has assembled construction cost data for various functional building types; however, the inclusion of the aforementioned cost could provide the rationale for reconsidering some decisions.

In additional, the assumption that Congress will adequately fund all CARES proposed changes must be questioned. The VFW and other IBVSOs are concerned that when CARES implementation costs are factored into the appropriations process, Congress will not fully fund the VA system, further exacerbating the current obstacles impeding veterans' access to quality health care in a timely manner. It is our opinion that VA should not proceed with CARES changes until sufficient funding is appropriated for the construction of new facilities and renovation of existing hospitals is approved.

We recommend that Congress appropriate **\$571 million** to the Major Construction Account for FY2005. This amount is needed for seismic correction, clinical environment improvements, National Cemetery Administration construction, land acquisition, and claims.

Allocated as follows:

- Seismic Improvements \$285,000
- Clinical Improvements 25,000
- Patient Environment 10,000
- Research Infrastructure Upgrade and Replacement 50,000
- Advance Planning Fund 60,000
- Asbestos Abatement 60,000
- National Cemetery Administration 81,000
- IB Recommended FY 2005 Appropriation \$571,000

We also call for the Congress to appropriate **\$545 million** to the Minor Construction Account for FY 2005. These funds contribute to construction projects costing less than \$7 million. This appropriation also provides for a regional office account, National Cemetery Administration account, improvements and renovation in VA's research facilities, a staff office

account, and an emergency fund account. Increases provide for inpatient and outpatient care and support, infrastructure, physical plant, and historic preservation projects. Allocated as follows:

Inpatient Care Support \$130,000
Outpatient Care and Support 100,000
Infrastructure and Physical Plant 150,000
Historic Preservation Grant Program 25,000
Other 25,000
VBA Regional Office Program 35,000
National Cemetery Program 35,000
VA Research Facility Improvement and Renovation 45,000
IB Recommendation FY 2005 Appropriation \$545,000

Annually, the VHA submits a list of Top 20 Priority Major Medical Construction Projects to Congress, which identifies the major medical construction projects that have the highest priority within VA. This list includes buildings that have been deemed at “significant” seismic risk and buildings that are at “exceptionally high risk” of catastrophic collapse or major damage. Currently, 890 of VA’s 5,300 buildings have been classified as significant seismic risk, and 73 VHA buildings are at exceptionally high risk.

Four exceptionally high-risk seismic correction projects—Palo Alto, San Francisco, West Los Angeles, and Long Beach—were included in VA’s recent budget submission; however, none of these seismic projects were funded. These four facilities have been classified as the most exceptionally high risk for catastrophic collapse or major damage.

The IBVSOs believe, as we have indicated in the past, that there is ill advised resistance to funding any major construction projects before the CARES process has been completed, and this includes correcting seismic deficiencies in VHA facilities. Regardless of the recommendations of the CARES program on facility realignments, it is our contention that VA must maintain and improve its existing facilities to support the delivery of health-care services in a risk-free environment for veterans and VA employees alike.

Most seismic correction projects should include patient-care enhancements as part of their total scope. Also, consideration must be given to enhanced service recommendations provided for CARES. Due to the lengthy and widespread disruption to ongoing hospital operations that are associated with most seismic projects, it would be prudent to make qualitative medical care upgrades at the same time.

We contend that Congress should appropriate \$285 million to correct seismic deficiencies. Further VA should schedule facility improvements projects and CARES recommendations concurrently with seismic corrections.

In another area, we point to the fact that VA's health-care facility infrastructure is grossly undercapitalized. Good stewardship demands that VA facility assets be protected against deterioration and that an appropriate level of building services be maintained. Given VA's construction needs, such as seismic correction, compliance with the Americans with Disabilities Act (ADA) and Joint Commission of Accreditation of Healthcare Organization (JCAHO) standards, replacing aging physical plant equipment, and CARES, VA's construction budget continues to be inadequate.

In *The Independent Budget for Fiscal Year 2004*, we cited the recommendations of the interim report of the ***President's Task Force to Improve Health-Care Delivery for Our Nation's Veterans (PTF)***. That report was made final in May 2003. To underscore the importance of this issue, we will cite the recommendation of the PTF again this year.

VA's health-care facility major and minor construction over the 1996 to 2001 period averaged only \$246 million annually, a recapitalization rate of 0.64% of the \$38.3 billion total plant replacement value. At this rate, VA will recapitalize its infrastructure every 155 years. When maintenance and restoration are considered with major construction, VA invests less than 2% of plant replacement value for its entire facility infrastructure. A minimum of 5% to

8% investment of plant replacement value is necessary to maintain a healthy infrastructure. If not improved, veterans could be receiving care in potentially unsafe, dysfunctional settings. Improvements in the delivery of health care to veterans require that VA and the DOD adequately create, sustain, and renew physical infrastructure to ensure safe and functional facilities.

It was also recommended by the PTF that “an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels. The importance of this initiative is that the physical infrastructure must be maintained at acceptable levels to avoid deterioration and failure.”

The PTF also indicated that “Within VA, areas needing improvement include developing systematic and programmatic linkage between major construction and other lifecycle components of maintenance and restoration. VA does not have a strategic facility focus, but instead submits an annual top 20 facility construction list to Congress. Within the current statutory and business rules, VA can bring new facilities online within 4 years. However, VA facilities are constrained by reprogramming authority, inadequate investment, and lack of a strategic capital-planning program.”

The PTF believes that VA must accomplish three key objectives:

- (1) invest adequately in the necessary infrastructure to ensure safe, functional environments for healthcare delivery;
- (2) right-size their respective infrastructures to meet projected demands for inpatient, ambulatory, mental health, and long-term care requirements; and
- (3) create abilities to respond to a rapidly changing environment using strategic and master planning to expedite new construction and renovation efforts.

Additionally, it was recommended by the PTF that “an important priority is to increase infrastructure funding for construction, maintenance, repair, and renewal from current levels.”

The VFW supports the Price Waterhouse recommendation that VA spend at least 2% of the value of its buildings or \$700 million annually on upkeep. Together with the IBVSOs we believe that \$400 million should be appropriated in FY 2005 with continued increases in the following years until an appropriate level of funding that will forestall the continued deterioration of VA properties is achieved.

Congress should appropriate no less than \$400 million for nonrecurring maintenance in FY 2005 to provide for adequate building maintenance. VA should direct no less than \$400 million for nonrecurring maintenance in FY 2005. VA should also make annual increments in nonrecurring maintenance in the future until 2% of the value of its buildings is budgeted and utilized for nonrecurring maintenance.

It has been suggested that the VA medical system has vast quantities of empty space that can be cost effectively reused for medical services. It has also been suggested that unused space at one medical center may help address a deficiency that exists at another. Although the space inventories may be accurate, the basic assumption regarding viability of space reuse is not.

Medical facility planning is a complex task because of the intricate relationships that must be provided between functional elements and the demanding technical requirements of the sophisticated equipment that must be accommodated. For these reasons, space in medical facilities is rarely interchangeable—except at a prohibitive cost. Unoccupied rooms located on a hospital's eighth floor, for example, cannot offset a space deficiency in a second floor surgery because there is no functional adjacency. Medical space has very critical inter- and intra-departmental adjacencies that must be maintained for efficient and hygienic patient care. In order to maintain these adjacencies, departmental expansions or relocations usually trigger

extensive “domino” impacts on the surrounding space. These secondary impacts greatly increase construction costs and patient care disruption.

Some permanent features of medical space, such as floor-to-floor heights, column-bay spacing, natural light, and structural floor loading, cannot be altered. Different medical functions have different technical requirements based on these permanent characteristics. Laboratory or clinical space, for example, is not interchangeable with patient ward space because of the need for different column spacing and perimeter configuration. Patient rooms need natural light and column locations that are compatible with patient room layouts. Laboratories should have long structural bays and function best without windows. If the “shell” space is not appropriate for its purpose, renovation plans will be larger and more inefficient and therefore cost more.

Using renovated space rather than new construction yields only marginal cost savings. Build out of a “gut” renovation to accommodate medical functions usually costs approximately 85% of the cost of similar new construction. If the renovation plan is less efficient, or the “domino” impact costs are greater, the small potential savings are easily lost. Renovation projects often cost more and produce a less satisfactory result. Renovations are sometimes appropriate to achieve desirable functional adjacencies, but they are rarely economical.

Early VA medical centers used flexible campus-type site plans with separate buildings serving different functions. Since World War II, however, most main hospitals have been consolidated into large, tall “modern” structures. Over time, these central medical towers have become surrounded by radiating wings and connecting corridors leading to secondary structures. Many current VA medical centers are built around prototypical “Bradley buildings.” These structures were rapidly constructed in the 1940s and 1950s for returning World War II veterans.

Fifty years ago, these brick facilities were easily site-adapted and inexpensive to build, but today they provide a very poor chassis for a modern hospital. Because most Bradley buildings were designed before the advent of air conditioning, for example, the floor-to-floor heights are very low. This makes it almost impossible to retrofit modern mechanical systems. The older hospital's wings are long and narrow (in order to provide operable windows) and therefore provide inefficient room layouts by contemporary standards. The Bradley hospital's central service core with a few small elevator shafts is inadequate for the vertical distribution of modern medical services.

In addition, much of the currently vacant space is not situated in prime locations. If the space were, it would have been previously renovated or demolished to clear the way for new additions. Unused space is typically located in outlying buildings or on upper floor levels. Its permanent characteristics often make it unsuitable for modern medical functions.

VA should perform a comprehensive analysis of its excess space and deal with it appropriately. Some of this space is located in historic structures that must be preserved and protected. Some space may be appropriate for enhanced use. Some may be appropriate for demolition. While it is tempting to focus on unused space, it should not be a major determinant in CARES realignments. Each medical center should develop a plan to find appropriate uses for its vacant properties.

Mr. Chairman and distinguished members of this Committee, this concludes my statement and I will be happy to respond to any questions you may have.