

**RIGHT-SIZING THE DEPARTMENT OF
VETERANS AFFAIRS INFRASTRUCTURE**

HEARING

BEFORE THE

**COMMITTEE ON
VETERANS' AFFAIRS**

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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RIGHT-SIZING THE DEPARTMENT OF VETERANS AFFAIRS INFRASTRUCTURE

THURSDAY, MAY 11, 2006

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

The Committee met, pursuant to call, at 11:26 a.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the committee] presiding.

Present: Representatives Buyer, Moran, Brown, Boozman, Brown-Waite, Filner, Michaud, and Berkley.

Staff Present: Jeff Weekly, Majority Counsel; David Tucker, Minority Counsel; and Jim Lariviere, Staff Director.

THE CHAIRMAN. The full Committee of the House Veterans Affairs Committee will come to order, May 11, 2006. We are here today to evaluate the requests by the Secretary of Veterans Affairs for authorization for several major construction projects and leases which will improve, renovate, and/or update patient care facilities at various locations. I'd like to thank all of our panelists today for their testimony. The Department of Veterans Affairs must by law receive statutory authorization for all major medical facility construction projects and leases that exceed \$600,000 per year before it may obligate or expend funds.

Secretary Nicholson has requested authorization for \$1.6 billion for major facility construction projects, and \$25 billion for major facility leases in fiscal year 2006. For fiscal year 2007, the Secretary has requested authorization for \$352 million in major facility construction projects and nearly \$27 million in major facility leases.

The Secretary's requests include immediate funding authorization to ensure the restoration and continuation of care for veterans who had depended on VA medical facilities damaged by Hurricane Ka-

trina in Biloxi, Mississippi, Gulfport, Mississippi, and New Orleans, Louisiana. Those veterans have our support and we commend the men and women of the VA and the Gulf for their exemplary work providing uninterrupted care to these veterans.

Today we must also look to the long term. Yesterday the Appropriations Committee declined VA's funding request for the replacement medical facility in Denver. The price had originally come in at over \$700 million, and the price tag has now been reduced to \$621 million, which itself indicates that there is a credibility gap insofar as the facility pricing goes, and we're interested in the Administration's testimony. For those to whom this is a disappointment and/or a surprise, we must all recognize the need for improved facilities in the Denver area, and I suggest that all of us have a wake-up call, and a real opportunity before us. It does not have to cost nearly a \$1 billion to build a world class medical center. Just last month, the VA's General Andy Love and General Heiberg visited the new Clarian Hospital in Indianapolis. This is a private sector, leading edge facility. It's in excess of 170 beds at a cost of \$280 million. And having been in the facility, when you look around it looks like the Four Seasons. While the core services provided by the VA and Clarian differ, as well as some construction standards, there appears to be quite a disparity between the private sector and the public sector's ability to build state of the art facilities at reasonable costs.

If the writing is on the wall we must also have examples of approaches that can lead to a sustainable path of quality of care. We must consider the advantages and the virtues offered by a approaches more innovative than the status quo process that goes it alone, and misses out in opportunities for greater quality and efficiency.

I commend the VA, in particular Dr. Perlin, and Mr. McClain, for seizing a great opportunity in Charleston, SC where the VA and the Medical University of South Carolina have a unique physical and business relationship, and have produced a collaborative report. In recent months, the two made progress on this enhanced collaboration and it will yield improved services to veterans. We now have what is called the Charleston Model, and before it could be enacted in Charleston we had Katrina. And it is now proposed to leverage the Charleston Model in the Gulf Coast region.

The purpose of the Collaborative Opportunities Steering Group is to explore the benefits of collaboration, which could include the construction of separate bed towers that share services and some equipment while retaining the identity of a Veterans Health System. Their April 30th interim report called this sharing "a very positive and exciting prospect that will enhance patient outcomes and efficiencies for both institutions."

Innovation is not limited to examples set by the private sector, or the harnessing of collaboration between public and private sectors.

Government agencies can work with each other to be more efficient. In a sign of progress, a 2002 agreement between the Navy and the VA to share facilities in North Chicago is much closer to being fulfilled. Collaboration between the VA and the Pentagon, as we have seen, is essential for the seamless transition of servicemembers into the VA and back again. We should commend these two agencies for their recent progress in developing an interoperable system of the sharing of electronic medical records. Yet, there is still more work to be done.

There is no denying that medicine has undergone a revolution that has dramatically boosted its potential, but also the cost and complexity. Our response must also therefore be commensurate. In the face of examples such as in Clarian or in Charleston, and now perhaps New Orleans, preserving the status quo approach to bricks and mortar should be an affront to the much proclaimed excellence of the VA's healthcare managers. The status quo approach to the bricks and mortar is certainly not good enough for America's veterans, and we can do better.

At this moment, I would yield to Mr. Filner for any opening comment that he would like to make.

MR. FILNER. I thank you, Mr. Chairman. Thank you for holding this hearing today to examine the major construction projects of the VA, and their lease requests, and to hear about the status of the CARES project.

I appreciate that our three colleagues are here, Congressmen Baker, Melancon and Feeney, because they will provide us insight into the issues of building in New Orleans and southern Louisiana, and the long time need for a VA facility in Central Florida. As you said, Mr. Chairman, I hope this hearing will assist in moving along the provision of healthcare facilities for veterans in these states.

I also appreciate the opportunity to hear testimony from the VA and two of our Veterans Service Organizations about the status of the CARES process. This can be a very useful tool, if we use it well. The VA should have a comprehensive study of its current infrastructure and its future needs, and if used wisely, CARES can help us ensure that veterans get the full value of every health dollar that Congress provides.

I was concerned that many construction projects were held up while we were waiting, longer than expected I guess, for the CARES report. I am concerned now that plans to accommodate mental healthcare and long term care were excluded from the CARES process. These two areas of service are becoming increasingly important. It has been estimated that at least one-third of returning troops have mental health issues. And increased life span is creating long term healthcare needs for our many veterans. The number of veterans ages 75 and older is projected to increase from four million to four and a half million by 2010, and the number of those over 85 will triple to 1.3

million in the same period. So I concur with the testimony of the Veterans of Foreign Wars that these services must be evaluated in terms of their facility needs. These questions are ones that I will pose to the VA and hope can be answered, if not today then very soon.

I am interested in finding out how CARES interacts with the Administration's construction request. What does the VA plan on doing to enhance services, and not just close facilities? Are there any criteria for when CARES priorities will be ignored, as were right away for a lower priority project? Though promises were made regarding funding for the CARES process, will the funding indeed be a reality in the future? We want to be certain that the CARES process lives up to its mission and does not leave veterans with a series of empty promises. I hope that the CARES report and a significant expenditure of resources does not end up on a shelf somewhere forgotten. We must make use of all the research and work that has been done and, Mr. Chairman, I thank you for holding this important hearing today.

THE CHAIRMAN. I thank the gentleman. Mr. Moran, an opening statement?

MR. MORAN. No opening statement, Mr. Chairman.

THE CHAIRMAN. Thank you. Mr. Michaud, opening statement?

MR. MICHAUD. Thank you, Mr. Chairman. I want to thank you as well for having this hearing. I am looking forward to hearing from my three colleagues, what you have to say as well as the second panel. I am also really interested in the whole CARES process. Dr. Perlin, hopefully you will be able to address some of the concerns that we have about the inadequate funding. So, with that Mr. Chairman I yield back.

THE CHAIRMAN. Thank you. Mr. Boozman? Ms. Berkley, you are recognized for an opening statement.

MS. BERKLEY. Thank you, Mr. Chairman. I want to thank my colleagues for being here. We appreciate the fact that you are going to enlighten us regarding projects that probably have particular interest to your constituents. But I want to share my pain, and my constituents' pain with you. So, hopefully we can all work together on a bipartisan basis to provide the necessary facilities that our veterans not only deserve but that we owe.

As you may know, the CARES report recommended a new Las Vegas VA Medical Complex that would be built in my district. Today, and one of the reason I am here, not only to hear about your issues, but to get some clarification as to why the completion date has been pushed back from 2009 to mid-2010, and why the Complex will not be operational until 2011. I want to know what the hold up is. In my district, we build five thousand room hotels in 18 months, and they are ready to go, and we cannot build a VA facility of 80 beds. Something is very wrong here. I have got the fastest growing veterans

population in the United States. It exceeds 200,000 veterans now. The need for a medical complex exists and it exists now.

Currently, my veterans are forced to take a shuttle to numerous clinics there are 10 different locations in the Las Vegas valley. What does that mean? That means that I've got 80 year-old veterans, standing there in 110 degrees temperature waiting for a shuttle to take them from location to location to have their promised and needed healthcare needs met.

My veterans have been promised this facility, the money has been partially appropriated. We have had press conferences with the VA Secretary in Southern Nevada, with great hoopla, and great excitement, and they are waiting, and waiting, and waiting. Las Vegas, as I mentioned, has the fastest growing veterans population. We need this facility now. Not 2009. Certainly not 2011. I can only imagine what the situation is going to be like in 2011 for my veterans.

We simply cannot wait any longer, and I would like to know, as I'm sure you would, why this delay, and without any notification to us. So I'm still representing to my constituents, my veterans, whenever I meet with them, we are online, we are on board, we are going to have this facility open in 2009. I find out I am complicit as a liar to my veterans. I do not like that. I do not think you guys do, either.

Also, with every passing year the cost of building these facilities continues to increase. We now need an additional \$147 million, which was promised to be in the 2007 budget. Low and behold, when the 2007 Veterans Budget came before this Committee, that \$147 million was nowhere to be found, with the promise, well, we promised you 2007, now, we're going to put it in the budget in 2008. Now, how do I know that? And what am I going to do when I go back home and my veterans ask me this question?

It is wrong. It is wrong at any time. It is particularly wrong during a time of war to treat our veterans in this manner. When we talk about supporting the troops, when we talk about standing up for our soldiers and giving them the strength they need to continue to fight and defend this nation, then we turn around and do this to our veterans? It's a disgrace. And not one of us, not any one of the 435 members of us should allow this to continue. It is a shame, it is a disgrace, and these people deserve better from us. And I am anxious to hear your testimony. Thank you very much.

THE CHAIRMAN. Thank you, Ms. Berkley. Chairman Brown, recognized for an opening statement.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. I would like to echo some of your remarks this morning as they relate to the new vision for VA and the infrastructure that will be required to meet the future veterans' demands for healthcare services.

In my opinion, there are few more important things we can do than engage in an earnest discussion about how the Department begins to

prepare itself for the future. I am grateful that all of those in attendance today will help us better understand what the Department's construction priorities are, how they match up with anticipated demands for health services, and how we re-engage in the business of building hospitals.

As most of the people in this room know, VA has not constructed a new hospital in nearly 15 years. As a result, a good amount of the institutional memory has been lost, and we have to try to reassemble processes that will allow us to build appropriately sized facilities where they are truly needed, and at the same time be prudent stewards of the taxpayers' money.

With that in mind, Mr. Chairman, I have some real concerns about the Administration's major construction request. It would appear that we are being asked to provide what I call "blanket authorizations" for major projects in the absence of any real detailed information about the project. Additionally, the Appropriations Committee has made clear over the last several days that they have real concerns about some of those projects and the sprawling costs associated with them. That's the bad news.

The good news is that this Committee now has an opportunity to reevaluate its traditional thinking, and create new models for facilities financing and construction. In my opinion, some of those models should seek to take full advantage of existing and potentially collaborative relationships with medical universities and research partners, and others might seek to have private or nonprofit organizations finance the construction of new facilities.

It is this type of thinking that should energize us all to find new ways of providing for our veterans. The bottom line is that our veterans have real needs, and we have the responsibility to identify ways to match VA's infrastructure to those needs. I personally believe a new level of creativity is called for, and I look forward to working with my colleagues to develop some of these new concepts.

Again, Mr. Chairman, I thank you for assembling this very important hearing today, and I look forward to having a frank discussion with our witnesses. With that, I yield back the balance of my time.

THE CHAIRMAN. I thank the gentleman.

Before we turn to the first panel, I would like to take a point of personal privilege. And that would be, in a bipartisan fashion, on behalf of my Democrat colleagues and staff, and the Republican side and the staff, I would like to recognize the Staff Director of the full Committee. Jim Lariviere, would you stand a moment? To let everyone know, we have known Jim Lariviere for 30 years. He is the only person I know here in Washington, D.C. that had ever dropped me for sit-ups as a freshman at the Citadel. Jim has commanded a rifle platoon in Beirut and lost a lot of good friends in the Beirut bombing as a Marine, commanded a rifle company, and commanded a weapons

company. He served one year at the White House, and he also commanded the Honors Company. When you go to 8th and I, and you go to Iwo --he commanded the Honors Company for the Friday evening and Tuesday Parades. He's commanded the 3rd Force Recon. He's been called to active duty twice. He was recalled immediately after September 11th. He was the Operations Officer for the Marine Anti-Terrorism Brigade. Jim Lariviere presently is the Assistant Commander of the Division, 4th Marine Division. He is the Assistant Commander, which means he is a full colonel in the Marine Corp., and he sits in a one star, a brigadier general's slot.

Jim has been recalled to active duty. He will be going to Afghanistan, and be leaving us soon. He will be the Advisor to the Operations Officer of the Afghan National Army. And that is a three star position. So, you see Jim, you talk to Jim, but you do not know the contributions that he has made, not only in the past but also what he is about to do for our country. He will be leaving his wife Jen and four children. And they will keep the watch fires burning, but we also, Jim, want you to know that we will care for them, and we wish you Godspeed.

[Standing ovation]

THE CHAIRMAN. Mr. Michaud?

MR. MICHAUD. Yes, Mr. Chairman, I, too, would like to thank Jim for his service. I have not known Jim nearly as long as you have, Mr. Chairman, but I have known him for a little while, particularly his work on the House Veterans' Affairs Committee. And I really appreciate his professionalism, his honesty, and his willingness to work hard for the Committee. But also, his commitment to the veterans of this country, and his service to our nation. I want to wish him the very best, and Godspeed, and our prayers and our thoughts will be with both him and his family. Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you, Mr. Michaud. We have before us today distinguished Members, and one of our Committee, Mr. Richard Baker representing Louisiana's 6th Congressional District. Richard has been a stalwart advocate for our nation's veterans, and it is a pleasure to have him before our Committee today. Also testifying is Mr. Charlie Melancon, representing Louisiana's 3rd Congressional District. He serves on the Agriculture, Resources and Science Committee and has an interest in lowering the healthcare costs. Our third witness on the first panel is Mr. Tom Feeney, representing the 24th District of Florida. Mr. Feeney serves on the Financial Services and Judiciary Committee, as well as the Science Committee.

Gentlemen, it is a pleasure to welcome the three of you before the Committee. And Mr. Baker, we will start with you. You are now recognized.

STATEMENTS OF HON. RICHARD BAKER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA; HON. CHARLIE MELANCON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA; AND HON. TOM FEENEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

STATEMENT OF HON. RICHARD BAKER

MR. BAKER. Thank you, Mr. Chairman. I appreciate your leadership in this matter. Certainly, provision of care for our nation's veterans is of the utmost importance to every Member of the Committee, and of the Congress. In this instance, there is the unique circumstance of the natural disaster in Louisiana, Katrina-Rita, they're now lumped as one. And the consequences for the provision of service in light of the tragic devastation that occurred in our state last year. Prior to landfall by Katrina, the VA facility in Orleans parish served 40,000 patients, with 1700 employees, with an annual operating budget of \$130 million, certainly a very significant healthcare provider in our region.

As we move forward, the VA in February of this year issued its own report and recommendation with regard to replacement of that facility with a shared operational management perspective with Louisiana State University. And on its face, it's certainly something that I think is worthy for us to explore to realize savings of joint ownership, of food services, laundry, parking facilities, and other operational savings that can be accrued from such a joint partnership. There certainly are benefits to be gained from the academic residences that might be employed or utilized within the VA system for the provision of care. So, at all levels, this recommendation makes great sense. But as is often the case in Louisiana, rarely are things as they seem. And there are concerns that have been raised that I would like to bring to the Committee's attention as we move forward.

There is now a June 1 deadline for the subsequent report to be issued relative to the change in demographics, and who the facility might serve. There are now about two-thirds of the patient load returning to the Orleans area for care. What is not determined is whether the temporary dislocation that has already occurred will become permanent, skewing the numbers in the Baton Rouge area above the current capacity of facilities that are located there. I am not suggesting today that this is a Baton Rouge effort to take a facility out of Orleans. Merely that we should measure carefully the distribution of the veterans and where they might best be served in making this strategic decision as to how we rebuild.

There is a second and dramatically more important revelation that I think the Committee should be made aware of. When Katrina

struck, Governor Blanco created a Louisiana Recovery Authority to be the interface between the federal government and the state government in overseeing the resolution and rebuilding of Louisiana. That Recovery Authority on its own created a foundation of individuals who collect resources, and therefore engage in important studies to assist the Authority in making policy judgements going forward. In a recent engagement of Price Waterhouse Cooper, the foundation received a report relative to the status of healthcare in Louisiana, and it was very, very troubling. As we begin to speak about an LSU-VA partnership, I think it's extremely important for the Members of the Committee and for the leadership of the VA to be aware of and understand the implications of this important study.

Let me just read one line that struck me most directly. "The report finds that the charity system," that is our publicly operated healthcare system, "is detrimental to the health of all Louisianians, and is likely an important reason for the lower system quality, the high cost, and lack of public and private sector benefits." The report goes on at great lengths to describe why the system is at fault.

Why do I bring this to this Committee's attention? Well, what is now being contemplated is an LSU-VA partnership. LSU is the administrator of the charity system. It would be like entering into a three-way partnership for a real estate development, and the third partner is bankrupt. We need to be very careful as we go forward.

Now, this report has, I think, important implications for reform for the provision of healthcare going forward. It is estimated by the report that the charity system was underfunded in the last fiscal year by some \$350 million. If the VA is entering into a partnership with LSU, we would need to be very careful about the supplanting of resources from one allocation to offset the losses in another.

I'm going to be much more direct back in my home state and district. I really believe our charity system should be undone. We are the only state that provides care in this fashion. It is extremely expensive. It results in a dual system, for those with money and those without resources. And those without resources are receiving inordinately poorer care. I do not wish to see the implications of irreparable injury, certainly extended, may be unintentionally, to the care of our veterans. We have an opportunity here to do something extraordinary. We can enter into a partnership using private and public resources, leveraging with academia valuable research opportunity, and to raise the quality of care to a standard which few have thought possible in our state in years past.

Mr. Chairman, I want to be very helpful as we go forward in this. Getting care restored to its pre-Katrina level is essential. But we should be very careful to deploy valuable taxpayer resources one time, in the most effective manner possible. And I hope to be helpful to you and the Committee as we go forward.

THE CHAIRMAN. Thank you very much, Mr. Baker. Mr. Melancon?
[The statement of Hon. Richard Baker appears on p. 56]

[The attachment appears on p. 115]

THE CHAIRMAN. Thank you very much, Mr. Baker. Mr. Melancon, you are now recognized.

STATEMENT OF HON. CHARLIE MELANCON

MR. MELANCON. Thank you, Chairman Buyer. Richard, does that mean we go on record for National Healthcare? We're friends.

MR. BAKER. We used to be friends.

MR. MELANCON. Yes, we used to be, just until a minute ago.

Mr. Chairman, Ranking Member, and Members of the Committee, I thank you for allowing me this opportunity to talk to you about an issue that is very important to me, and the citizens of my district: which is veterans' healthcare.

As everyone is well aware, after Katrina, the Gulf Coast suffered many devastating losses. The grief felt by the people of the Gulf Coast is incomprehensible. Hurricane Katrina was the worst natural disaster in this nation's history, followed by the devastation wrought by Hurricane Rita. South Louisiana has experienced more hardship and more loss in a period of mere weeks than most communities, states or regions face in a lifetime. This is evidenced by the fact that nearly nine months after Katrina hit, we are struggling day by day to rebuild and recover. This is a long term project for us, because what was lost in Katrina was not just structures, but history, memories, culture, communities, and perhaps saddest of all, many lives.

But the spirit to return and reclaim our place in the world is strong in the hearts of the people of South Louisiana. And though we are down, we are not out, not by a long shot. During our time of need, Louisiana has had many friends who have helped us in innumerable ways in the immediate aftermath of the storm, and continuing to this day.

I would like to take this opportunity to thank the VA for its efforts to evacuate all of the 241 patients, the 272 employees, and the 342 family members from the New Orleans VA Medical Center. Not only that, but by September 7th, 2005, all community-based outpatient clinics in the affected areas were operational, and five mobile clinics were sent to Louisiana. The VA's efforts in the aftermath of the storm on behalf of the veterans' community were outstanding and will not be forgotten.

However, in this period of rebuilding, some are questioning whether the VA Medical Center in New Orleans should be rebuilt. As a result of the immense flooding in New Orleans after Hurricane Katrina, two

LSU hospitals, Charity and University, which served as vital health-care safety net and only level one trauma center in the area, remain closed due to extensive and irreparable damage. The VA Medical Center in New Orleans, which is located a block away from Charity Hospital, suffered a similar fate. In other words, much of the health-care infrastructure of South Louisiana is in ruins, and with limited access to healthcare the region's entire recovery is in jeopardy. That is why the recent proposal to build shared facilities for LSU and the VA holds some hope. This merger could provide the beds and doctors that the general population needs if the city is to have a chance at recovery, as well as restoring services to the thousands of area veterans who depend on the VA.

And, off script, while I understand and agree in many ways with what Mr. Baker says, I think we can work through these problems of administration.

The burden on our veterans since the destruction of the VA in New Orleans has been enormous. Access to care for them has always been an issue, particularly for the veterans in my district who have to travel long distances for the services they need. The situation has only been made worse in the wake of Katrina and Rita. And every day my office hears from veterans who no longer have a place to go for the care they have earned with their service. Many had to evacuate the area altogether and with no operating VA facilities in New Orleans, may not ever return.

It's a situation that's not limited to veterans. Right now thousands of families displaced from the Gulf Coast are looking at the recovery process and trying to decide whether or not to come home. Levees are being fortified in most areas. There are a growing number of jobs to be had. Homeowners can now expect to see at least some payment for their loss of housing. And some schools are starting to come online. A tremendous amount of effort has gone into making that simple list happen. But a family asking themselves whether they can move back, has to ask the questions, "Where do I go if I get sick? What doctor can I see if I get hurt?"

The answers to those questions lie in a strong healthcare community. Of key importance is the need to rebuild not just bricks and mortar, but the human capital that it takes to delivery quality healthcare. The hospitals in the LSU system were not just providers of care, but were also teaching hospitals. Without these teaching hospitals, there is a huge hole in the fabric of medical professionals that are the foundation of a strong healthcare community. The LSU-VA plan gives us an opportunity to regenerate this important component. And again, there are ways.

This is an historic partnership for historic times. From an efficiency standpoint, it makes sense. From a fiscal standpoint, it makes sense. And from a moral standpoint, after everything these Gulf veterans

have experienced and endured with these storms, it makes sense. I urge the Committee to support those efforts to rebuild the healthcare infrastructure on the Gulf Coast for our veterans and for the rest of our citizens in these affected areas. Thank you, Mr. Chairman, and Members.

[The statement of Hon. Charlie Melancon appears on p. 63]

THE CHAIRMAN. Thank you, Mr. Melancon. Mr. Feeney, you have now been recognized.

STATEMENT OF HON. TOM FEENEY

MR. FEENEY. Mr. Chairman, Members of the Committee, I am really delighted to be here, and am very grateful for the Committee's time and providing me this opportunity. The veterans population in the United States currently stands at 26,549,704 veterans, give or take. More than 1.8 million of those veterans reside in the state of Florida. Our state has the second largest veterans population in the country, with over 350,000 veterans in the Central Florida area alone. This does not include veterans that like to visit our state, and a lot of veterans that winter in our state. We call them "snowbirds" and there are snowbirds that served their country admirably, and they need service as well.

And yet, Central Florida is the largest metropolitan area in the country without a VA medical facility. Many veterans residing in Central Florida average more than two hours travel time to get to a VA hospital located in Tampa, Gainesville, or Jacksonville. That includes veterans living in counties like Orange, Seminole, Brevard, Volusia, Osceola, Polk, and Lake. In fact, only 45 percent of veterans in the Orlando region are within the VA's access standards for hospital care, meaning that 55 percent are not being treated in accordance with the standards. Central Florida is the number one destination for combat veterans over 65 years of age. It's also the number one area for veterans who have 50 percent or more service connected disability. 18 percent of our veterans have Post-Traumatic Stress Disorder.

There are 128 active veterans organizations in the Central Florida area alone. We have got a number of great American heroes and people that served their country ably have been working very, very hard to get a veterans hospital for some two decades plus, now. John Kellat, for example, some of the DAV veterans, leaders like Jerry Pierce, Charlie Brenner, Dr. Neil Euliano, Charlie Price and George Taylor are all friends of mine that have been working very hard for close to two decades. Also Bill Carlson, Earle Denton, and I could name many more.

Orlando and its surrounding area was identified by the VA through

Capital Asset Realignment for Enhanced Services as an area in need of a new VA hospital. At the same CARES identified the need for a new facility in Las Vegas, and I appreciate the gentle lady's frustration with the challenges that she has meeting the needs of her constituents. The need was both appropriate and warranted in Las Vegas, and they have received funding and are scheduled to break ground this year, although I guess there are some questions about that schedule which I will be paying close attention to.

However, a hospital in Central Florida still remains, at this point, just an idea. Design and planning initiatives have been authorized by the VA, and efforts are underway to select a site that best suits the needs of the Central Florida veterans community. Balancing accessibility needs of Central Florida's veterans with the long term economic impact the hospital will have on the state is essential as we look for ways to leverage funds to maximize investment benefits.

I'm delighted to announce to you that the Florida Board of Governors recently approved a proposal for the University of Central Florida to build a new medical facility right in the East Orlando area. As Chairman Brown pointed out, there are huge benefits, I think Chairman Baker did as well, to co-locating a facility with a medical school. And the fact that you can build them at the same time is an enormous opportunity that I hope the Committee and the Site Selection Committee will consider. This will be valuable both to local veterans and the VA, as a medical school environment provides insight into innovative and cutting edge technology. We also believe we are going to have all sorts of spin off, and collateral biomedical research facilities that will be established in our area.

The commitment to ensure that veterans have access to additional resources to further enhance the medical services to the VA is an important one. Concerns have arisen from the Central Florida Veterans Associations in the area that the Central Florida VA Medical Center may not come to fruition in a timely manner. Again, we have waited over two decades, and there is concern that we seem to be falling behind again, perhaps. On May 1 of this year, a public hearing was administered by the Orlando VA Hospital Site Selection Committee. Many veterans accused lawmakers throughout the country, including their own from Central Florida, of dragging their feet on this very important issue of servicing 350,000 unserved veterans.

Veterans in Central Florida have been waiting for nearly three decades for a complex that continuously has met with delays. Mr. Chairman, I urge the VA to select the site in a timely manner, so that our growing veterans population may finally have appropriate access to a much needed hospital. Again, I am very grateful for the willingness of this Committee to have me come and advocate on behalf of 350,000 people that have ably served their country. And we would be grateful for any help you can give us in serving these people in

return.

[The statement of Hon. Tom Feeney appears on p. 60]

THE CHAIRMAN. Thank you very much to my colleagues for your testimony. And, let me start with you, Mr. Baker. VISN 16 has been looking closely at the demographics issue, and I am glad you bring it to our attention. And maybe you can be insightful and helpful here to the Committee on what exactly is happening in New Orleans? I know a lot of the population came into your area in Baton Rouge. Are people going back to New Orleans? Or do they now kind of like where they are, because now they have new jobs, and obviously the demographics may be changing Baton Rouge. And this could have an impact on site selection and negotiations with LSU, and where we are in working together to build a collaborative effort. If you could enlighten us a little bit more on that?

MR. BAKER. Thank you, Mr. Chairman. It is unclear at the moment exactly the ramifications of the storm. I think in Charlie's district it is impossible for people to return, simply, in St. Bernard there is nothing there yet. There is no houses, it's not a question of being damaged, there is just no structures. In Orleans Parish, it will vary depending on where one was. The central business district, the French Quarter, some areas are relatively and modestly affected. While other areas, the lakefront, Lakeview as it is known, or the Lower Nine, utter devastation, and no people are returning.

The consequence of this is there are at least a hundred thousand people that are new to my congressional district that are in any number of housing circumstances, from the infamous FEMA trailer deployment, to absorption into whatever available rental market. Many business owners have simply relocated their businesses and bought real estate sight unseen and moved the business operation into the region. From the guess-timates that I have heard, it is that they believe a permanent dislocation as to veterans will be disproportionately low to the general population. Meaning, they believe that more veterans are likely to stay in the Orleans area for services than would be for a customary analysis of the business community or any other demographic sector.

However, about a third of the current service area, served in the New Orleans area, is likely to be permanently located somewhere in the Baton Rouge marketplace. So there will be, in effect, and I am very anxious to see the professional analysis that I hope will be made available early June, to help get a better understanding of the potential deployment. But, clearly, it is going to change the market, change it for a long time. And as to the speed of recovery, it is at a snail's pace. Nothing will return to normalcy until we have a significant housing inventory for people to live in, and it simply is not happening. And the desolation is beyond imaginable scope, even en-

tering into this hurricane season. You know, I would ask everybody's prayers that we be spared at least a year before we have to deal with the calamity of even a modest storm.

THE CHAIRMAN. Well, you have to go back almost 60 years for our federal government to have had to face major construction projects. We have got five to six that are in front of us. It has been 15 years since we have built a major facility. There is a lot of institutional knowledge that has left. And it appears that the priority of all of these, now, is New Orleans. And, we are going to have to turn to and rely upon you for your counsel, and also your guidance to the VA. They also receive their input through the VISN, and through veterans. We really do not know where this is to go. We are going to have to rely upon you and your counsel. This is about not only where they presently are, but what is the forecast?

MR. BAKER. And the fact that it served from Eastern Texas to a great number of folks from Mississippi. This was a regional facility of great quality care, I might add, as well. So replacing it, and the services that are now lost, is a very difficult task. And I just counsel to move slowly and get all the professional advice we can get from any source before making what will be a very long term decision, and one that we cannot easily turn from once the deployment is made.

THE CHAIRMAN. Thank you, Mr. Baker. Mr. Melancon, what is your best counsel? Not only to this Committee, but also, you know, you have got VA leadership behind you.

MR. MELANCON. Thank you, Mr. Buyer. Down in the bayou it's Melancon, up the bayou it's Melancon.

THE CHAIRMAN. Melancon?

MR. MELANCON. Above Baton Rouge it's Melancon. Here, just call me Charlie. It is a lot easier.

THE CHAIRMAN. Melancon, this is de Buyer. For those who do not know me, it is Buyer.

MR. MELANCON. Richard, both of our districts have been impacted, and for that matter the entire region has been impacted. And to tell you where anybody has gone is somewhat of a guess. We have got some approximation of numbers, but as far as ethnic groups, or veterans, or who, or, you know, income levels, no one knows that number yet. But I do have a place, Richard, if you would like, at the intersection of 55 and I10, where we could put it in St. John the Baptist Parish. I am being facetious. But the need is definitely going to continue.

The frustrations, I guess, and Richard has noted the state and its financial problems, are going to continue on for quite a while. Of course, the federal government and its continuing problems, as noted by Mr. Filner and Ms. Berkley..... You know, there is nobody out there that has a whole lot of money hanging around. But we have an obligation to all of our veterans that we made to them. And it goes

back long before any of us sat in the Congress.

I will support and do whatever it takes to protect our soldiers as long as they are at war. But I think that we need to make sure that we expend whatever capital it takes to make sure that when they come back, they will have their medical needs and services taken care of, as they are fully due. Thank you, sir.

THE CHAIRMAN. My last question, Mr. Feeney. Have you endorsed a site at all, since you are working closely with the Site Selection Group?

MR. FEENEY. Well, I had not until about two months ago. And then, in conversations with your staff, and with Mr. Brown's staff, we were able to determine that there was one site that apparently meets all of the criteria for co-location. And even before the University of Central Florida Medical School was approved by the Board of Governors,-this is now a done deal and there is funding in the state budget that has been passed just two weeks ago- I endorsed the site because of the potential and the likelihood of having a co-location. And that would be Site C, which is the Lake Nona Site.

I should say, Chairman Buyer, that there is an ICP site that when veterans were asked to testify on the May 1st hearing, virtually all, if not all, of the veterans that testified that because of access reasons, that that would be their preferred location. And there were a couple questions about that Lake Nona site that I hope that we will take a look at and resolve that veterans have raised. There is a fourth runway of the Orlando International Airport which is active right now. And there are questions about things like the sound and noise disturbing veterans that have Post-Traumatic Stress Syndrome. There was also questions raised about emergency helicopters, and whether the flight patterns would be interrupted. I think those questions can be resolved as part of the site selection process.

And the bottom line is that with respect to the entire Central Florida Congressional Delegation, I think including Congresswoman Brown, and all of my Republican colleagues, we want a quality site. And we want it as soon as possible. Where is a lot less important to us if we have the best quality site at the earliest possible time. I think that probably sums up 99 percent of the feelings of the people of Central Florida.

THE CHAIRMAN. All right. Thank you, very much. Mr. Filner?

MR. FILNER. No questions.

THE CHAIRMAN. Mr. Moran?

MR. MORAN. No questions, sir.

THE CHAIRMAN. Mr. Michaud? Ms. Berkley? Chairman Brown? Everybody's being really kind to all of you guys. All right, this panel is excused. Thank you very much. If I could have the second panel, Dr. Jon Perlin, Under-Secretary of Health at the Veterans Health Administration. Dr. Perlin's background includes healthcare qual-

ity management, health information technologies, medical education, and health services research. Dr. Perlin, you are now recognized.

STATEMENTS OF DR. JONATHAN R. PERLIN, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION; ACCOMPANIED BY HONORABLE TIM S. MCCLAIN, GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; ROBERT L. NEARY, JR., ACTING CHIEF OF FACILITIES MANAGEMENT OFFICER, VETERANS HEALTH ADMINISTRATION

STATEMENT OF DR. JONATHAN PERLIN

DR. PERLIN. Mr. Chairman, Members of the Committee, good morning. It is a pleasure to join you this morning. I am joined today by our General Counsel, Mr. Tim McClain, Mr. Bob Neary, the acting Chief of Facilities Management for VA.

In July of 1999, GAO found that VA was spending \$1 million a day on unneeded or unused facilities. In response, VA essentially declared a moratorium on new healthcare construction from 2000 to 2004 to develop a coherent national plan for modernizing our facilities. Capital Asset Realignment for Enhanced Services, or CARES Program, is that plan. It allows us efficiency in our healthcare operations and to more prudently use the funding taxpayers entrust to us. And it allows us to transform an infrastructure created for previous generations of veterans into one that provides 21st century care and 21st century technology for 21st century veterans.

VA is the owner, tenant and operator of the largest healthcare related real estate portfolio in the United States. The Department also maintains facilities for the Veterans Benefits Administration, and most of our nation's national cemeteries. VA's goal is to always use these resources efficiently and effectively for the service of veterans.

Former Secretary Anthony Principi released the CARES decision on May 7th, 2004. Since that time, 12 construction contracts under CARES have been awarded and are underway. We plan to award an additional 12 contracts by the end of this fiscal year. Guided by Secretary Nicholson's Blue Ribbon Panel, the construction advisory board which is chaired by General Heiberg, this Board offers recommendations for contemporary, transparent and accountable approaches to construction. These are attributes amplified by our capital investment process.

VA's draft bill to authorize construction for fiscal year 2007 was submitted to Congress on April 5th, 2006. In it, we are asking to reauthorize 19 previously approved CARES projects. Also, for six new construction authorizations, and approval of eight leases and two

projects resulting from Hurricane Katrina's devastation. In particular, a replacement facility for our New Orleans VA Medical Center, and the expansion of the Biloxi hospital to accommodate the workload from the now closed Gulfport campus.

For fiscal year 2007, the President's budget identifies a total of \$714 million in capital funding. This includes \$399 million for major construction projects, two projects of over \$7 million in value, and \$190 million for minor construction for projects under \$7 million. It also identifies \$85 million in grants for the construction of state veterans homes, and \$32 million in grants for the construction of state veterans cemeteries.

VHA's request for construction funding for medical facilities is \$457 million. This includes \$307 million for major construction projects, and \$150 million for minor construction. These resources will be devoted to implementing projects identified in our CARES program. If our 2007 budget request is adopted, VA will have received more than \$3 billion to implement CARES to date.

We appreciate Congress' and the President's support as we maximize veterans access to the high quality healthcare for which our Department is renowned. Let me highlight one of the projects currently funded under CARES, the renovation of our Biloxi VA Medical Center.

Biloxi was damaged during Hurricane Katrina, and its Gulfport division was completely destroyed. The CARES report called for us to collaborate with Keesler Air Force Base to meet VA and DOD needs in the area, and to transport Gulfport's current patient care services to the Biloxi campus. Katrina required us to accelerate the process, and with the \$293 million emergency supplemental funding we received, we are proceeding rapidly with our DOD partners to meet the needs of Gulf Coast veterans, as well as servicemembers and their families.

We are also working, as you know, collaboratively with New Orleans to bring state of the art medical care back to that city, and to the region. In February we signed an agreement with Louisiana State University to work together to develop plans for new medical facilities, maximizing efficiencies through sharing. Together, we hope to create sharing agreements that will benefit veterans and all the citizens of Louisiana, as well as the American taxpayer.

Mr. Chairman, the \$53.4 million in major construction funding, and the \$25 million in minor construction are resources that this budget provides for the National Cemetery Administration will ensure that nearly 84 percent of veterans will be served by a burial option in a National or State Veterans Cemetery within 75 miles of their residence. The National Cemetery Administration is now engaged in its largest expansion since the Civil War, and is making all National Cemeteries it administers national shrines commemorating veterans'

service to our nation.

Thank you for your support in fulfilling our mission of service in honoring America's veterans. Thank you.

[The statement of Dr. Jonathan Perlin appears on p. 65]

THE CHAIRMAN. Dr. Perlin, while I understand that the core services and construction standards themselves in the VA differ somewhat from the private sector, how do you explain what seems to be a drastic disparity between the cost estimates to construct a new state of the art facility for the VA and what is employed in the private sector?

DR. PERLIN. Thank you, Mr. Chairman, for that question. I should note that VA facilities are built to higher standards in terms of security. The hardening of the first two floors is estimated to add about five percent to the cost of the facility.

I would, however, suggest that the costs are not different when one actually looks at what the VA medical centers typically include. They often include spinal cord injury units, nursing home, and our patient population is an older and sicker, less mobile patient population. Because of the illnesses, the complexity of the illnesses, and the unique services VA offers, as well as facilities which are not just hospital bed towers but also include substantial ambulatory services, when one actually includes these other factors, as well as the federal labor requirements that are part of the construction process, it actually turns out that our construction costs are on par with private sector construction costs. I think it is fair to say that all of us are reeling from the inflation in not only construction in the United States, based in part on the inflation in fuel, in concrete, and in steel, with expansion in construction worldwide, but also with a hospital boom that is particularly affecting the cost of construction in the healthcare industry.

THE CHAIRMAN. I have here the two Collaborative Opportunity Steering Group reports, one for Charleston, between the Medical University and the VA in Charleston. I also then have your interim report, of April, 2006, by the Collaborative Opportunity Steering Group for Louisiana, in particular the Southeast Louisiana Veterans Healthcare System and LSU. I would like for you to share with us what you have learned from this process, and where we are going from here.

DR. PERLIN. Let me first, Mr. Chairman, thank you and Chairman Brown for the opportunity to set a stage to really look at how we might improve our efficiency, both in terms of capital construction, as well as operating efficiency, by sharing and partnership. We believe that the Charleston approach to evaluating potential synergies was so successful that we have actually now called it the Charleston Model. We did not anticipate to, but because of the natural disaster, that was Katrina, and its tragic circumstances, have applied it very rapidly when we looked at the opportunities for those sorts of capital

and operational synergies in New Orleans. And, indeed, we discovered that where there is an opportunity to collaborate we believe that we can reduce the cost to taxpayer, and improve the quality of services by creating sharing agreements. In fact, we believe that there are some unique opportunities in New Orleans, Louisiana, and the absence of a medical center.

But we are still learning. What we learned in the New Orleans Model will bring us back to the Charleston Model, and will take us to another level of granularity as we evaluate potential synergies in that environment as well.

THE CHAIRMAN. Thank you. Mr. McClain, I want to thank you for your efforts. My last question on the same subject is, do you have anything to add, since you personally participated in this process?

MR. McCLAIN. No, I think Dr. Perlin has stated it very eloquently. I think the one thing that I learned from it is that the first thing we have to do is for both parties to be talking on the same wavelength as far as a cost in one facility needs to be based on the same items as a cost in the other facility. And once you get to that level, which took us a while in Charleston, but now we have been able to apply in New Orleans, then you are able to talk apples to apples. And it really opens up the discussion on both sides. And the one thing about the Charleston Model, especially working with Dr. Greenberg at MUSC, was that once you get to that level, both sides open up and are then free to talk economics as to what really makes sense in any particular area. And I think that that really was helpful to us in talking with LSU and getting them and us quickly on the same page. And that is why we have been able to, I think accomplish the interim report in almost record time. And, as I understand it, the final report will be ready on June 1st.

THE CHAIRMAN. Dr. Perlin, Michael Moreland, who is the Director of the VA Pittsburgh Healthcare System, is an extraordinary individual, a real asset to the VA, and so to the gentleman to your right, for leading these two efforts to define something anew, congratulations. With that, now I yield to Mr. Filner.

MR. FILNER. Thank you, Mr. Chairman. I just want to talk a little bit, if I might, Dr. Perlin, about the use of this CARES process and your prioritizing of projects. Can you first explain to us how the VA develops its annual construction request, and what role will the CARES report now play?

DR. PERLIN. Mr. Filner, thank you for that question. Let me, if I might, start with the role of the CARES report. As I mentioned in my statement, we essentially had a moratorium on new construction for the better part of the last half decade. And the CARES initiative was a national inventory of our current physical infrastructure. And it sought to look at whether we were meeting the needs of veterans, and whether there was infrastructure that actually was taking resources

away from serving veterans. So, it provided a plan, a template, a blueprint for 20 years.

Now, I should let you know, while this is a schematic, we pay attention to world events. And it serves a template, absent any sorts of seismic shifts. We believe it is a good template for where veterans are, and it identifies some very pressing needs that are expressed in our 2007 budget request, and in the CARES projects for new construction that are put forward. Let me ask Mr. Bob Neary to talk about the annual process of prioritizing construction activities.

MR. FILNER. Did you use "seismic shifts" metaphorically, or did --

DR. PERLIN. Well, sir, I certainly hope so.

MR. FILNER. Me, too.

MR. NEARY. Thank you. We in VA have a state of the art capital planning process that has been developing over the past several years. It relies on linking our strategic benefits delivery goals to the infrastructure needs to support those goals. Some of the guiding principles, first of all, on the prioritization of projects relates to their sound business and economic principles; promoting a one VA vision; the linkage of not only the Veterans Health Administration, but the Veterans Benefits Administration and the National Cemetery Program; alignment with the VA's strategic goals as established by the Secretary and the Secretary's key staff; and also supporting any Presidential management agenda items.

Projects are all submitted, and the major construction programs submit what is referred to as an Office of Management Budget 300 Application. A detailed description of the project and the economics of the project are prioritized, and then the budgets are established based on the priorities that arrive from that process. There are, of course, instances where for one or another reason, primarily patient safety or employee safety, might suggest that a project be moved up on the list. Or, there are some projects that are more complicated and take longer to plan for, and they might not be proposed in total consistency with the priorities. But other than that, we are proud that we stay strictly with our priorities as they are established in the process.

MR. FILNER. Let me just, since I am not sure that I understood everything you said, ask you specifically. Now, you had in your fiscal year 2007 request a project in Columbia, Missouri, that had a priority in CARES of 21, or 21 on the list. Why was that chosen ahead of others with higher priorities? Is that policy clearly stated somewhere, or is that just what you decided?

DR. PERLIN. Mr. Filner, I can take that, because I, in fact, bear some of the responsibility for the priority of that issue. As Mr. Neary said, the prioritization of projects is based on first, our service mission to veterans, second, making sure any special needs of veterans are met,

and of nearly equal weight, and actually a mathematical process is used, is life safety. In fact, a change circumstance occurred at Columbia, and the operating room is having electrical failure and has some infrastructural failures, that presents immediate life safety issues, as well as limits the capacity to continue to serve veterans in that OR.

MR. FILNER. Why did the CARES process not take that into account?

DR. PERLIN. I think the CARES process reviewed things, but there were some failures of the infrastructure that became evident that needed to be addressed, and addressed immediately.

MR. FILNER. Okay.

DR. PERLIN. While the CARES process is a blueprint, this is a fairly fine point on that, and one that you would expect us to pay attention to in real time.

MR. FILNER. It is just sort of frustrating, and I think it needs further explanation, probably in the documents. We have been told for a long time that CARES is going to be an all-encompassing kind of thing, and we have to hold off capital investments until it is finished. Then it appears that there are projects that do not appear in the top ten, or even top 20, right after the plan is finished. So, you are going to build up a frustration, or a sense that, "Why did we go through all this?" if you continue to do that. Do you think that is a worry that we should have?

DR. PERLIN. As I said, the CARES is a template, and this was a new circumstance, or a change in circumstance, that affected a particular operating suite with the patient care at risk there. And it needed immediate attention. Our goal is to be as accountable, transparent, as we possibly can, and I do appreciate the opportunity to discuss this particular circumstance.

MR. FILNER. Thank you.

THE CHAIRMAN. I thank the gentleman. Mr. Moran?

MR. MORAN. No questions, sir.

THE CHAIRMAN. Thank you. Mr. Michaud, you are recognized for questions.

MR. MICHAUD. Thank you, Mr. Chairman. In the essence of time, I will narrow it down to one question. Dr. Perlin, the VA has promised many in Congress an increase in community-based outpatient clinics, assuring us of an aggressive program to build these facilities. How many of these proposed clinics does the VA plan to build, activate or keep open within the next three years?

DR. PERLIN. Thank you, Mr. Michaud. Thank you for your support of the community-based outpatient clinics as one of the best ways to provide outreach services to veterans. In fact, in our appropriations, or budget hearings, the Secretary testified that in 2006 and 2007 that there will be a total of 58 community-based outpatient clinics under consideration in terms of developing operating plans. We will get

those plans from each of the networks, and go over those. Ultimately, it will be up to and including that number of clinics. There may be reasons additional clinics would be brought forward. I would be unprepared to talk about years out beyond that in terms of the specific number of CBOC's.

MR. MICHAUD. I have a follow-up question. But what do you do, when the VISN personnel will not submit a plan. For instance, VISN 1, there is only one CBOC that is proposed. However, they will not even submit a plan for VA to consider because they have no money to deal with it.

DR. PERLIN. Sir, you are absolutely correct that the funding for the Community-based Outpatient Clinics comes from operating dollars. Their goal is to bring on the clinics not only in terms of what the operating dollars support, but also in terms of the ability to recruit and match the infrastructure to the patient needs. So they prioritize clinics over time. And I actually, along with my senior team, track the workload. And we know that, in particular, in Maine that there is an opportunity for one clinic that is coming up this year, and addresses one of the areas where there are workload issues that are not up to our standards. The other areas actually are within standard, but we recognize the need for introducing those clinics over time.

Again, the CARES plan was a 20-year plan. And, in fact, it identified 156 clinics. I think the Secretary has testified to this body that 58 are really under consideration in this year and 2007 alone. So, pretty substantial progress.

MR. MICHAUD. In the essence of time, Mr. Chairman, I will submit the rest of my questions in writing, because I know we do have to go vote.

THE CHAIRMAN. I thank the gentleman. Well, Mr. Michaud, there is nothing more important than this hearing, than this panel. So, we have got a 15 minute vote, and then a five, and we are going to come back. They are going to have to wait. I apologize, but we are going to have to come back. So, I will recognize you again, and then I will go to Mr. Brown. Is that fair?

MR. MICHAUD. Okay. That is fair. Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. Dr. Perlin, following up on the Collaborative Opportunity Steering Group process in Charleston, several operational issues still remain unresolved. When can we expect the COSG 2 to be established to keep the Charleston collaboration going?

DR. PERLIN. Let me first, Mr. Brown, thank you very much for your endorsement of the approach, looking at Charleston, looking at New Orleans. It is a good template, and as I mentioned, we learned a lot in Charleston, and we also learned in Louisiana. So I will be returning and asking a group to come together this month to, again, look at another level of granularity on Charleston.

MR. BROWN OF SOUTH CAROLINA. One further question, do you agree that public/private partnerships can be a catalyst for modernization and development of a new and improved service for veterans. You support that idea, do you not?

DR. PERLIN. Mr. Chairman Brown, we do support the opportunity for collaborations. We believe that there are opportunities where there are synergies, win-win's. As our General Counsel mentioned, that the ability to use models such as the Charleston Model to understand the cost basis of activities for each partner, the opportunity to provide services to one another, to support capital infrastructure, all improve the opportunity to serve veterans and not only reduce the capital costs, but reduce the operating costs every time.

MR. BROWN OF SOUTH CAROLINA. Thank you, and I will wait until the next session.

DR. PERLIN. Thank you, sir.

THE CHAIRMAN. Ms. Berkley.

MS. BERKLEY. Mr. Chairman, thank you very much. Dr. Perlin, thank you very much for being here. I am going to dispense with the niceties because I have got some very specific questions and I need some very specific answers. When are we breaking ground on the Las Vegas complex?

DR. PERLIN. Let me ask our Chief of Facilities Management to --

MS. BERKLEY. And please do not tell me sometime later in 2006. We have been saying that for months. It is now later in 2006. When are we doing this?

MR. NEARY. We are scheduled to break ground in Las Vegas on the first phase of construction in August, 2006.

MS. BERKLEY. You will let me know the exact date of that as soon as you know it?

MR. NEARY. Yes, ma'am.

MS. BERKLEY. All right, number two. When is your estimated time of completion?

MR. NEARY. We anticipate, the current schedule to complete the entire project in August of 2010.

MS. BERKLEY. Now why is that a year later than was originally anticipated?

MR. NEARY. When the design of this project began with two really nationally recognized healthcare architectural firms, they felt that the design schedule we had established was far too aggressive to be reasonably accomplished. They felt the design would take longer. And that is the primary contributor, really the only contributor.

MS. BERKLEY. So we have no design yet?

MR. NEARY. We have completed the first phase of design, which is called schematic design.

MS. BERKLEY. Yeah, how many phases do we have in design?

MR. NEARY. There are three phases in design: schematic design,

design development, and then the preparation of the construction documents.

MS. BERKLEY. So where is the difficulty, in which phase? If one is done, is it number two or number three that is causing us the delay?

MR. NEARY. They felt that in each phase of the design our schedule was too aggressive.

MS. BERKLEY. In what way? I would like to know what way that is going to be. I know how quickly buildings can go up in Las Vegas. I want to know why this one is too aggressive and ambitious.

MR. NEARY. Not the construction, I do not think they felt construction was aggressive, but the design itself. In their view --

MS. BERKLEY. I would like to know exactly what it is, if you do not mind finding out from them and letting me know. And here is another question. Why is it going to take an extra year? I understand that completion is 2010, but we are not going to be operational until 2011. Why the lag?

MR. NEARY. I think the reference to 2011, I assume, relates to the fiscal year.

MS. BERKLEY. Can you find that out, too?

MR. NEARY. The building, when completed in August, should be able to be occupied within the next two to three months after that.

MS. BERKLEY. I would think so. I just attended an opening, a viewing of a hospital in Pahrump, Nevada. It was completed, they did the tours, they disinfected it, and they opened it up, and it is taking care of patients. I need that hospital and complex open. We need it now, and now we know we have got another year delay. And, is the \$147 million, and I guarantee knowing the cost of construction is skyrocketing that is going to go up before this is completed. Will that money be in the 2008 budget? It was promised for the 2007, it was not in there. Secretary Nicholson sat right where you are, Dr. Perlin, and assured me in a not so pleasant conversation that this would be in the 2008 budget. Will it be?

DR. PERLIN. Well, let me just say, we have \$259 million in the bank to support this project.

MS. BERKLEY. I know, that is what I keep telling my veterans.

DR. PERLIN. Obviously, we are not going to start a project and not complete it. We want to get this project open. As you know, we have to bring our budget forward through the Office of Management and Budget, and the President's budget is ultimately published, and I would not preempt that. But it would be entirely, entirely illogical to assume that we would make a nearly \$260 million investment and not follow through in a timely opening.

MS. BERKLEY. That is not my question. My question is, will the \$147 million be in the 2008 budget as promised by the VA Secretary as he sat in that very seat?

DR. PERLIN. I would have to defer to the Secretary's testimony.

MS. BERKLEY. Then the answer is, "yes?"

DR. PERLIN. I do not recall the specifics of --

MS. BERKLEY. I recall it very well.

THE CHAIRMAN. Ms. Berkley?

MS. BERKLEY. Yes, sir?

THE CHAIRMAN. We have about five minutes for our vote?

MS. BERKLEY. Yes, and it takes about five minutes to get there. I thank you gentleman. I am very serious about this. We need this facility. Thank you.

THE CHAIRMAN. We are going to recess for about 15 minutes, and return. The Committee stands in recess.

[Whereupon, at 12:38 p.m., the Committee recessed, to reconvene at 1:05 p.m., the same day.]

THE CHAIRMAN. The hearing will come back to order. Dr. Perlin, I want to ask a question regarding the Denver facility. And, perhaps, Mr. Neary, you can be helpful to us. As you are aware, the House Committee on Appropriations completed their Mark for fiscal year 2007, the Military Quality of Life Appropriations Bill. The bill does not include any funding for a replacement medical facility in Denver, because of the large cost, which has doubled the previous estimates. So, what we have is an appropriations bill ahead of our authorization bill, but we want to take this issue up and address it. And I am curious about the Administration's reaction to this, and whether or not you have recommendations on how we should proceed in the authorization bill, so that the Appropriators get a signal that this is something that they can get their arms around.

DR. PERLIN. Mr. Chairman, thank you very much for the question focusing on Denver. This is a project that is tremendously important. It is part of the CARES decisions. It is also a project that received initial funding of \$25 million in fiscal year 2004, I believe. It is an Administration priority. There is an infrastructure that needs improvements, and in the spirit of the same sort of opportunities for synergy if offers, the ability to provide ready sub-specialists that are university-based and opportunity for a geographic proximity to where University of Colorado is moving. And for both capital opportunities as well as operational efficiencies and improvements in care, we believe that the new site for Denver is particularly important and would like your authorization to proceed, certainly in obtaining land for this new facility.

THE CHAIRMAN. When you propose to obtain the land, are you proposing that we take Denver and break it up incrementally?

DR. PERLIN. Mr. Chairman, I know that you have expressed, and the Committee has expressed, some concern about the cost of the project, and does really want to compel in us transparency, accountability and efficiency in the stewardship of the resources. And we welcome

your oversight at any point in the process, but do recognize, as you have recognized to us, that delay leads to cost increases, inflation.

THE CHAIRMAN. So, at a minimum in our authorization bill, we should authorize you to do the land acquisition. Do you know at approximately what cost, or is this something you need to get back to us on? Mr. Neary?

MR. NEARY. Mr. Chairman, there are multiple parcels involved. I believe there are four parcels involved. The largest coming from the Fitzsimons Redevelopment Authority. It is estimated that three of the four parcels will cost \$25 million, and the fourth parcel contains a recently completed new office building, which we expect we could purchase for \$30 million and integrate that into our plan. It would lessen the need for construction of new space. And so, in total \$55 million.

THE CHAIRMAN. Now, tell me whether I am accurate or not. You want us, the federal government, to spend \$25 million for land that we had given away? Is that right, Mr. Neary? We, the federal government, gave away this land to the locals, and they in turn are going to charge us \$25 million. Is that about accurate?

DR. PERLIN. Mr. Chairman, I might ask our General Counsel, who has been following this process to look at the history.

THE CHAIRMAN. I do not blame you.

MR. McCLAIN. Sir, you are right. There was a BRAC process that occurred in 1995. Fitzsimons was part of the BRAC. It was put up and made available under the BRAC process for federal agencies, and so I cannot say that it was ever specifically offered to VA but it certainly was made available to federal agencies to express interest in this property. VA did not express interest at that time. Department of Education actually acquired some of the property, on which the University is located, and Children's Hospital. And the rest of the property went to the Fitzsimons Redevelopment Authority, who paid a price, not a very high price, but paid a price for the property. And they now control the property, and that is who we are trying to purchase it from.

THE CHAIRMAN. Okay, help me so that I can explain to the taxpayers why it is a good deal. Spending \$25 million on property that we just gave to somebody does not feel good.

MR. McCLAIN. This is property that the FRA had originally designed to utilize as a tax base. They were going to have a convention hotel on it, I understand. Our greatest desire was to be close to our affiliate, the University of Colorado Health Sciences Center. This whole thing precipitated when the University decided to move the Fitzsimons. They are located, of course, right across the street from us in downtown, on Colorado Avenue. But when they moved, that created a problem for us. And we needed to accelerate our plans to stay with our affiliate.

In fact, they were originally going to complete the move to Fitzsimons, I believe it was 2011. And now they have accelerated their plans, and they are going to complete the move by next year, by 2007. And, so we have a rather old hospital in downtown that is landlocked, and we wanted to be on Fitzsimons. And this is one of the last remaining properties on Fitzsimons that we could negotiate for. And so I think the good deal for the veterans and for the American taxpayer is that we are going to build a state of the art facility very close to our affiliate, and in very close proximity to other major medical facilities, such as Children's Hospital.

THE CHAIRMAN. So, you are saying that I should not view this as a shake down by the University of the VA?

MR. McCLAIN. This is not the University property, Mr. Chairman.

THE CHAIRMAN. Well, the Redevelopment Authority.

MR. McCLAIN. This is the Fitzsimons Redevelopment Authority.

THE CHAIRMAN. You know, a lot of people would love to have a VA Hospital be placed on their land. In fact, they would also almost give you the land, because of the values which we bring, and all the other synergies, and things that could happen, Dr. Perlin, as you described. So I am trying to get there. Am I viewing this wrong? Is the Redevelopment Authority seeing this as an opportunity to milk the federal government for some money?

MR. McCLAIN. No, sir, I do not believe. And I have been involved in some of the negotiations, and I do not view it that way. They certainly want to get value for their property, because they took control of it, they have it, they paid a certain amount for it, and they want to get value for it.

THE CHAIRMAN. How much did they pay for all of this land?

MR. McCLAIN. Sir, I will have to get back to you on that. As to how many acres it was after Department of Education took their chunk, and the exact purchase price, I do not have that.

THE CHAIRMAN. All right, let me ask this question: with regard to where your present facility is and the University, this affiliation, how far do the doctors travel today between hospitals?

MR. McCLAIN. Across the street.

THE CHAIRMAN. Today?

MR. McCLAIN. Today. Or do you mean the new hospital that they have?

THE CHAIRMAN. Right now, the present VA compared to where the University is.

MR. McCLAIN. When they complete their move to Fitzsimons, in other words, sir? I believe it's in the neighborhood of 15 miles.

THE CHAIRMAN. Fifteen miles. Let me ask you, is the University Hospital the only game in town?

MR. McCLAIN. Not the only game in town, but we have an established affiliation with that hospital in Denver.

THE CHAIRMAN. And if you let Denver know that you are willing to breach or sever that relationship because the Redevelopment Authority is gouging the taxpayer for money on property that we had already given back to them, is there another relationship that we could establish with someone else? I do not know, I am just asking.

MR. McCLAIN. And I think that that is a very, very fair question, and one that I know was looked into. And I would like to get back to you on that, if I could, as to what other opportunities there are available. I know it has been looked at, and the choice was to be on Fitzsimons, that would be our first choice. But I know that there were other options that were considered, and I would like to get back to you on what they were.

THE CHAIRMAN. Well, the number one priority is either maintaining or increasing the quality of care for our veterans in Denver, and access. At the same time, being cognizant, or using your word, Dr. Perlin, being the good steward. And it just does not feel good to me, I just want to let you know that. Something does not feel right, here.

DR. PERLIN. Mr. Chairman?

THE CHAIRMAN. Yes.

DR. PERLIN. As you know, we currently have the opportunity to express interest in parcels of land under this current BRAC. And we are making known interest in 11 sites, seven Army, two Air Force, two Navy. Unfortunately, I agree with some of the feelings around what might have been available, but there was a timing problem after, of course, the mid-90's BRAC, it was '95, and would that the conditions were that we could have expressed interest then.

The University is not the only game in town. It is the game that offers certain specialty services, and certain sorts of synergies for sub-specialties, as well as the opportunity to share workload through the use of fellows and trainees in an educational experience. So there are desirable attributes. The ability, for instance, if we need half of the very sub, sub-specialist's time, to be able to go from one facility to the other, when we really do not need the full time of the person, is simply unlikely for an individual who has to travel that sort of distance. If it is across the street, if it is a couple miles, it is really feasible to share, particularly for procedural specialties. For the others, it really becomes more difficult.

So, I agree with the sentiment. I appreciate your passion for the stewardship of resources. We do feel that the efficiencies that would be derived over the longer haul, operating efficiencies, make this a worthwhile investment.

THE CHAIRMAN. All right. Puerto Rico, are you personally comfortable with spending nearly \$300 million on renovations in San Juan, Puerto Rico considering we are talking about a facility that is already nearly 50 years old?

DR. PERLIN. The situation in Puerto Rico, Mr. Chairman, presents

some unique challenges. It is a facility that is very convenient for veterans. It is on the light rail system. It is a facility where substantial renovations have already been made. Improvements in the nursing home, and minor construction projects, and parking garage improvements to outpatient clinic. It is a facility, also, that has seismic challenges, and we need to make seismic corrections to Building No. 1, about \$145.2 million, as well as create a new bed tower. And the investment would be in the order of \$230 million. At the end of the day, we would have an improved, functional facility, but you are right, the basic infrastructure would be 50 years old. It is one that raises that question, what are alternatives? And it is one that we explore.

The challenge in that particular environment is that we have an immediate need and immediate occupancy requirements. And whatever the choice, we need to continue to care for veterans whether we invest it in this current facility, or seek to create a new one.

THE CHAIRMAN. Gentlemen, have you seen the private/public business proposal as it relates to construction for a new medical facility in Puerto Rico? You have not?

DR. PERLIN. We have not seen it. We have heard that there is interest.

THE CHAIRMAN. The delegate of Puerto Rico, a colleague of ours here, is interested in that. If you will note, also in the Appropriations Committee Mark under Puerto Rico, they are also asking that you begin to look at that a little bit further. I would, well, you need to look at it a little bit further, but we sent Committee staff down to Puerto Rico to examine the facility. And we want to work with you as to whether it would make any sense to consider the San Juan, Puerto Rico as a pilot site for the public/private partnership project. Given the substantial facility deficiencies that the Department is proposing to address with very expensive renovations that in the end will fall short of the capacity needed to handle the workload. So, we would like to work with you on the Puerto Rico sight, on the authorization, all right?

DR. PERLIN. Thank you, Mr. Chairman, we would be pleased to explore it.

THE CHAIRMAN. With regard to Mr. Baker's testimony, do you have any comment on his testimony?

DR. PERLIN. We appreciate the Congressman's testimony, and do recognize that there is a deluge of, perhaps the wrong word, or quite a sizable population shifts up to the Baton Rouge area. As Congressman Baker testified, the New Orleans Medical Center was a Referral Center serving veterans from Mississippi to Texas. I think it is important to note that even if Orleans and St. Bernard Parish were not to repopulate, the environment would still support the need, very much support the need, for a Referral Hospital for Veterans region-

ally.

The opportunity to partner, again, for all the reasons we discussed, introduces certain synergies. The Congressman made certain points regarding a report about the concerns of the Charity Hospital system. In fact, one of the reasons that LSU is interested in partnership with VA is because they have seen the transformation in VA from really serving as a safety net to becoming a prevention net. The great thing about that transformation is it not only provides individuals with better care, it is also far more efficient. So they would hope to take a page from our play book in the way that care is delivered.

So on the basis of population, and the basis of synergy, and the belief that their philosophical interest in VA is because they want to model the way that VA now approaches care; health promotion and disease prevention, as opposed to a safety net. We view this as an important opportunity for improving service to veterans, and for them to improve service to their Louisiana patients.

THE CHAIRMAN. Now, regarding the VISN and you, I do not know so I am asking this. You are investigating the demographics, the trends, as to where to properly go, where to build a collaborative site? You're already doing a demographic study at LSU saying, "Well, come to our site. Come on back downtown." Tell us what's happening here.

DR. PERLIN. Yes, sir. We've been working with actuaries to try to understand what the demographic shifts are, and not only in New Orleans but in the state of Louisiana, what the impacts are in terms of projected workload for a VA medical center in that region. In fact, even if St. Bernard Parish and Orleans Parish were not to repopulate, there is still absolutely a sizeable workload that is regionally based. In fact, the three new clinics, at Slidell, Hammond and La Place, which ring the New Orleans city area proper, but are part of the surrounding community, are extremely busy already, as is, in fairness, the clinic up in Baton Rouge. So there is already the workload to support to support a referral hospital. And even if, again, St. Bernard and Orleans were not to repopulate, the growth projections for the region, and the surrounding parishes of New Orleans proper, is very substantial. So it would seem to be appropriately placed.

THE CHAIRMAN. Well, can I throw this to you? Let us go to your testimony, "appropriately placed," and let me just ask this question. There is an emotional desire to rebuild New Orleans. If our goal is to increase quality and access, and we want to build up the levies, and even if we are to build a VA facility that would protect itself against a Category 4 storm or above, we could still find ourselves, the VA, as an island. So we would still have an access problem. Veterans would have to go somewhere else. I know that there are some that are saying, "Well, if you are going to build this facility, or a collaborative effort, move to the population trends in Slidell or others." Are we caught between this emotion to build New

Orleans, yet we find ourselves compounded in a problem we have just gone through? Or are we to go where the population trends are, whereby we do not have a repeat?

DR. PERLIN. Mr. Chairman, I think every feeling American is sympathetic to the plight of the individuals of New Orleans, but I hope we will make our decision on the basis of good business and transparent analysis of the demographics. With that in mind, you raise a very fair point. Which is, okay, what would the risk be even for a hardened facility in that location? One permutation, because this is a question that, I can assure you, I asked and the Secretary asked, is how could you prevent, if the city were, heaven forbid, to flood again, how could you prevent the facility from becoming an island? In point of fact, above sea level is the expressway, and one permutation that has been proposed is to actually have an exit ramp built directly to these facility sites so that in fact there were elevated access to these facilities. One plot of land happens to be very proximate to that expressway. But a very fair question, for all of the reasons that you suggest.

THE CHAIRMAN. I remember, when I was serving on the Katrina Commission, gosh, please do not ask me where I got this. This is one of those things that you just kind of remember. That areas that had some devastation by hurricane, 30 percent do not come back. Then they slowly trickle back, over time, and a decade later, they will return. So, take Hugo, for example. It took 10 years for them to come back, and then for the population to explode. Homestead, 50 percent. And, so this demographic and trend analysis will be pretty important. Mr. Michaud?

MR. MICHAUD. Thank you very much, Mr. Chairman. I would like to follow up on where I left off previously. Dr. Perlin, since I have been here I have heard a lot about, the CARES process, that it is all encompassing and that we need it to hold off capital investments until it is completed. And we heard the Chairman talk about buying some land back that we gave away with a significant amount of dollars, and a lot of these other expenditures. I guess, how much is the Department still interested in the CARES planning? I am really having concerns because it is an all-encompassing plan. Granted, things might be a little different than when the plan originally came out, and I can understand that.

However, in all of VISN 1, there is one CBOC recommended and four outreach clinics. VISN 1 hasn't got the capability financially to even submit a business plan for the CBOC. So, if you have a VISN, and this is the same VISN that actually had to borrow money to make ends meet because they did not have the financial resources. So, if the CARES plan says, yes, a CBOC and four outreach clinics are important, granted it has to be a priority. But what I am seeing is now, when you look at some of the capital construction funds, other projects are jumping over another priority. I am just concerned that

the Department is not maintaining, the CARES process as a top priority. Comments?

DR. PERLIN. Yes, thank you, sir, for the question. I want to tease apart two aspects. In terms of the CARES process, I think that is the major blueprint for the major capital infrastructural investments, and we have requests for authorization and reauthorizations in the Authorization Bill that the Department submitted. And so that really is a template. In terms of the Community-based Outpatient Clinics, the CARES plan, as you have alluded, also noted the need for 156. The CARES plan is a 20-year plan. I think it is pretty compelling that the VA has had a 350 percent increase in points of access over, nearly the past decade in terms of opening new clinics. I know that we make decisions, and I really want to stress this, not just on the basis of what is in the operating budget, but what is the immediate operational need.

This is why, as we have discussed, the Lincoln Outreach Clinic is prioritized, but we recognize that there will be growth in other areas, and the network will bring them on. So I think it is important to recognize that dollars are important, but so are the operational needs will drive the timing of requests for particular clinics. And I will track not only the individual clinics, but the workload at each of the facilities that the clinic would be in the catchman area of. And I know that there are some in Maine, in particular, and you have my commitment to watch those.

MR. MICHAUD. I appreciate that. And I will be watching it very closely myself. Because you could have some VISN's, who have identified need and are entitled to a CBOC, and has the money to actually submit their business plan, but that CBOC might not be a higher priority than other VISN's that cannot even submit a business plan because of lack of funding. And things do change, particularly when you look at different regions, and what is happening over in Iraq and Afghanistan creating more veterans. And that is my concern. VISN's who are inadequately funded in the first place will fall further and further behind in opening CBOCS and outreach clinics because of the lack of the resource.

My second question deals with a GAO report that just came out. In light of the GAO report that came out on the collaboration in Denver and in Charleston, have you changed or modified the Charleston Model, based on the GAO recommendations.

DR. PERLIN. Thank you for the question. I am going to ask Mr. Neary to provide comment on that.

MR. MICHAUD. Thank you.

MR. NEARY. I think one of the things that we learned in Charleston is that we did not bring enough architectural support to the thinking that was going on in the group. So, in New Orleans we have added that component. We have the architectural firm of Leo Daly, a noted

healthcare architectural firm, working with the Mike Moreland planning team to assist them in any way they can.

MR. MICHAUD. Thank you. Okay, and my last question deals with

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THE CHAIRMAN. Will the gentleman yield on this for a second?

MR. MICHAUD. Yes.

THE CHAIRMAN. I just want to share with you, if the focus is on communication, is what the GAO is saying, the history here is, with regard to the Denver facility, the hope was that was where the collaboration was going to be. But it did not work out. There was real conflict in personalities between a VISN Director and the University Hospital Director. And the architectural firm that did that, tried to do the Charleston Model, which really would have been the Denver Model, had it worked. Four years ago, I met with Charleston, and everybody wanted to run off and build their own facilities everywhere. And so Henry Brown, four or five years ago, we met with them and encouraged them to hire the architectural firm that did the planning in Denver, and did it in Charleston.

And so we asked the GAO to come in and look at Denver. What were the lessons learned, why did it fail? Because some of the same input was given for Charleston, and to assess some of the, what, failings? So we could figure out how to improve it, and they really wanted to focus on communications. But I wanted to share with the gentleman sort of the history of that. I yield back.

MR. MICHAUD. I appreciate that very much, Mr. Chairman. My last question, it seems that collaborative opportunities for the VA will increase, particularly with what happened in the Gulf Region, because of disasters. In the environment of constrained funding, how can the VA deal with the construction issues caused by disasters as well as move forward on the CARES process? Because clearly we have to take care of the hospitals damaged by disasters, but that is going to have an effect on the CARES process.

DR. PERLIN. Thank you, Mr. Michaud, for that question. I think it is important to say that our first mission is the care of veterans, the ability to improve the care of veterans, the ability to serve veterans is really what we hope to serve through any sort of collaborative activity, and that alone.

Second, you have asked the question about how we prepare for disasters. This is one of the great advantages of being a national system. We are operational. We deal with the care of patients day in and day out, and because of that we have relationships with suppliers. We also have a system which also has a very systematic approach to readiness, and we exercise that.

So, in point of fact, our infrastructure while in the shared environments with others is one that can actually be supported, bolstered by the national organization providing supplies, providing personnel,

and providing resources in times of disaster. It is hard to believe, but come June 1 we again face the prospect of hurricane season, and some of the preparatory activity includes such things as beginning to stockpile certain supplies, rather than having our usual just in time inventory. But, we will continue to have a very systematic approach, it will be exercised to approach the specter not only of local emergency but of regional and even national emergencies.

THE CHAIRMAN. Mrs. Brown?

MS. BROWN OF FLORIDA. Thank you, Mr. Chairman. Just one second, thirty seconds about me. I represent most of Florida. I have Jacksonville, Orlando, Gainesville, I have a lot of veterans in my area, and I have got to tell you I want to say, I want to associate myself with the remarks of, I understand, Congressman Feeney came in here earlier. I have represented the area for 14 years. It has been a fight on this hospital for over 25 years. And the people that have lost have been the veterans in the Orlando, you know, Central Florida area.

Secretary Brown did come in and helped us a great deal when they recommended closing the Naval Training Center, and the Department of Defense gave it to the veterans and we in Congress got the money to renovate it. And it has been a good deal up until this point. We really need a hospital in that area. And I guess my first question is, once you are close to making a decision then where are we with the request for the funds, that is my first question.

DR. PERLIN. Yes, ma'am. Let me start by thanking you for your support of the Orlando facility. We are very excited about this finally coming to a decision point. As you may know, there was a site team that went down on May 2nd and 3rd, I believe those were the dates, and evaluated the contending sites. There are some that, for many of the reasons discussed today, appear to be favorable. But the Secretary will have the opportunity to review those data, and I believe begin to make a preliminary decision within the next few weeks.

MS. BROWN OF FLORIDA. Okay.

DR. PERLIN. And that is something that I very much look forward to, I'm sure, as you do.

MS. BROWN OF FLORIDA. I want to make sure my statement is included in the record, Mr. Chairman, pertaining to my written comments in the record, because it pertains to the Orlando facility.

THE CHAIRMAN. You would like to submit a statement into the record?

MS. BROWN OF FLORIDA. Yes, sir.

THE CHAIRMAN. Yes, hearing no objections, so ordered.

MS. BROWN OF FLORIDA. Now, we have a situation in Jacksonville that I have scheduled a meeting with the VA on Monday, and I am going to ask you a national question, but first of all you have got to get your local situation taken care of. So my first question is, it pertains to Jacksonville.

I do not know whether you know, but I met 30 minutes ago with the President of the University of Florida who is over Shands Hospital. Two weeks ago I met with the Mayor of Jacksonville, and I met with the VA, and now I am putting all those same people in a room on Monday at 3:00, because I do not know what you do when failure is not an option. And we have been working, the city and Shands, they had a facility that they have torn down, and they moved an agency that was in there that has been a great disturbance to the community. And everybody thought we were moving forward, and then I heard it was some problem about the parking garage, or something. So I met with the mayor, they are willing to resolve it. So I do not really know the problem, but I hope everybody gets their notes together, and when we come together Monday, when we get out of that room this will be resolved and we will be moving forward.

DR. PERLIN. Well, Congresswomen, thank you very much for your support of us, and in particular bringing people together on Monday. I think this will be very helpful. As you know, we are very committed to the increasing outpatient presence needed in Jacksonville. The Deputy Secretary himself has been down there to really affirm VA's commitment to serving veterans in that area, and we appreciate the relationship with Shands.

I would be less than forthright if I did not acknowledge that there has been some wrestling over the number of parking spaces. I believe some of that has to do with city code, and I think that can be easily resolved, and I think some of it has to do with capacity of some buildings. And I would appreciate your help very much on Monday on bringing parties together such that we can provide the necessary parking for veterans, and get on with this activity.

MS. BROWN OF FLORIDA. Okay, and can you just give me an update on the cemetery in that area, also?

DR. PERLIN. If I might, I would refer to Mr. Bill Jayne of the National Cemetery Administration.

MS. BROWN OF FLORIDA. Yes, sir.

MR. JAYNE. Yes, ma'am, we just finished the environmental assessment for three properties that we are looking at, potential sites for the National Cemetery in Jacksonville that was authorized by Public Law 108-109. And we are reviewing the comments and we will be preparing a recommendation to the Secretary to make the final decision in the next couple of months. The process will probably take about that long, but it is going along well, and we feel like we have got some good potential sites. They are all located roughly north of the airport there in Jacksonville.

MS. BROWN OF FLORIDA. Well, good. My question is, do you all have this, I know that in order to expedite the time, that you all have some kind of a model that you all use, that you are using all over the country?

MR. JAYNE. What we try to do to expedite the provision of service is that we will divide the first phase of construction into what we call a Phase 1A and Phase 1B. And the Phase 1A will be intended to prepare some of the site, a small portion of the site, for burials as soon as possible. And we will rely to some degree there on temporary facilities, such as a temporary office, temporary maintenance facility, that will be replaced during Phase 1B with permanent facilities. But the idea is to bite off, if you will, a small workable chunk and design that in so that when the entire Phase 1 is done, it will meld into the rest of the cemetery. It will not look like it is part of something, a different project.

MS. BROWN OF FLORIDA. How long for each phase?

MR. JAYNE. We hope to be able to finish that Phase 1A by late 2008, early 2009.

MS. BROWN OF FLORIDA. And final completion?

MR. JAYNE. Final completion would be about a year later, of Phase 1.

MS. BROWN OF FLORIDA. Of Phase 1?

MR. JAYNE. Right. And that would be, the Phase 1A would be open, available to veterans and their families in late 2008, early 2009, and about a year later we would be able to finish the rest of Phase 1, that is the permanent buildings and so forth.

MS. BROWN OF FLORIDA. Okay, thank you very much. On the national system, I just returned from New Orleans I guess about a month ago. And I met with the Army Corp. and wanted a status report as far as where we was as far as the levies is concerned. But my concern goes to, it is not just New Orleans. I mean, like you said, I live in Florida. The hurricane season is coming, and it is not just coming to New Orleans, but Florida. And the national system, my understanding was that part of the problem was the veterans, if they are displaced, and many were displaced after the hurricane. But, are we plugged in so that no matter where a veteran goes, you can pull up his records? Is that straight now?

DR. PERLIN. Yes, ma'am. Let me assure you that as we use our electronic health record, you can actually go to a function called remote data view, and see their medical conditions, refill prescriptions, also a function called VistaWeb. And we would certainly want to put in also back-up communications. And in fact, we are in the process of establishing, and we appreciate the help of our Office of Information and Technology, establishing satellite uplinks so that in the event there is not communication on, ground based fiber and cable, we can actually use high band width satellites to communicate between facilities.

MS. BROWN OF FLORIDA. So we will be able to assist the veterans no matter where this takes place?

DR. PERLIN. Yes, ma'am, absolutely.

MS. BROWN OF FLORIDA. Well, that is good. I want to thank the

Chairman for what he did as far as the communications, making sure that we put that system in place, and we held up the money a little bit until we could really get a system that would serve the veterans. So, thank you, and thank you for the time.

[No statement was submitted.]

THE CHAIRMAN. Thank you very much. I have just a few more questions. This is an authorization for a lot of money, so I know this is a long hearing, and I thank you for the patience of the American Legion and the VFW. We are going to get to you.

As I go down the list, you also are asking for \$189 million in Pittsburgh, Pennsylvania. So, let us turn to our buddy, Mr. Moreland. What is he doing?

DR. PERLIN. Sir, in Pittsburgh, Pennsylvania, it is actually an opportunity to improve service to veterans while improving efficiency. Pittsburgh has been operating virtually as three campuses, and in this area we will be able to consolidate down to two. And the University Drive campus, actually bring much of the workload to that facility, and also supports a second facility with improved residential treatment. Bring the management and the overhead of three facilities into two, improved access, improved facilities, improved technology, improved efficiency. So we appreciate the investment and realizing the promise of the CARES program.

THE CHAIRMAN. What is Mike Moreland doing there with regard to collaboration, if any?

DR. PERLIN. Mr. Moreland is doing tremendous things in terms of collaboration. This is really a great example where, in collaboration with the University of Pittsburgh Medical Center, they share certain specialties. In other areas, they actually use some of our services, that makes it a long term win-win partnership. And in other areas, Mr. Moreland's entrepreneurial approach has created a template that allows for leadership in programs that are extremely complex, like transplant surgery. And that facility is really an extremely well managed facility, as you would expect from Mr. Moreland, but one that benefits both from internally efficient operations as well as good collaborative relationships.

THE CHAIRMAN. All right, as a Committee we have the challenge here in front of us. Earlier I had mentioned, it has been decades since the VA has found itself with this many major construction projects in front of it. The list goes on and on, with a lot of the consolidation of clinical and administrative functions, and outpatient clinics, ambulatory care, expansion of spinal care, seismic corrections, ward upgrades, electrical systems, bed renovations, I mean, the list goes on. But we have a challenge here in front of us. So I feel no differently from how the Appropriations Committee must have felt.

You submit a request for us for \$675 million for New Orleans, Loui-

siana. Appropriators put in an emergency supplemental in excess of \$550 million, subject to an authorization to expire on June 30th. So, we as a Committee do not know where you want to go, and we need good counsel from you to us.

We also have the Biloxi facility. And I know you just met with Mr. Taylor of Mississippi, and I know that he would love to keep the Gulfport facility, but I had to explain to him also, and I know you were very candid with him, about the realities, and to follow CARES, and that we are going to upgrade Biloxi. And I do not have a problem with that at all.

But New Orleans, break this one out a little better for us. I mean, because I feel conflicted inside a little bit, just where I am with Denver. So, give me your best shot.

DR. PERLIN. Mr. Chairman, it is not possible at this moment to tell you exactly what corner, what intersection in New Orleans this facility will be located. What we can tell you is that for reasons that have convinced the Secretary, convinced me, we have the opportunity to improve efficiency and restore services to veterans with a facility in New Orleans proper.

We appreciate the discussion and the responsible oversight provided by you and the Committee in asking the question, "What if?" And that is something we take very seriously, having weathered Katrina as a hospital that was in a flooded area. The ability to assure access is something that is absolutely paramount. The ability for a facility to be hardened and withstand damage is absolutely paramount. And given that the demographics from actuaries demonstrate that there is still a population basis, even if Orleans and St. Bernard were not to repopulate, that would support the need for a tertiary referral center, now and in the future, our request is for authorization for a facility in New Orleans proper.

THE CHAIRMAN. And if we were to do this in New Orleans, authorize it subject to the collaboration between you and LSU, do you have a problem with that?

DR. PERLIN. Mr. Chairman, we believe that the collaboration will offer efficiencies. Not only do we not have a problem, we look forward to not only approving care, but improving efficiency and the stewardship of resources.

THE CHAIRMAN. And increasing the quality at the same time.

DR. PERLIN. Yes, sir.

THE CHAIRMAN. All right. Mr. McClain and Mr. Neary, I know that there are some outstanding leases out there, and that we have got to get this authorization of the leases. Mr. McClain, our present liability, could you address that right now? I mean, we are in a present liability because of not having gotten this authorization done, so can you help explain about time being of the essence?

MR. McCLAIN. Many of the leases will run out, as I understand

it, at the end of the fiscal year. So, unless we have authorization to reenter into those leases, or extend them, we are probably going to be paying more afterwards when we do get the authorization. We will be paying market rates or whatever the market rate will be at that point.

THE CHAIRMAN. These are contract penalties?

MR. McCLAIN. Yes, sir. So I believe that that is the case. I defer actually to Mr. Neary.

THE CHAIRMAN. Do we have any leases right now that have expired, which were in penalty?

MR. NEARY. No, Mr. Chairman, we do not. The leases for which we are requesting authorization in a couple of instances are new facilities, we do not have anything existing. As Mr. McClain said, the sooner we get authorization the sooner we can proceed to a contract and lock in that market rate. As we talked earlier, building costs are growing. And so, the sooner the better.

The other leases are in situations where we are in an existing facility, the leases will be expiring. We will, if needed, attempt to work with that lessor to enter into an extension of the lease while we get authorization, and then acquire the new facility.

So the only additional liability I believe we have at this point is, as Mr. McClain said, as the market increases, the sooner we can lock in the better.

THE CHAIRMAN. Thank you, very much. These penalties would be approximately what over an annualized basis, per facility, would you know that? Someone I think had informed me one time it was around \$100,000, is that right? Over a year, is that about accurate?

MR. NEARY. I think maybe penalty is not exactly the right word used. When we go and extend the lease, the lessor will obviously want to increase our rental rate to current market. And some of these are clinics that have been in existence 20 years, so we are paying a darn good rate now.

THE CHAIRMAN. I guess I am calling it a penalty only in that if we do not get our job done on time, you have got to pay more money. That is a penalty to the taxpayer.

MR. NEARY. Correct.

THE CHAIRMAN. I stand corrected. The \$377,700,000 you are asking for on the Orlando facility, can you break this out for us?

MR. NEARY. Our working number currently for the site is \$30 million. So the design and construction costs we have presently estimated \$347 million.

THE CHAIRMAN. So, your request to us is not 377 it is 347?

MR. NEARY. No, we would need authorization for the total of 377. We require authorization --

THE CHAIRMAN. How much is the land, approximately?

MR. NEARY. Our working number is \$30 million.

THE CHAIRMAN. Your working number, but as of right now --

MR. NEARY. We are looking at six sites. As Dr. Perlin said, we will soon in the next few weeks be shortening that number up. We will then engage in real estate due diligence, seeking appraisals of the sites, begin negotiating with the landowner.

THE CHAIRMAN. Obviously that is all being done before you announce.

MR. NEARY. I'm sorry? One of the requirements --

THE CHAIRMAN. If I were a landowner I would love for you to announce that you are coming to buy my property.

MR. NEARY. We are required to follow --

THE CHAIRMAN. Right? They are only going to put the price up.

MR. NEARY. Well, the good thing for us is we have choices. There are a number of competing sites.

THE CHAIRMAN. Yes?

DR. PERLIN. Mr. Chairman, you are exactly right. We would caution, we do not want to bid against ourselves.

THE CHAIRMAN. Yes, do not tell us, right?

DR. PERLIN. Exactly.

THE CHAIRMAN. Mr. McClain, you go out there and you negotiate, and then you can tell us.

DR. PERLIN. Exactly.

THE CHAIRMAN. All right. I'm good. Are you good with that, Mr. Michaud? Going down this list, Mr. Michaud, do you have anything further on any of these sites? I think we have covered them. The only thing I have would be this, and it is a follow-up from the conversation we had had.

At some point in time, and from my conversation with General Love, is this idea of when the Secretary and your team have put together the time lines of this construction so you can begin to overlay and utilize this institutional knowledge, these time lines when you set them will be very helpful to us. And it is helpful also to OMB, because over this next decade, building these six facilities, we have not been here before. And as you lay that out to OMB, lay it out to us, and the appropriators, and the Senate, so everybody has confidence in your plan and in your number, and we all can proceed. For the veterans service organizations you have used, the word transparency, getting their input from the localities so that the national leadership of the organizations understand how it is going, and the time line.

When that happens, then you calm the emotion of a Ms. Berkley. Right? I mean, you calm the emotions of others. And we want to work with you to do that. Do you have anything that you would like to add?

DR. PERLIN. No, sir. We agree with you in terms of that, and in fact do have Gantt charts on play out layout, and we commit to being more transparent about making those very public so you are with us

as we progress through these important constructions.

As well, I would simply note again that General Heiberg's advice and the Construction Advisory Board --

THE CHAIRMAN. Hold on, just a second. Would you be willing to submit that for the record? Your chart?

DR. PERLIN. Absolutely, yes, sir.

THE CHAIRMAN. All right, how do you identify your document?

DR. PERLIN. This is a Gantt chart on the construction timetable for Las Vegas.

THE CHAIRMAN. The document shall be entered into the record, so ordered. Please, I'm sorry.

DR. PERLIN. I would simply conclude by saying that the Construction Advisory Board, that blue ribbon panel that the Secretary chartered, that really compels us to use the most contemporary, transparent and accountable approaches. We know how important that is, not only to the Committee, but to the taxpayer. We owe taxpayers and veterans that.

THE CHAIRMAN. All right, thank you very much, gentlemen for your -- yes?

DR. PERLIN. If I might, sir, before we leave, it would be remiss if on behalf of our colleagues at the Department of Veterans Affairs we did not join you in expressing our admiration and appreciation for the service of Jim Lariviere. I would just like to really acknowledge his tremendous leadership and service.

THE CHAIRMAN. Thank you. I will make sure he sees that. Thank you, gentlemen for your testimony. You are now excused. Third panel, please come forward.

Mr. Salazar, I ask that the opening statement of Mr. Salazar shall be offered to be entered into the record. Hearing no objections, so ordered.

[No statement was submitted.]

THE CHAIRMAN. Our final panel will receive the endurance award. I've got a couple like energy bars here, if you need them. Are you okay? You operate well on an empty stomach?

MR. CULLINAN. So far, so good, Mr. Chairman.

THE CHAIRMAN. I do apologize to you. You have been here since 10:30, but you also have been able to sit there and take in some very valuable testimony. Not only from our members, in particular our two members from the New Orleans/Baton Rouge area, and Mr. Feehey of Orlando. I mean, you get your input from your membership, but it is kind of interesting to listen from their perspective. At the same time, we have huge challenges in front of us on how we get this construction done and know what the plan is, and how we get it into the budgets.

So, thank you very much for enduring, but you were able to listen

to all of this testimony.

Representing the American Legion is Cathleen Wiblemo, a U.S. Army Veteran, and she is the Deputy Director for the Veterans Affairs and Rehabilitation Commission of the American Legion. And our final witness on this panel, Dennis Cullinan, is the Director of the National Legislative Services for the Veterans of Foreign Wars. Dennis was discharged from the United States Navy in 1970. Ms Wiblemo I did not say when you were discharged. That is because I am a gentleman.

MS. WIBLEMO. Oh, thank you. Thank you.

THE CHAIRMAN. Ms. Wiblemo, you are now recognized.

STATEMENTS OF CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DENNIS CULLINAN, DIRECTOR NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

STATEMENT OF CATHLEEN C. WIBLEMO

MS. WIBLEMO. Good afternoon Mr. Chairman, and Members of the Committee. Thank you for the invitation to present the American Legion's views on the Rightsizing of the Department of Veterans Affairs. The American Legion has a keen interest in this very important process. My oral remarks will be brief, but I ask that my written testimony be submitted in its entirety for the record.

THE CHAIRMAN. Hearing no objections, it is so ordered.

MS. WIBLEMO. From the beginning of the CARES process, the American Legion has taken an active role. We have formed an advisory committee made up of volunteer legionnaires to look at facility assessment and possible use or reuse of reported vacant space. We appointed a volunteer legionnaire in every VISN to report on the local concerns on legionnaires regarding CARES. These volunteers also testified before the CARES Commission during the Commission Site Visits in 2003. We have sent a representative to every Local Advisory Panel meeting that has been held to date. If and when Stage 2 starts and the LAPS resume, rest assured that we will be present. It is frustrating that we have tried since November to find out the status of the LAPS and have been unsuccessful. We even called all the LAP points of contact that were given to us, and they were as much in the dark as we were.

The American Legion would like to emphasize that stakeholder input has been a key component in the CARES process. The LAPS were set up to ensure continued stakeholder input. Veterans across the country were astonished to hear that after seven months of dormancy, and complete lack of communication with stakeholders, ma-

job realignment decisions in 16 of the CARES affected communities are soon to be made by the Secretary of VA.

The American Legion has conducted site visits to every medical center in the VA Healthcare System across America as part of our System Task Force mandate. We have recently visited Las Vegas, Denver and New Orleans. We have seen first hand the state of VA healthcare at these sites.

The CARES decision was meant to be used as a blueprint, a guideline, a method of developing the tools necessary to shape the VA healthcare system into the future. Congress tasked VA to come up with a plan, and they did. For many years, construction dollars were hard to come by awaiting the outcome of the CARES process. What we would like to see is a more pronounced sense of urgency to implement decisions that have already been made, and get quality, accessible healthcare to veterans in specific areas that the CARES determined are not only high priority but urgent and critical.

It is time to move forward and fund major and minor construction throughout the VA healthcare system to catch up for the years when capital improvement projects were frozen awaiting the CARES plan, along with the years since CARES when funding has fallen short of the well-defined need.

CARES was triggered by a GAO report in 1999 that showed VA was spending millions of dollars a year on unused space. Solving that problem guided CARES from beginning to end. Seven years later, this costly problem of inefficiency not only remains but has grown bigger. Former VA Secretary Principi warned that one of the biggest threats to CARES was "paralysis by analysis." It is the plan Congress asked for. It is a plan that envisions the right size for VA healthcare and veterans deserve that. Thank you, and I look forward to your questions.

[The statement of Ms. Cathleen C. Wiblemo appears on p. 78]

MR. CHAIRMAN. Thank you very much. Mr. Cullinan?

STATEMENT OF DENNIS CULLINAN

MR. CULLINAN. Thank you very much, Mr. Chairman. On behalf of the men and women of the Veterans of Foreign Wars of the United States, and our Ladies Auxiliary, I want to thank you for inviting us to participate in today's most important and revealing hearing.

As you know, the VFW handles the construction portion, and independent budget, and I will continue in that vein.

THE CHAIRMAN. Does the gentleman have a written statement?

MR. CULLINAN. I would ask that our written statement be made a part of the record.

THE CHAIRMAN. Hearing no objection, it is so ordered.

MR. CULLINAN. To begin, I would say that the VFW and the IBVSO's continue to be supportive of sharing of collaborative ventures, you know, when they benefit both the veteran and indeed the community. We are, of course, concerned that VA maintain, it continue to protect VA's identity as a provider of care and service --

THE CHAIRMAN. Mr. Cullinan, may I ask a question?

MR. CULLINAN. Yes, sir.

THE CHAIRMAN. Just for a point of clarity, your testimony here today, is it on behalf of the VFW, or is it also as the --

MR. CULLINAN. We are representing the IBVSO's as well.

THE CHAIRMAN. Okay.

MR. CULLINAN. So, IB.

THE CHAIRMAN. Very good.

MR. CULLINAN. IB.

THE CHAIRMAN. All right, thank you. So you are representing both here today, the Independent Budget and the VFW?

MR. CULLINAN. Well, the VFW is part of the Independent Budget, and we handle the construction portion.

THE CHAIRMAN. I just want to make sure it is clear. You are here providing testimony, what hat are you wearing?

MR. CULLINAN. The IB.

THE CHAIRMAN. Thank you.

MR. CULLINAN. You are welcome, sir. Some of the things that you are emphasizing here today, also pertain mightily, as far as we are concerned, with respect to collaborative ventures. It has to do with things like access. The facility has to be located somewhere where a veteran can get to it. Accessibility, we have talked about this before. If a facility happens to be, say, situated on a military base, you know, is the security too daunting for veterans to get in there. And what you really emphasize is the issue of quality. That is very, very important. In a sharing arrangement, we want to ensure that veterans will get quality care. That is a key issue with us.

We are, of course, and we testified to this extent before, with respect to funding of the Gulf Region. In past testimony, we have indicated that the money has to come not only just through the VA's construction budget, but through other sources as well, and we are very pleased to see that there is money in the emergency supplemental for both Biloxi and New Orleans. But, with respect to New Orleans, I believe we share a concern with you that VA not be put in a position where it is acting prematurely with respect to building a new facility down in New Orleans. We have got to look at the demographics. There are safety issues of concern. Your image earlier of a VA medical facility as an island was pretty impressive and pretty daunting as well.

So these are things that have to be looked at. We are concerned that there may be a tendency to want VA to sort of lead the way, and

that may not be in veterans' best interests, and that is where we are coming from on this issue.

I also have to say that Mr. Baker's testimony earlier was troubling indeed. I mean, usually when we are talking about, both with respect to New Orleans and sharing arrangements in general, usually when we are talking about a collaboration between a medical school and a VA facility, our biggest concern generally is that the VA not get pushed around, and everything not sort of work in the medical school's favor. It would seem here, from what Mr. Baker was indicating, is that it could be a situation where VA could end up as a form of cash cow for a facility, and I do not know this, but for a healthcare system that is in jeopardy, that is in trouble. That is troubling to us. I cannot say how accurate of an assessment that is. I am sure Mr. Baker understands it very well, and it is something that we would ask for you to look at.

You know our general budget number. I am not going to review those again. I would say, in earlier testimony we talked about the situation of non-recurring maintenance. As you know, that is not funded under budget. It is part of the healthcare funding. That sets a form of competition between providing care to veterans and keeping up with essential maintenance projects. The other issue there is that it is funded via VERA, which may be the best way going to fund medical care, but it can misdirect dollars with respect to construction. You can have an old facility that costs a whole lot of money to maintain, and not have very many veterans using it. If the decision is to keep that thing running, then it has got to be properly funded.

Another area, we are pleased to note that the VA is going forward with some seismic corrections. However, it is indicated some 890 VA facilities are at significant risk. We have to move forward with this. And we continue to support an architectural master plan.

I have a little note to myself here. It says, "Delays cost money." This is a point we have made in earlier testimony, and then today it was revealed that there are now 14 projects which are not going to go forward in a timely basis. That costs a lot of money. It also means that veterans are denied, or are not getting, the care that these facilities should be providing. We have court support extending the authority to 2009 to provide it, but, again, this is a case where we are not doing the right thing by veterans and we are not doing the right thing by the taxpayer. And that is a concern. We are worried system-wide. You can have the best plan in the world, but if money is not there to pay for it, what happens next? So, and this was brought up in Senate testimony about a month ago. What do we do with CARES? What happens if the money is simply not there to pay for it? And there will be a time where the IB will ask to look at this, and say, "Need we do something else?" If the money is not there to pay for it, what do we do? And we, all of us, the American people, the veterans' community,

have invested a lot of time, energy, money into this thing. It would be a shame to see it squandered.

The last thing I would like to say here, Mr. Chairman, is that we very much appreciate your urging total transparency in the process, in the construction process. I mean, this is a situation we have not had to contend with for years and years with respect to building VA facilities, figuring out where they have to go. It is essential that the local veterans be involved in the process. And that concludes my testimony. Thank you.

[The statement of Mr. Dennis Cullinan appears on p. 74]

THE CHAIRMAN. Yes, I definitely agree with your last statement. When we first began this issue on collaboration, a step beyond personnel to facilities, there was confusion at the local level as to what was going on. And then the mysteries and the boogie men started to appear. And you know what? It goes back to the communication. And it was very good that Mr. Michaud was present, because he also gave some good counsel to everyone to, wait a minute, let us make sure that everybody gets included in the process. One of the district Legion individuals was present, but the state commander did not know. And then you had your own intra-politics going on within your own groups. Whoa. But communication I think is beginning to work itself out, and I appreciate your final testimony on that point.

Let me turn to Ms. Wiblemo of the American Legion. In your written statement, on page four, if you have it in front of you, if not let me just read this to you, with regard to this Charleston Model that is being leveraged, now in New Orleans. So under your paragraph regarding New Orleans, in the second paragraph, you said for the American Legion, you "support the relationships that the VA enjoys with the medical school. However, we remain adamant that the VA health system retain its own identity." Carry that forward. What do you mean?

MS. WIBLEMO. Well, a lot of that has to do with the history, South Carolina being one of them, MUSC. And we are adamantly, it is a challenge, because I know with the collaborations, and the sharing that goes on, and we support sharing and collaborations, and that. We are very afraid that the VA will lose its identity, and lose its unique specialty. It holds a special place in veterans', I mean, obviously, in veterans' hearts, but to get --

THE CHAIRMAN. Ma'am, have you seen, or read both of these?

MS. WIBLEMO. Yes, I have. No, I have not seen the New Orleans one, but I have read the MUSC one.

THE CHAIRMAN. All right, I will tell you what. Before you leave here today, we will get you a copy of this one.

MS. WIBLEMO. Thank you.

THE CHAIRMAN. Because when you read both of these, I think ev-

everyone has given the great assurance, and agrees, we want the VA to retain an identity.

MS. WIBLEMO. Right. And I will tell you, part of the South Carolina issue was veterans were not at the table at the time, and they were only briefed.

THE CHAIRMAN. And early on they got confused because they were going to be in the same ward with civilians, and --

MS. WIBLEMO. There was a lot of confusion.

THE CHAIRMAN. That is not going to happen. That is not what this is about.

MS. WIBLEMO. So, yeah.

THE CHAIRMAN. So, if we are in agreement --

MS. WIBLEMO. That would be --

THE CHAIRMAN. Pardon?

MS. WIBLEMO. That is very important, obviously. Not just to us, but I am sure to a lot of people.

THE CHAIRMAN. It is important to me.

MS. WIBLEMO. Obviously.

THE CHAIRMAN. It is important to Mr. Michaud. It is important to Mr. Brown.

MS. WIBLEMO. Yes.

THE CHAIRMAN. So I want you to know that with regard to that statement as it appears in your testimony, we in fact all agree.

MS. WIBLEMO. Great.

THE CHAIRMAN. Okay? So, as they proceed, it is the Charleston Model that is being leveraged now to New Orleans, and this one is going to try to --

MS. WIBLEMO. When did the New Orleans one come out? Was that just this month?

THE CHAIRMAN. Yes, it just came out. April 30th.

MS. WIBLEMO. I have not seen that one. But I have read the other one.

THE CHAIRMAN. Well, you will enjoy this.

MS. WIBLEMO. Thank you.

THE CHAIRMAN. Because Mike Moreland, this is a very sharp individual, and he took the best of having gone through this process and leveraged it into New Orleans. And where we are from here, is, that now we need to go to Stage 2. Because this was the heavy lift. This was the identification of all of the no-go categories that must be defined. And once they got defined, then you have to go into the next step. And that is where we are to go, and we are going to move in tandem with both. So, it will be important. If you have any questions, IB, American Legion, as this proceeds, please stay in touch with us. We will be more than happy to let you know what we know as we know it.

MS. WIBLEMO. Thank you.

THE CHAIRMAN. Okay. All right? Will you make a copy of that right now? We are going to get it to you. Mr. Michaud, I yield to you, and then I have other questions.

MR. MICHAUD. Okay, thank you very much, Mr. Chairman. I want to thank you both for your testimony and willingness to stay as well. I appreciate that very much. Getting back to, and the reason why I mention VISN 1 is that I am familiar with VISN 1 compared to the other VISN's. And I am sure we are not unique in our concerns when you look at the whole CARES process. Do you think that this Committee, or the VA, should actually re-look at the whole CARES process? See if it should be changed; what are your thoughts on that? Because, as you heard Dr. Perlin, it is a 20 year plan, and things do change in 20 years. They change from year to year. And priorities do change. But what is your overall thought as far as to make sure that CARES, the plan that is put out there, is still valid, you know, next month, next year, the year after?

MR. CULLINAN. Thank you, Mr. Michaud. I mean, clearly, we do not have another 20 years to wait. I mean, that is what I was afraid of when I was listening to Dr. Perlin. Was it about a month ago the Secretary was presented with the CARES report? Now is the time to look to see if something comes of this. If nothing comes of it, at a certain point, we are going to have to say and I keep saying, I know it is vague to say a certain point. And I do not want to say, and there certainly is not agreement within the IB that the time is right now to say, "Okay, CARES ain't working because the money is not there." But clearly, you know, within the not so distant future, if nothing is coming out of CARES, I mean, the construction has been held up for years because of CARES, waiting for CARES to emerge. Well, it is emerging now. So, let us see what comes of it, and let us see if the Congress will fund it.

MS. WIBLEMO. I suspect, CARES is just a plan to help guide the VA. It will be up to the VA managers and those of us that use the VA system, and oversee the VA system, that if it needs to change, or evolve, that we are involved in that process. I imagine that, 10 years from now, when technology is advanced even more, and the way that they deliver healthcare and where they deliver it is all going to be changed. It will all be changing. So we have to be open to that type of change that might be needed. And, you know, you could, VA is in genomic medicine right now. You know, they are talking about that. That is pretty futuristic, or it used to be.

So, I think the CARES plan is good for what it was intended to do. We supported the process, and now it is up to VA management to take it and put it into place.

MR. MICHAUD. Thank you. To follow up on your question, you mentioned about the VA keeping its identity, which I think is extremely important. I hear that a lot from veterans in Maine. And when you

look at the CARES process, particularly as it relates to rural areas, would either of you comment on, as far as a collaborative effort what your thoughts are. For instance, it might not be cost effective for the VA to build their own outreach clinic or CBOC in the rural area where they can work closely with a federally qualified healthcare clinic, or hospital. Do you care to comment on that? Do you think that is something acceptable for your organizations?

MS. WIBLEMO. Absolutely. I mean, rural healthcare is its own little bit problem, access to rural healthcare, access to quality healthcare. And, I mean, we recognize the necessity to contract out to ensure that veterans that live in, I'm from South Dakota, you know veterans that live in Aberdeen, or out there in the west, you know, they are hundreds of miles from a hospital. And, yeah, sure. I mean, you have to recognize that as something that is needed. So, we recognize that and sure we would support that.

MR. CULLINAN. Mr. Michaud, we agree with that assessment. There are certain areas, certain parts of the country where that is the only way to provide care. And we do not want veterans denied simply because they live in a rural or a remote area.

MS. WIBLEMO. Could I just add one other thing? The only thing that we have ever, as far as contracting out, the only thing that we have ever really said about that, that we do not want it used as a blanket option for the VA. I mean, they need to look at other avenues. But, certainly we understand the need to have to do that. And in the rural areas.

MR. MICHAUD. Great. Thank you. My last question, and Chairman Buyer had alluded to it. When we went down to South Carolina, we saw the bulk of the problem, and the reason why there is a lot of concern among veterans, is the fact that there was not that communication, they were not kept in the loop, so to speak. And at that time, Dr. Perlin had agreed to make sure that they will be kept in the loop from here on out. Is that a common practice, that your organizations have seen? Or is it just a rare occurrence where on big projects, whether it is the collaboration in South Carolina, or Denver, or the CARES process, where your organizations are not kept in the loop.

MR. CULLINAN. Communication is key. I would say with the big projects our people are brought into the process. The problem is, a lot of times it is just too complicated, it is too technical. I mean, unless a great deal of effort is expended to make it clear. I mean, they could be brought in, but they are not really understanding what is going on, and that is a problem. Of course, that is in part inherent with the problem of construction, it is a very technical area. But I think sometimes, it has been better of late. Some of our people have felt that they have been talked down to, but.

MS. WIBLEMO. With the Chicago CARES Phase 1, the VA really after that, because one of the biggest problems with that was there was

no buy in from the stakeholders from the beginning and they did not even have a voice. So, at the time, when Secretary Principi brought the stakeholders in and ensured us a voice, we have not run into that. I was kind of really surprised when I got the e-mail from the Department in South Carolina that said this was going on. Although we knew that the collaboration effort had started, because we wrote about it in one of our task force reports, that they were looking at that. This was years ago, I mean, 2002, 2003, that they were looking at it, and that it was starting. But I was kind of surprised for him to call and not have been kept in the loop. So I do not think that it is a, I do not think it is usually a problem. I mean, I know at the national level, Dr. Perlin and his people, they give us lots of, I mean, we are usually overwhelmed with information from them. But, usually it is not a problem. And South Carolina was probably an anomaly. That was a huge study going on. And they did not know anything about it, so.

MR. MICHAUD. Great. Thank you very much. Thank you, Mr. Chairman.

THE CHAIRMAN. Mr. Cullinan, you opened your testimony, and you mentioned the word "quality" with regard to the collaborative efforts, and it is one of the drivers. It was an idea that I had on how I can increase the quality of care, and save money. Now, how do you do that? Think about that. That is a challenge, right? And what I learned is that too often in this town, and maybe it is even human behavior, it is easy to say no. "Oh, do not do that. This is how we always do it, this is what we do. Oh, nah."

And sometimes, you know, in this town, we will expend 80 percent effort to stop something, and 20 percent to do something. This is an unusual town. But maybe there is some human behavior there.

But what got exciting about this was in those, I told you, those no-go areas, you know, and you read that in the report. It is fascinating to put all of these great minds together and say, "Okay, wow, let us explore this." And down in Charleston when they testified and said that a paradigm had been broken, to think that right now you have the tomotherapy, the machine has been purchased, they are building the room around it, and two angiographic suites are also included in it. And these are things whereby Dr. Greenberg at MUSC, because of the population and economies of scale, they really could not afford to buy. And this is equipment not even located in South Carolina or North Carolina. So, when the VA went and said, "Okay," we are intrigued by this effort of collaboration. And our first effort of building the trust was that we will go together." The VA is going to purchase this, they are going to begin to do this collaborative effort, figure out how to do the clinical services, and the legal part, and all the other sides of this one, the finances and everything. It is all going to be explored, really, through this. And when they do this, and

the treatment of cancer, what have we done? We have just elevated the quality of care that is delivered in South Carolina, or even North Carolina. People will want to go to it. And so, now all you have to do is replicate that with some other things.

But one of the things that is important in all of this, and it was important to us in negotiation of this, is priority. It is our machine, we are going to let you use the machine, we are going to get reimbursement for it. But our veterans have priority with regard to utilization. So that goes back to, I think, your testimony about identity, you know? And that is what we want to do. And I want to take the time to be open and honest here with you, and just let you know where I am coming from, and where the Committee comes from. And strike me if I am wrong, but Mr. Michaud has been working very well with Mr. Brown, in how we proceed forward, and both of them have been working very well together to do this. And as a matter of fact, the only caution on this one is before we can even begin to digest it, Katrina hits, New Orleans, leverage, you know what I mean, and it is moving.

And so, Mr. Michaud that is where I want to make sure that now that we have these two collaborative studies now going, the smartest man on the block is Mike Moreland. The guy that has really done them both, along with Mr. McClain. I mean, that is the guy that now has the institutional knowledge of both of these things. And, not that we want to keep a watchful eye, well, maybe that is the thing. We want to figure out, how do we do this in the next stage, and to blend these two going forward. In other words, I do not want to go, "Okay, we started with Charleston, we are going to go to New Orleans, we are going to do New Orleans, and then maybe sometime later we will go back to Charleston." See what I mean? Let us proceed forward.

And that is why my last question to Dr. Perlin was so important. I did not even know they had done that chart. I had asked them before about doing that, graphing it, giving us a time line so that we can know. That was the first time, I did not even know that they had already done it.

MR. CULLINAN. We certainly did not know about it, Mr. Chairman.

THE CHAIRMAN. Well, I did not either. Maybe Mr. Michaud knew about that.

MR. CULLINAN. I would have to say that we really appreciate your keeping a watchful eye on this. Because collaborative efforts, we think, are a great idea where they work. But it is something that has to be watched, our big fear.

THE CHAIRMAN. They do not work everywhere.

MR. CULLINAN. No, I know. But generally, some places they will work and where they work we support them strongly. You know, at one point we had the specter of the VA healthcare system becoming the federal healthcare system, which kind of smacks of something

else a little bit, too. But we just do not want to see that happening. And where there are collaborations we want to be sure that they work. And that issue, when you said priority, that veterans remain the top priority.

THE CHAIRMAN. And you know what, I think, we are just having an open conversation. What kind of makes some people nervous is that, I do not think they want to say, "Okay, this one is number one, and this one is number two, and this one is number three." You know, you are going to upset Orlando, or do you upset Las Vegas? No, no, we will put it all on paper, and we are all working on it, you know? So they really do not like to do the time line thing. But from our perspective, on the authorization, we want to know these time lines. I just wanted to share that with you.

MR. MICHAUD, do you have anything else?

I will end where I started. And that is, the big lift in front of us. We have not built a new facility in 15 years. The last facility was built, a behemoth down in Florida with many floors that were not even used for patients. It was built under an old system. And we provide healthcare much differently today. And so, when you look at the map of the United States, we want to continue our valued collaboration with medical universities. We have Las Vegas and Orlando, and the states are saying, "We want to build medical universities." So now, UNLV wants to bring the medical university in close proximity, to our facility, to what we are doing in Las Vegas. And we think it makes sense to put this Orlando facility next to Central Florida, just to let you know. I do not know what they are going to be saying, but where we have been sending them, this makes sense.

And then we have, you have heard my comments on Denver, I have read your testimony on Denver. Maybe I have to get over this pit in my stomach, because it has already happened. The federal government gave it away, and now we need to figure out where we are going. But I just do not feel good about this one.

We then are left with three others, Charleston, New Orleans, and Puerto Rico.

And the last thing I will say about the Puerto Rico that I find is interesting is that this private partnership and enhanced use lease with the construction of a hospital is worthy of analysis. Right now, we cannot do it. The law would not permit you to do something like that. But it is worthy of looking at it. How are we going to build six major facilities in a short period of time?

So, I am willing to explore different alternatives, how we can do it, and do it in a manner whereby we increase the quality and the access. And we want to continue to work with you, okay?

MR. CULLINAN. Thank you very much.

MS. WIBLEMO. Thank you, Mr. Chairman.

THE CHAIRMAN. All right. Thank you very much. This panel is

excused. I ask unanimous consent that the statement on behalf of the Honorable Cliff Stearns be submitted into the record. Hearing no objections, it is so ordered. And I also order that all Members of the Committee may have five legislative days to submit statements for the record. Hearing no objections, it is ordered. The hearing is now concluded.

[No statement was submitted for Hon. Cliff Stearns.]

[The statement of Hon. Jeff Miller appears on p. 55]

[Whereupon, at 2:32 p.m., the Committee was adjourned.]

APPENDIX

Honorable Jeff Miller
Opening Statement

Right-sizing the Department of Veterans Affairs Infrastructure

May 11, 2006

Thank you, Mr. Chairman.

Our nation's veteran population is constantly changing on many fronts. The total number of veterans changes, their healthcare needs change, and their place of residence changes. Congress and the VA both have an important responsibility to ensure that these veterans are able to receive the needed care when and where they need it.

Much to the chagrin of many, Congress cannot continuously pour out funding to projects that someone *thinks* will benefit veterans. Not only is it prudent to carefully monitor current populations and forecast future populations; it is also prudent to involve an aspect of financial planning. This committee, to the best of its ability, provides as much funding as it can for programs and projects that will serve veterans across all fronts, and it also observes to see that VA does the same. Items such as the CARES Report provide a useful framework, but we cannot accept it as the only way of serving veterans. Where and when healthcare facilities need to be built is a changing issue, and because of that I continue to urge my colleagues to act carefully and after conducting necessary research.

Today, we look at existing requests for several construction projects and leases across our nation. I look forward to hearing from our witnesses a valid justification and support for these projects. Some are quite costly. Some are based off older data that might not be as correct and practical at this point in time. Representing a congressional district with one of, if not *the*, highest veteran populations in our nation, I hear quite often of the desire of my constituents to be able to access inpatient care in a timely fashion. Currently, they have to drive over two hours to receive this. I truly hope this does not remain the case much longer. While much of what we hear about today brings veterans' care in the right direction, it is clear that there is much more to be done.

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Testimony
of
Representative Richard H. Baker
6th Congressional District of Louisiana

Before the
United States House of Representatives, Committee on Veterans Affairs

“Rightsizing the Department of Veterans Affairs Infrastructure”

May 11th, 2006

Chairman Buyer, and distinguished Members of the full Committee on Veterans Affairs. I thank you for holding this hearing today and for the opportunity to discuss our efforts to rebuild the Veterans Administration (VA) Medical Center in New Orleans, Louisiana.

Mr. Chairman, as you know, Louisiana experienced a natural disaster of epic proportions when Hurricane Katrina roared ashore our coast in August, 2005. As such, the VA Medical Center in New Orleans suffered extensive damage and remains closed for inpatient care.

Mr. Chairman, prior to Hurricane Katrina, the VA Medical Center in New Orleans played a critical role in providing healthcare for veterans throughout southern Louisiana, eastern Texas and western portions of Mississippi; treating nearly 40,000 patients in 2005. Pre-Katrina statistics included staffing of 1,700 employees and an annual operating budget in excess of \$130 million.

Additionally, the New Orleans Medical Center operated in close proximity to both Louisiana State University (LSU) and Tulane Medical Schools and supported extensive research and training programs.

In February 2006, VA released a report to Congress on options for re-establishing a medical center in New Orleans. The report concluded that the preferred option is the construction of a new medical center as a "shared" facility with LSU and its managed Medical Center of Louisiana, the state's public safety-net health care system. As such, both VA and LSU signed a Memorandum-of-Understanding (MOU) to establish a mutually beneficial relationship and to foster discussions addressing the basic framework for a future VA and LSU medical care delivery collaboration.

As the agreement outlines, *critical* to discussions between the VA and LSU will be a determination of the present and future demographics of the seven-parish New Orleans metropolitan area and how the makeup of the population, including its size, will impact the need for health care services, medical research and medical education for both LSU and Tulane health care professional students. As you know, Mr. Chairman, the MOU mandates that all findings and details be submitted to a joint Collaborative Opportunity Study Group (COSG) committee by June 1, 2006.

On a side note, a recent study conducted on behalf of the Louisiana Recovery Authority reflects a growing civilian population shift in the greater Baton Rouge area. (According to VA statistics, 2/3 of the pre-Katrina veteran population continues to access clinics and outpatient services in the greater New Orleans area). The report strongly suggests a need for replacing Baton Rouge's aging public hospital, as well as the need for a new, acute care hospital. In addition to this finding, I highlight for the committee a second important finding regarding the LSU hospital system, sometimes known as the Charity Hospital System. The report finds the Charity system is "detrimental to the health of all Louisianans and is likely an important reason for the lower system quality, both in the public and private sector." Although these findings may be of more interest to

officials within the Department of Health and Human Services, I believe the findings are instructive to VA as well. Put simply, the ultimate success of a VA and LSU partnership hinges on the provision of the highest quality of care for all patients. If the old Charity system has not worked for Louisiana, I believe it is prudent for VA to examine the Charity system, and if need be, request those reforms the department may consider necessary in order to ensure there is an equal partnership between Charity and VA.

I reiterate my belief that opportunities exist for a strong partnership between VA and LSU to provide veterans, as well as the people of Louisiana, the highest quality of care in the most up-to-date facilities. Let me stress, however, with such partnerships we must not forget to maintain and protect our mission to provide the highest quality of care for each and every veteran.

While we await more forthcoming details, the potential for a VA and LSU collaboration presents itself as an exciting opportunity. The opportunity to maximize limited dollars through collaboration is immense, especially in a post-Katrina environment. With such collaboration, economies of scale could be employed, making the provision of health care and the expenditures of taxpayer dollars more prudent.

For example, a site in proximity to the current medical center would be acquired by the State of Louisiana and donated for the shared campus, thus saving VA millions of dollars. Further, both parties envision one single campus, but with separate, autonomous bed towers and outpatient clinical space. Common areas would provide space for shared non-clinical support services such as parking, food services, laundry, and energy and utility management. Since the facility would be shared, VA could save millions of dollars in annual recurring operating costs.

Finally, Mr. Chairman, as the Committee begins to consider wider-ranging construction priorities, it should examine leveraging this, and other models nationally, in order to take advantage of already existing clinical and education relationships with universities and local hospitals.

Both VA and LSU officials are paying particular attention to the Texas Medical Center model in Houston. The Texas model is made up of 42 member institutions, including medical schools and nursing schools, in which all are dedicated to the highest standards of patient and preventative care, research, and education.

It is imperative to remember that prior to Hurricane Katrina, the New Orleans medical center had a valuable and productive relationship with both the Louisiana State Health Sciences Center, as well as the Tulane University Health Science Center. In 2005, 124 resident positions were allocated to the medical center. In total, over 500 university residents, interns and other allied health students were trained at the medical center. A collaborative VA and LSU effort could further expound upon this relationship by truly creating a state-of-the-art teaching healthcare facility.

Mr. Chairman, thank you for holding this hearing today and for the opportunity to testify before you and the Members of the full Committee. I look forward to working with you, and most importantly, further enhancing quality healthcare opportunities for America's veterans.

United States House of Representatives
Committee on Veterans' Affairs

Hearing on the Construction and Lease Authorization Needs of the
Department of Veterans Affairs

May 11, 2006

Rep. Tom Feeney

I would like to thank Chairman Buyer, Ranking Member Evans, Chairman Brown of the Subcommittee on Health and the entire Veterans' Affairs Committee for the opportunity to discuss this issue that is critical to the veterans of the State of Florida.

The veterans' population in the United States and Puerto Rico currently stands at 26,549,704. More than 1.8 million of these veterans reside in Florida. Our state has the second largest veterans population in the country with over 350,000 veterans located in the Central Florida area. This does not include those veterans who choose to make Florida their home during the winter months of the year and veterans who visit the numerous vacation areas in Central Florida, which can number in the thousands.

Yet Central Florida is the largest metropolitan area with out a VA Medical Complex. Many veterans residing in Central Florida average 2 hours of travel time to get to a VA hospital located in Tampa, Gainesville or Jacksonville. This includes veterans living in Orange, Seminole, Brevard, Volusia, Osceola, Polk and Lake Counties. In fact, only 45% of veterans in the Orlando region are within the VA's access standards for hospital care.

Central Florida is the number one destination for combat veterans and veterans 65 years or older. It is also the number one area for veterans who have 50% or more service connected disability. 18% of our veterans have Post Traumatic Stress Disorder (PTSD).

There are 128 active veterans organizations in the Central Florida area. My constituent, John Kellat, is the Chaplain for the Disabled American Veterans (DAV), and drives veterans from New Smyrna Beach to the nearest facility in Gainesville. A Central Florida facility would cut his drive time almost in half, making it more convenient for veterans in the area and also cutting

down on the cost to Service organizations like the DAV and the Veterans of Foreign Wars (VFW). A closer facility would also mean veterans would pursue the medical services provided by the VA and lead to a better quality of life.

Leaders like Jerry Pierce, President of the Central Florida Veterans, Inc.; Charlie Brenner, past President of the Central Florida Veterans, Inc. and Dr. Neil Euliano, Chairman of the Central Florida Veterans Memorial Park Fund have worked diligently to express the critical importance of a new medical facility to our area veterans. I have also received countless correspondence from constituents like Brigadier General (Ret.) Bill Carlson, US Army, Colonel (Ret.) Joe Kittinger, US Air Force and Lieutenant Colonel (Ret.) Earle Denton, US Army, regarding the urgent need for the hospital.

Orlando and its surrounding area was identified by the VA through the Capital Asset Realignment for Enhanced Services (CARES) program as an area in need of a new VA Medical Center. At the same time, CARES identified the need for a new medical complex in Las Vegas, Nevada. This need was appropriate and warranted and I am pleased that the facility in Las Vegas has received funding and is scheduled to break ground this year. However, a hospital in Central Florida still remains an idea.

Design and construction initiatives have been authorized by the VA and efforts are underway to select a site that best suits the needs of the Central Florida veterans' community. Balancing the accessibility needs of Central Florida's veterans with the long term, economic impact the hospital will have on the State is essential as we look for ways to leverage funds to maximize investment benefits.

The Florida Board of Governors recently approved a proposal from the University of Central Florida to build a new medical school in the East Orlando area. I am enthused by the economic benefits a new medical school at UCF will bring to the entire state, attracting more doctors and high-tech biomedical industries to the region. This will be valuable to both local veterans and the VA as a medical school environment provides insight into innovative and cutting edge technologies and can serve as a vehicle for sharing expensive medical equipment.

We also have confirmation from Orlando's Florida Hospital that they look forward to partnering with the VA to help share in the costs of diagnostic

equipment and contribute to residency and staffing needs. This commitment will ensure that veterans have access to additional resources to further enhance the medical services the VA may offer to them.

Concerns have arisen from Central Florida veterans associations in the area that a Central Florida VA Medical Center will not come to fruition. At a May 1st Public Hearing administered by the Orlando VA Hospital Site Selection Committee, many veterans were accusing lawmakers of not caring for veterans because of the slow process that has been made.

Veterans in Central Florida have been waiting for nearly three decades for a new complex that has continuously met delays. I urge the VA to select a site in a timely manner so that our growing veterans' population may finally have appropriate access to vital health care services.

Again I appreciate this opportunity to express Central Florida's immediate and urgent need for a medical facility and look forward to working with you all to make this important project a reality in the near future.

Good Morning,

Chairman Buyer, Ranking Member Evans, members of the committee- I thank you for allowing me this opportunity to talk to you about an issue that is very important to me, and many citizens in my district, which is veteran's health care.

As everyone is well aware, after Katrina the gulf coast suffered many devastating losses. The grief felt by the people of the gulf coast is incomprehensible. Hurricane Katrina was the worst natural disaster in this nation's history, followed by the devastation wrought by Hurricane Rita, South Louisiana has experienced more hardship, and more loss in a period of mere weeks, than most communities face in a lifetime. This is evidenced by the fact that nearly nine months after Katrina hit, we are struggling day by day to rebuild and recover. This is a long term project for us- because what was lost in Katrina was not just structures, but history, memories, culture, communities, and- perhaps saddest of all- many lives. But the spirit to return and reclaim our place in this world is strong in the hearts of the people of South Louisiana, and though we are down- we are not out. Not by a long shot.

During our time of need Louisiana had many friends, who helped us in innumerable ways, in the immediate aftermath of the storm and continuing today. I would like to take this opportunity to thank the VA for its efforts to evacuate all 241 patients, 272 employees, and 342 family members from the New Orleans VA medical center. Not only that, but by September 7, 2005, all Community Based Outpatient Clinics in the affected areas were operational, and five mobile clinics were sent to Louisiana. The VA's efforts in the aftermath of the storm on behalf of the veterans community was outstanding, and will not be forgotten.

However, in this period of rebuilding some are questioning whether the VA Medical Center in New Orleans should be rebuilt. As a result of the immense flooding in New Orleans after Hurricane Katrina, the Medical Center of Louisiana at New Orleans, which consists of Charity and University Hospitals, and is part of the LSU system and served as a vital safety net hospital and the only Level 1 trauma center and a major teaching hospital in the area, has remained closed due to extensive and irreparable damage. The VA Medical Center in New Orleans, which is located a block away from Charity Hospital, has suffered a similar fate.

In other words, much of the healthcare infrastructure of South Louisiana is in ruins and with limited access to healthcare, the region's entire recovery is in jeopardy. That is why the recent proposal to build shared facilities for LSU and the VA holds so much hope. This merger could provide the beds and doctors that the general population needs if the city is to have a chance at recovering, as well as restoring services to the thousands of area veterans who depend on the VA for care.

The burden on our veterans since the destruction of the VA in New Orleans has been enormous. Access to care for them has always been an issue, particularly for the veterans in my district who have to travel long distances for the services they need.

The situation has only been made worse in the wake of Katrina. Everyday, my office hears from veterans who no longer have a place to go for the care they have earned with their service. Many had to evacuate the area altogether and – with no operating VA facilities in New Orleans – may not ever return.

It's a situation that's not limited to veterans. Right now, thousands of families displaced from the Gulf Coast are looking at the recovery progress and trying to decide whether or not to come home. Levees are being fortified in most areas, there are a growing number of jobs to be had, homeowners can now expect to see at least some payment for their lost houses, and some schools are starting to come online. A tremendous amount of effort has gone into making that simple list happen but a family asking itself whether it can move back has to ask the question 'where do I go if I get sick?'. 'What doctor can I see if I get hurt?' The answers to those questions lie in a strong healthcare community. Of key importance is the need to rebuild not just bricks and mortar but the human capital that it takes to deliver quality medical care. The hospitals in the LSU system weren't just providers of care but were also teaching hospitals. Without them, there is a huge hole in the fabric of medical professionals that are the foundation of a strong health care community. The LSU/VA plan gives us the opportunity to regenerate that important component.

This is a historic partnership for historic times. From an efficiency standpoint, it makes sense. From a fiscal standpoint, it makes sense. And from a moral standpoint – after everything these Gulf Coast veterans have endured with these storms – it makes sense. I urge the committee to support these efforts to rebuild the healthcare infrastructure on the Gulf Coast for our veterans and the rest of our citizens in these affected areas.

STATEMENT OF
THE HONORABLE JONATHAN B. PERLIN, MD
UNDER SECRETARY FOR HEALTH
FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
MAY 11, 2006

Mr. Chairman and members of the Committee, good afternoon. I am pleased to appear here this afternoon to provide you with an overview of the Department of Veterans Affairs' (VA) construction program and 5 Year Capital Plan. I will also provide information on VA's portfolio management approach and how the Capital Asset Realignment for Enhanced Services (CARES) process and the Enhanced-Use Leasing program play an integral role in the management of VA's portfolio.

VA has a vast holding of diverse capital assets consisting of buildings and real estate, VA-leased buildings, enhanced-use leases, and infrastructure. Assets include hospitals, clinics, cemeteries, and office buildings. Many of these facilities currently are used, managed, and maintained in relation to and for promotion of the respective activities of VA's Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA), and Staff Offices (General Administration). At the close of FY 2005, VA held 1,053 operating leases, and owned 5,306 buildings and 32,527 acres of land. Various construction programs are used to fund infrastructure for the Department. Operating dollars fund lease requirements and maintenance projects. The major construction program provides for constructing, altering, and improving any

VA facility with a total project cost over \$7 million and the minor construction program funds construction activities under \$7million. Two grant programs are also utilized for building or improving state veterans cemeteries and state nursing homes and domiciliary facilities.

The VA FY 2007 budget request includes \$714 million in capital funding. Our request includes \$399 million for major construction projects, \$198 million for minor construction, \$85 million in grants for the construction of state extended care facilities, and \$32 million in grants for the construction of state veterans cemeteries.

The 2007 request for construction funding for our medical facilities is \$457 million—\$307 million for major construction and \$150 million for minor construction. These resources will be devoted to implementing projects identified in the Capital Asset Realignment for Enhanced Services (CARES) program. The projects will renovate and modernize VA's health care infrastructure and provide greater access to high-quality care for veterans. VA also received funds enacted in the Hurricane Katrina emergency supplemental funding in late December 2005: \$293 million to fund a CARES project for a new hospital in Biloxi, Mississippi; and \$75 million for planning and design for the restoration/replacement of the medical center facility in New Orleans, Louisiana. To date, including the FY 2007 budget request, VA will have received in excess of \$3 billion to implement CARES. In addition, VA currently has an emergency supplemental request for \$600 million before the Congress for the construction funding of the restoration/replacement of the medical center facility in New Orleans.

Our FY 2007 major construction request for health care will fund the continued development of two medical facility projects—\$97.5 million to address seismic

corrections in Long Beach (California); and \$52.0 million to continue the work necessary to prepare for construction of a new medical center facility in Denver (Colorado). In addition, our request for major construction funding includes \$38.2 million to construct a new nursing home care unit and new dietetics space, as well as to improve patient and staff safety by correcting seismic, fire, and life safety deficiencies at American Lake (Washington); \$32.5 million for a new spinal cord injury center at Milwaukee (Wisconsin); \$25.8 million to replace the operating room suite at Columbia (Missouri); and \$7.0 million to design improvements through renovation and new construction to reduce underutilized vacant space located at the Jefferson Barracks Division campus at St. Louis (Missouri) as well as provide land for expansion at the Jefferson Barracks National Cemetery.

We also requested \$53.4 million in major construction funding and \$25.0 million in minor construction resources to support our burial program. This includes funds for cemetery expansion and improvement at Great Lakes, Michigan (\$16.9 million), Dallas/Ft. Worth, Texas (\$13.0 million), and Gerald B. H. Solomon, Saratoga, New York (\$7.6 million). Our request will also provide \$2.3 million in design funds to develop construction documents for gravesite expansion projects at Abraham Lincoln National Cemetery (Illinois) and at Quantico National Cemetery (Virginia). In addition, the major construction request includes \$12 million for the development of master plans and the initial design for six new national cemeteries in areas directed by the National Cemetery Expansion Act of 2003—Bakersfield, California; Birmingham, Alabama; Columbia-Greenville, South Carolina; Jacksonville, Florida; Sarasota County, Florida; and southeastern Pennsylvania.

CARES

Former Secretary Anthony Principi formed the Capital Asset Realignment for Enhanced Services (CARES) Commission to conduct a “comprehensive, system-wide approach, identifying the demand for VA care and projecting into the future the appropriate function, size, and location for VA facilities.” The CARES Commission submitted findings and recommendations in February of 2004, and on May 7, 2004, the Secretary released his CARES Decision based on the Commission’s findings and recommendations for each CARES site. This CARES decision became VA’s roadmap into the future.

Since that time, much has been done to move these infrastructure improvements forward. Architectural and engineering firms have been retained to prepare designs and 12 construction contracts have been awarded and are underway. An additional 12 construction contracts are planned to be awarded by the end of this Fiscal Year. These projects bring needed improvements for veterans at these locations.

Public law 108-170 provided the Secretary with interim authority to proceed with CARES approved projects subject to a 45 day notice to the Committees. This legislation was used to provide authorization for the first 30 CARES projects. The legislation will sunset on September 30, 2006. Fourteen projects authorized under this public law are not likely to award construction contracts by September 30 and four additional projects which will have construction underway will have second phases of construction that will begin later. Therefore, the Department has requested an extension of that authority until September 30, 2009 in the FY 2007 Budget, 5 Year Capital Plan, and the Omnibus 2006-2007 Construction Authorization Bill. Also in need of authorization are three projects: Biloxi,

Mississippi; Denver, Colorado; and New Orleans, Louisiana, for which the Department has identified as an immediate need in FY 2006. A request for authorization for medical facility leases for FY 2006 and FY 2007 construction projects and medical facility leases are also included in the budget request, capital plan, and authorization bill, which was transmitted to Congress on April 5, 2006. In total, VA is requesting authorization of \$3.7 billion for major medical facility projects and \$51.6 million for major medical facility leases.

5 Year Capital Plan

The Department's 5 Year Capital Plan is the ultimate product of VA's capital investment process, which reflects trade-offs between funding the operational expenses for existing assets and the acquisition of new assets by the most cost-effective and beneficial means. The VA capital plan includes the highest priority capital investments that were vetted through a comprehensive Department wide capital investment process to ensure the assets fully support the mission, vision, and goals of the agency. The plan outlines VA's implementation of the CARES decisions. The plan also includes descriptions of other initiatives and capital asset management tools that VA is utilizing to better manage its large capital portfolio.

For FY 2007 the capital plan is published together with the Department's construction budget. Combining the two documents provides a comprehensive view of the VA construction budget for 2007 and plans for the future

Enhanced-Use Leasing

VA utilizes a capital asset management tool called "enhanced-use leasing" (EU leasing) to better manage its vacant and underutilized real property assets. The authority was initially authorized in 1991, is codified at 38 U.S.C. §§ 8161-8169, and currently is set to expire on December 31, 2011. It permits VA to lease Department-controlled real property to private or other public entities for a term not-to-exceed 75-years. Each lease must be in exchange for "fair consideration" as determined by the Secretary. Such consideration may consist of monetary, and/or "in-kind" consideration including construction, repair, remodeling, improvements, or maintenance services for Department facilities, or the provision of office, storage, or other usable space.

The EU leasing program has enabled VA to leverage its diverse, underutilized real estate portfolio to generate significant revenues. Such revenues are redirected towards the healthcare and capital operations of our medical centers, which serve our nation's veterans daily. It also has resulted in several privately-financed, developed, and operated facilities which provide valuable, mission-compatible services to the Department and eligible veterans, non-veterans, and VA employees. Such facilities and services have included co-generation energy services, office facilities, parking facilities, hospice care, mental health, single-room occupancy (homeless shelters), affordable housing, transitional housing, low-cost senior housing, and child day care services. Notably, VA's varied EU leases also have resulted in a substantial short and long-term stimulus for the impacted local, state, and federal governments and economies, due to tax revenues, sales, and job creation.

In FY 2005, through its EU lease program, VA received over \$900,000 worth of in-kind consideration, and \$28,000,000 via a single payment of monetary consideration. The

EU Leasing program is a proven method of leveraging VA's diverse real estate portfolio and market position.

VA's Portfolio Management Approach

VA utilizes a three-tiered portfolio management approach. This approach is the blueprint for VA portfolio management nationwide.

First, VA manages what we have more effectively through Federal Real Property Council (FRPC) performance standards as well as using unique technology-assisted inventory management system. VA is committed to four metrics that set the goals for performance. They include: 1) the percent of space utilization as compared to overall space (owned and direct leased); 2) the percent condition index (owned buildings); 3) the ratio of non-mission-dependent assets to total assets; and 4) the ratio of operating costs per gross square foot (GSF) adjusting for inflation. These goals are based on the FRPC standards for performance measurement in capital portfolio management.

VA is striving to utilize information technology and established capital asset management principles to improve the management of its capital resources. VA created the Capital Asset Management System (CAMS), an integrated, Department-wide system, enabling VA to analyze, monitor, and manage VA's portfolio of capital assets. Data are organized and presented to strategically monitor performance against capital asset goals within and across asset types and VA Administrations (VHA, VBA, and NCA).

Secondly, VA selects prudent capital investments through appropriated dollars. VA uses appropriated dollars to manage CARES capital investment projects that have proven to be sound investments. Each project's performance is measured to ensure the best use of our overall portfolio needs. This innovative approach has allowed VA to manage underutilized assets in a more efficient and cost-effective manner.

VA's third approach is the use of its enhanced-use leasing authority, which has been previously mentioned. Over the past 14 years VA has awarded 47 projects through the enhanced-use leasing authority. An additional 100 initiatives are being studied, of which 45 projects are currently active.

Closing

In summary, Mr. Chairman, the \$714 million that VA is requesting in FY 2007, in addition to the \$293 million provided in the Hurricane Katrina emergency supplemental, will provide the resources necessary for the Department to:

- Continue implementation of the infrastructure improvements identified in CARES to insure that facilities are available to support the provision of timely, high-quality health care to nearly 5.3 million patients. It is important to note that 79 percent are among those who need VA the most—those with service-connected disabilities, lower incomes, or special health care needs;
- Increase access to our burial program by ensuring that nearly 84 percent of veterans will be served by a burial option in a national or state veterans cemetery within 75 miles of their residence; and
- Provide safe and secure facilities for the Department built to current specifications to withstand natural and manmade disasters.

I look forward to working with the members of this committee to continue the Department's tradition of providing timely, high-quality benefits and services to those who have helped defend and preserve freedom around the world. I would be pleased to answer any questions the committee may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF

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

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA's INFRASTRUCTURE & PENDING MAJOR MEDICAL FACILITY PROJECTS AND
LEASE AUTHORIZATION REQUESTS

WASHINGTON, D.C.

MAY 11, 2006

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.4 million men and women of the Veterans of Foreign Wars of the U.S. (VFW), this nation's largest combat veterans organization, I would like to thank you for the opportunity to testify today on rightsizing the Department of Veterans Affairs' (VA) infrastructure and its major medical facility project and lease authorization requests.

Over the last few years, construction projects and leasing arrangements have been overshadowed by the Capital Assets Realignment for Enhanced Services (CARES) process. CARES, which aims to reorganize the VA health care system to properly plan for the future, and, in turn, realize improved health care service for veterans, has been a long and difficult process.

We will continue to support CARES as long as VA returns to its primary emphasis and intent: the "ES" portion of CARES. We accept that locations and missions of some VA facilities may need to change to improve veterans' access, to allow more resources to be devoted to medical care rather than to the maintenance of old buildings, and to accommodate more modern methods of health-care delivery. Accordingly, we concur with VA's plans to proceed with the feasibility studies of the remaining 18 facilities contained in the Secretary's decision document. We note that those processes are moving forward on the local level with establishment of local advisory committees and public hearings, allowing the veterans, who are stakeholders in this complex process, to have a voice. We support this transparent approach to public policy, and intend to remain active in it.

In July 2004, the previous VA Secretary testified before the Subcommittee on Health of the House Veterans' Affairs Committee. He stated that CARES "reflects a need for additional investments of approximately \$1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care."

Using that as a baseline, and accounting for the 18 CARES-related projects being assessed, the IB calls for \$860 million to be allocated for CARES projects. We must keep in mind, however, that as projects advance and as ground is broken, funding levels will need to be increased dramatically.

Over the last few years, the funding for major construction has ebbed. This moratorium was caused by the planning of the CARES process. There was much political resistance to funding any projects before the planning process took place. Now that it has occurred, it is time to move forward, and advance this important plan.

Delays cost money. With the rate of construction inflation roughly 9% nationwide (and regionally as high as 35% in some parts of the South), pushing these projects further into the future will only increase the amount of money Congress will need to provide to maintain this nation's commitment to veterans' health care.

Under the major construction account, we are calling for a total investment of \$1.447 billion. Of particular importance on that list is the funding for seismic corrections. Currently, 890 of VA's 5,300 buildings have been deemed at "significant" seismic risk, and 73 VHA buildings are at "exceptionally high risk" of catastrophic collapse or major damage. We understand that the list of major construction priorities that VA has provided to Congress includes the seven facilities most at risk of damage. Accordingly, this will increase VA's need for construction funding. This is a chance to be proactive and fix a problem before the health and safety of VA's patients and workers is further compromised.

We also call for funding for an architectural master plan. Without this plan, the benefits of CARES will be jeopardized by hasty and shortsighted construction planning. Such a master plan will also go a long way in determining where and when leasing arrangements will be the most advantageous.

Currently VA plans construction in a reactive manner—i.e., first funding the project then fitting it on the site. Furthermore, there is no planning process that addresses multiple projects; each project is planned individually. "Big picture" design is critical so that a succession of small projects don't "paint" the facility into the proverbial corner. If all projects are not simultaneously planned, for example, the first project may be built in the best site for the second project. The development of master plans will prevent shortsighted construction that restricts, rather than expands, future options. As the cost of construction rises with inflation, the importance of optimal planning becomes paramount.

We believe that architectural master planning will also provide a mechanism to address the three critical programs that the CARES study omitted. Specifically, these are long-term care, severe mental illness, and domiciliary care. These programs should be addressed as quickly as possible.

For Minor Construction we are calling for \$505 million in funding. The funds for minor construction comprise construction projects costing less than \$7 million. This appropriation includes

funding for the National Cemetery Administration, the Veterans Benefits Administration, and the Inspector General.

With the reticence over the last few years to provide construction funding, the amount appropriated for maintenance has lagged far behind what has been needed. Price-Waterhouse, following standard industry practices, has recommended that VA spend at least 2-4% of the value of its building for nonrecurring maintenance. These small projects, such as replacing a roof or improving the fire alarm system, are necessary for the safety of patients, but also to maintain the integrity of the building so that it is viable for its entire lifespan. Accordingly, VA should spend no less than \$1.6 billion for nonrecurring maintenance in FY 2007. Unfortunately, the Administration has only allocated \$514 million for maintenance, which will only make the already backlogged maintenance lists grow.

Further, because maintenance comes out the medical care account, not the construction budget, much of the funding for the last few years has been used to provide medical care. VA needs to cover deferred maintenance. In fact, according to VA's own assessment, which is conducted on three-year cycles, the investment necessary to bring all facilities currently rated "D" or "F" up to an acceptable level is \$4.9 billion. There should not be a choice between fixing a roof and buying medical supplies. It is Congress' job to allocate properly funding for both.

Funding for maintenance is allocated to the VISN level using the VERA methodology. While this moves the money to the growing demand for veterans' health care, it tends to move the money away from the oldest capital structures, which need the most maintenance. It also increases the tendency in some VISNs to use maintenance money to address shortfalls in medical care funding.

It is also important that VA recapitalize their infrastructure beyond nonrecurring maintenance. Properly reinvesting in facilities extends their useable life, and saves costs over the long run. Both Price-Waterhouse and the American Society of Hospital Engineers say that a 35 to 50-year recapitalization rate is required for VA facilities. Of note, most hospitals rely on a 25-year or less rate of recapitalization. VA traditionally has a historically low rate of recapitalization. From FY 1996-2001, for example, it was just a paltry 0.64% of VA's total plant replacement value. To overcome this shortfall, a minimum of 5-8% 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. Congress must ensure that VA has adequate funding to ensure the life of its infrastructure.

We thank you for allowing us to testify today, and we would be happy to answer any questions that you or the committee may have.



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

Dennis Cullinan is a native of Buffalo, New York, and was promoted to the position of Director of the National Legislative Service of the VFW Washington Office.

Prior to being honorably discharged from the U.S. Navy in 1970, Dennis served as an electronic technician aboard the USS Intrepid (CVS-11) and completed three tours of duty in Vietnamese waters. After his discharge, Dennis studied abroad with two years at the Catholic University of Nijmegen, the Netherlands. He later completed his undergraduate education at State University of New York in Buffalo where he also received his M.A. degree in English.

After several years of teaching freshmen composition and creative writing, Dennis became a member of the VFW Washington Office staff in its National Veterans Service department. He later advanced to positions in the VFW's National Legislative Service department and became its Director in August, 1997.

Dennis enjoys an active involvement in crew as a member of the Occoquan Boat Club of Northern Virginia. He and his family reside in Lakeridge, Virginia, where he is a member of VFW Post No. 7916.



The Veterans of Foreign Wars is not in receipt
of any Federal grant or contract.



STATEMENT OF
CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

RIGHT-SIZING THE DEPARTMENT OF VETERANS AFFAIRS INFRASTRUCTURE

MAY 11, 2006

STATEMENT OF
CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
RIGHT-SIZING THE DEPARTMENT OF VETERANS AFFAIRS INFRASTRUCTURE
MAY 11, 2006

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present The American Legion's views on the ongoing effort to realign health-care facilities in the Department of Veterans Affairs (VA). The American Legion has continued to monitor progress in this very important process. Equally important is that we not lose sight of why VA has been tasked in recent years to re-evaluate the utilization of its infrastructure. With the rapid advancements in technology and medicine that the national health-care system is experiencing, VA will be compelled to continue the evolution of its health-care delivery system far into the future. It should be a never-ending process.

History

In 1994, VA was under severe scrutiny and faced the very real prospect of becoming an outdated system of health-care delivery. Users' expectations were not being satisfied and VA was falling noticeably short in providing high quality and timely health care.

During this time, many concerns were raised about the viability and future role of VA health care. Some advocated turning VA functions over to the private sector because the veterans health-care system had not been as responsive as it should have been to changes in health care and in society.

Dramatic change needed to take place, and in late 1994 VHA leaders developed a plan to transform the system. The transformation was more than just the creation of the Veterans Integrated Service Network (VISN) management structure that decentralized the decision-making processes. From 1995 to 1998, VHA implemented universal primary care, the shift from inpatient to outpatient care and the establishment of community-based outpatient clinics. During this time, a national formulary was developed under the new pharmacy benefits management program and VHA's education and research programs were restructured. Additionally, landmark eligibility reform legislation; new cost accounting and clinical management system; and initiating changes in personnel practices, program functions and performance assessment were implemented.

The paradigm shift and transformation of VA health care that occurred in those four or five years left the department with an infrastructure that was outdated and more than it needed in order to provide health care into the 21st century. VA's infrastructure reflected a time when bed-based care was the standard mode for providing health care.

In March 1999, the then General Accounting Office (now Government Accountability Office, GAO) published a report on VA's need to improve capital asset planning and budgeting. GAO cited the fact that VHA's asset challenge was due, for the most part, to four reasons. First, VHA owned 4,700 buildings, over 40 percent of which have operated for more than 50 years, including almost 200 built before 1900. Second, over 1,600 buildings (almost one-third) have historical significance. Third, VHA used fewer than 1,200 buildings (about one-fourth) to deliver health care services to veterans. They further noted that VA had over 5 million square feet of vacant space, which could cost as much as \$35 million a year to maintain. Fourth, VHA's health-care buildings have significant unused inpatient capacity. Basically, the report found that VA's asset plan indicated that billions of dollars might be used operating hundreds of unneeded buildings over the next 5 years or more. The report went on to further state that VA did not systematically evaluate veterans' or asset needs on a market (or geographic) basis or compare assets' life-cycle costs and alternatives to identify how veterans' needs could be met at lower costs.

Additionally, GAO estimated that over the next few years, VA could spend one of every four of its health-care dollars operating, maintaining, and improving capital assets at its then 181 major delivery locations including 4,700 buildings and 18,000 acres of land nationwide.

Recommendations stemming from the report included the development of asset-restructuring plans for all markets to guide future investment decision-making, among other initiatives. VA's answer to GAO and Congress was the initiation and development of the Capital Asset Realignment for Enhanced Services (CARES) program.

During the initial stages of the CARES process, the construction budget was nearly flat-lined pending the outcome. This caused a major backup in construction projects and needed seismic repairs. Further, the CARES initiative attempted to address many of VA's hot-button issues to include long-term care, mental health and access to health care for rural veterans. While not initially successful, CARES did lead to the publication of a mental health strategic plan, and a long-term care plan is in the works. VA has also somewhat addressed a major feature in the CARES report -- the rural access issue -- by completing a study and implementing new guidelines.

In May 2004, the CARES decision was released. While it was not really a final decision for many locations, it outlined needed guidance for many VA leaders. The CARES decision also called for additional studies at 18 locations to continue developing and refining the analyses for those locations. VA also estimated a "substantial" amount of money would be needed to start the process and that it would need \$1 billion a year for the next five or six years to carry out the hundreds of construction projects that were recommended.

Finally, the Veterans Health Administration (VHA) began to fold CARES into its strategic planning process beginning with the Fiscal Year (FY) 2005 submissions.

Major Medical Facility Projects

Las Vegas

The American Legion has seen firsthand the unbearable situation the veterans in Las Vegas have faced for many years in accessing health care. After the brand-new ambulatory care clinic nearly collapsed on itself due to poor craftsmanship, the building was condemned which forced veterans to get their care in geographically dispersed buildings. There are five primary health clinics all operating under short-term leases.

In many cases, veterans have to ride the shuttle to get from one appointment to the next. If they are late, their appointment gets cancelled. It doesn't matter if it was because the bus or shuttle was stuck in traffic.

Veterans served in Las Vegas have been promised for years that they will get a new facility. It now looks like it won't be until at least 2011. That's a long time. The area is growing and the veteran population along with it. So too is the cost of construction.

As of today, there has been funding for site selection and design, but nothing for actual construction.

Denver

In June 2005, then National Commander Tom Cadmus visited the Denver campus as part of the System Worth Saving (SWS -- an American Legion on-site inspection of VA medical facilities) Task Force site visits. It was reported to him that costs to maintain the 50-year-old facility continue to escalate. The medical center is also operating at well above its designed capacity. VA has conceded through CARES planning that the present Denver facility must be replaced, and it was listed along with Las Vegas and Orlando as priorities for new VA medical centers when the CARES decision was issued.

According to the Denver VA's own critique of its physical condition:

- **Fixed equipment.** Most are past useful life, particularly for radiology and nuclear imaging.
- **Interior finishes.** Most are circa 1986. Areas such as doors, wall bumpers, and carpet need replacement.
- **Fire-alarm system.** These are in poor condition and are being replaced.
- **Air-handling systems.** Most are no better than average condition, some below standard, or are inadequate.
- **Duct work and piping.** Fair to poor condition.
- **Refrigeration.** Most coolers and chillers are in fair to poor condition and have exceeded useful life.
- **Ventilation.** In fair condition, with some areas underserved.

- **Plumbing.** Some 80% of water and drain piping are original to structure and are at the end of their useful life.
- **Boiler plant.** Boilers and peripheral equipment, with some exceptions, are in fair condition, though controls are obsolete and must be replaced.
- **Parking.** "Insufficient for employees."

It has been recognized and acknowledged over the past several years, even before the CARES process, that Denver was in need of a new medical center.

Orlando

Through the CARES process, the Central Florida market was underserved. Less than half of the area veterans are within access standards for hospital care. There is clearly a need to build a new inpatient facility in Orlando.

New Orleans

The American Legion's SWS team visited the New Orleans area in February 2006. Prior to the cataclysmic effects of Hurricane Katrina at the end of August 2005, the New Orleans VA Medical Center (VAMC) provided primary, secondary and tertiary care to over 36,000 veterans throughout southeast Louisiana, the Mississippi Gulf Coast and the Florida Panhandle. The VAMC in New Orleans together with its Baton Rouge clinic together accommodated some 370,000 visits annually. Today, the VAMC no longer exists as a functioning hospital. Its functions having been taken up by VA clinics across the state which have sprouted almost like mushrooms since the hurricane. The top floors of one of the old medical center's buildings, known as "10G" for its building location designator is now being utilized as an outpatient clinic. Another floor is to open shortly, designated "9G" with more to follow. The New Orleans PTSD program was slated to return in March but has, unfortunately, been delayed to this summer.

In February 2006, VA signed an agreement to rebuild with a brand-new hospital in New Orleans in partnership with Louisiana State University. At the signing VA Under Secretary for Health Dr. Jonathan Perlin said, "We will replace an aging, outdated facility built in the 1950s with a state-of-the-art medical center to provide care for veterans well into the 21st century." The American Legion supports the relationships that VA enjoys with the medical school. However, we remain adamant that the VA health care system retains its own identity.

The American Legion supported the CARES process conditionally. The American Legion believes that generally it was a fair and honest effort at attempting to assess the future needs of VA, both through the evaluation of needed infrastructure and services to veterans. We do not want to see the process stalled due to the effect of "paralysis by analysis." VA has thoroughly documented the need for new hospitals or replacement facilities in each of the above-mentioned locations. There are still 17 sites that are awaiting some type of decision by the Secretary regarding facilities and services in local communities. The American Legion urges VA to continue with the CARES process. The veterans who receive care at VA facilities deserve that.

VA has improved by leaps and bounds since 1994. It has been recognized on numerous occasions as a leader in providing safe, high-quality health care to the nation's veterans. In addition to setting the public and private sector benchmark for health-care satisfaction for the sixth consecutive year, VA has also received accolades on patient safety and quality and is considered by many to be a model for health-care delivery in America.

The American Legion has long recognized the necessity for a health-care system that revolves around the special needs of veterans. Veterans serving in Iraq, Afghanistan and all corners of the globe are returning home with severely debilitating injuries and are now faced with new challenges they never considered before. Loss of limb(s), traumatic brain injury, mental conditions, stress reactions, post-traumatic stress disorder, spinal cord injury and blindness are now realities to these young heroes. VA must be there, leading the way, to help heal them and rehabilitate them. VA must be capable of providing the programs and services needed to help all qualified veterans lead the most productive and healthy lives possible. VA must continue to look to the future and assess the needs of this ever-changing population.

Thank you Mr. Chairman, again, for this opportunity to appear before this Committee. We look forward to working with you to help shape the future of VA health-care delivery.

The
American
Legion



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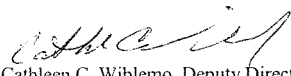
May 11, 2006

Honorable Steve Buyer, Chairman
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Buyer:

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the May 11th hearing, concerning Right-sizing The Department of Veterans Affairs Infrastructure.

Sincerely,



Cathleen C. Wiblemo, Deputy Director
Veterans Affairs and Rehabilitation Commission

BIOGRAPHY
CATHLEEN C. WIBLEMO
DEPUTY DIRECTOR, HEALTH CARE
VETERANS AFFAIRS AND REHABILITATION DIVISION

Ms. Wiblemo has been with The American Legion National headquarters since November 1999. She is currently the Deputy Director for Health Care. Prior to serving in her current position, she was the Assistant Director for Resource Development and before that she served as an Appeals Representative with the Special Claims Unit.

Ms. Wiblemo is a graduate of Black Hills State University in South Dakota, where she received her B.S. degree in History. She was the recipient of a ROTC scholarship and the George C. Marshall award. Upon graduation in December 1984, she was commissioned a 2nd Lieutenant in the United States Army. During her 10 years in the military she served in various positions both in country and overseas. She is currently a Major in the reserves.

During her military service, Ms. Wiblemo received many awards, most notably the Meritorious Service Medal. In August 1999 she received her Masters of Health Administration from Chapman University.

Ms. Wiblemo is a member of Post 176 in Alexandria, Virginia. Originally from Mitchell, South Dakota, she and her son, Zachary, currently reside in Alexandria, Virginia.

**STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 11, 2006**

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present written testimony on the views of the Disabled American Veterans (DAV) and its Auxiliary concerning the Department of Veterans Affairs (VA) capital investment programs for fiscal year (FY) 2007, including the necessity to authorize major medical facility construction projects and address other capital asset and construction issues.

As an organization of more than 1.3 million service-connected disabled veterans, DAV has had a vital interest in VA plans to restructure its health care system under the Capital Asset Realignment for Enhanced Services (CARES) initiative. This testimony is intended to focus on VA's proposed FY 2007 major medical facility construction program, with specific attention to its relationship to the ongoing CARES initiative.

According to VA, the goal of CARES since its inception was to enhance access to health care services for veterans while ensuring the integrity of the health care system through a rigorous review of populations, markets and current versus needed infrastructure. We have supported but closely monitored CARES since its inception more than five years ago. During those years of study, very few VA major medical facility projects were proposed by VA and none were authorized by Congress, pending the resolution of CARES. One of the most important VA benefits for service-connected veterans is available and accessible VA health care—especially for those who have suffered severe or catastrophic disabilities as a direct result of military service. Therefore, preservation and enhancement of the VA health care system and its specialized programs to meet those needs are of the utmost importance to DAV and its membership.

Clearly, CARES was the most comprehensive assessment ever undertaken in VA to determine the capital infrastructure VA needs to provide modernized health care to veterans now and into the future. VA staff, contractors, the CARES Commission, Congress, veterans service organizations, and many DAV members have invested a significant amount of time and energy in gathering data and providing oversight of this initiative. VA has expended millions of dollars to make CARES an effective, transparent, and equitable system of determining VA's future capital investment needs, as well as to fairly identify VA facilities not needed in the future and to develop plans to dispose of those facilities. The CARES process was seen then, and is seen now by DAV, as extremely important since it will impact the system and the delivery of health care services to veterans for decades to come. Similar to veterans of previous wars now

enrolled in VA health care, many of the wounded and sick men and women who have served in military deployments in Iraq, Afghanistan and other trouble spots around the world will need to depend on the VA health care system for decades. As an organization, it is our obligation to ensure they have access to a strong and viable system, dedicated specifically to their health care needs.

The VA FY 2007 budget request included a total of \$714 million in capital funding, including \$399 million for major construction projects, \$198 million for minor construction, \$85 million in grants for the construction of state extended care facilities (state veterans homes), and \$32 million in grants for the construction of state veterans cemeteries.

We note that in December 2005 VA received \$293 million to restore the Biloxi, Mississippi facility, and received \$75 million more for advance planning for the eventual replacement of the New Orleans, Louisiana facility. Because Hurricane Katrina severely damaged both of these VA facilities, Congress provided funding to replace and repair these structures in an emergency supplemental appropriations act. While we appreciate Congressional support for replacement of appropriate facilities that suffered damage along the Gulf coast in this instance, we are concerned that these completed actions not be allowed to distract Congress from the larger unmet need for VA and Congress to fully fund the CARES process for the remainder of the national VA health care system. Costs for these two facilities alone well exceed the level of funding VA intends to spend to carry out CARES-based projects nationwide in FY 2007.

The FY 2007 request for construction funding for VA medical facilities is \$457 million—\$307 million for major construction and \$150 million for minor construction. VA indicated these resources, if provided by Congress, are to be devoted to implementing projects identified in CARES. We draw the Committee's attention, however, to then-VA Secretary Anthony Principi's words in his acceptance of the CARES Commission report in May 2004: "*I anticipate the [CARES] process will require additional investments of approximately \$1 billion per year for at least the next five years, with substantial infrastructure investments then continuing for the indefinite future.*" (Emphasis added)

Trusting Secretary Principi's prediction to be an accurate description of identified needs, we believe VA is already seriously in arrears on that schedule. At the expected funding rate for major medical facility projects prioritized under CARES and accepted by Secretary Principi and presumably by Secretary Nicholson, then considering the level of funding requested for FY 2007, VA will require a decade or more to modernize its facilities in conformance with the Secretary's CARES decision. This comes after a five-year major medical facility construction "time out." Given the history of CARES, this is unacceptable to DAV and we believe it should be unacceptable to Congress. We believe Congress should hold VA accountable for following through on its promises with respect to CARES by allocating \$1 billion per year for this purpose (for VA major medical facility projects identified in CARES and accepted by the Secretary) over a five-year period to make the promise of CARES a reality. Otherwise, veterans are being

shortchanged and VA, in the words of Secretary Principi, would be left, "...with numerous redundant, outmoded, or poorly located facilities..." for the care of veterans.

As indicated in the budget, the FY 2007 major construction request for health care would fund the following projects:

- medical facility project, in Long Beach, California, and land acquisition for the replacement project in Denver, Colorado;
- a seismic and facilities project in American Lake, Washington;
- a spinal cord injury center in Milwaukee, Wisconsin;
- a new operating room suite in Columbia, Missouri;
- a relatively small improvement at the Jefferson Barracks Division, in St. Louis, Missouri.

The remainder of VA's construction request relates to non-medical projects. Given these plans, DAV is concerned that VA is straying off course from CARES only two short years after the VA Secretary formally accepted the results of the initiative and indicated it would be the primary driver of capital decisions for years to come.

The CARES Decision Memorandum of May 2004, approved by the VA Secretary, identified the need to complete a large portfolio of major capital projects (almost all of which would be categorized in law as "major medical facility construction projects," and thus, must be authorized and appropriated by Congress). The Secretary conveyed those major needs in a letter report to the Committee dated May 20, 2004. A copy of that communication is attached to this statement for the information of this Committee. Given that the vast majority of these projects have not progressed in two years, we recommend Committee oversight to inquire as to their status, versus those that VA now recommends to Congress.

We are concerned that several of the projects VA deemed high priority CARES projects do not appear in VA's FY 2007 budget request. To maintain transparency in the CARES process, we would like to know why other projects have taken priority or supplanted them, or why VA is not requesting the level of funding for projects in accordance with the CARES Decision Memorandum. We believe strong Committee oversight is in order to re-focus VA on setting a more appropriate level of resources to address these needs in established priority order, and in a timely manner. Doing so will keep the promise of CARES and keep faith with those who supported CARES over the past five years.

In closing, we want the Committee to know DAV is searching through the "lens" provided by CARES, to see if Congress in fact will use CARES to improve the infrastructure of the VA health care system so that it can best meet the needs of sick and disabled veterans into the future. In our view the Administration, VA, and Congress should collectively work together to provide sufficient resources to assure these improvements are realized in accordance with the CARES plan, and the Secretary's CARES Decision Memorandum. Likewise, we in the veterans organization community

intend to remain vigilant to ensure the value of VA's physical assets is neither wasted nor goes wanting. Significant upgrades and replacements of many VA facilities are long overdue. The unique needs of individual VA facilities and associated projects are clearly identified in CARES, and should be addressed expeditiously. Finally, oversight by Congress, veterans, veterans service organizations and other interested parties is essential to the success of CARES. In the words of Secretary Principi, "The case is clear. Veterans will be best served by action to modernize VA now, not by delay."

DAV appreciates the Committee's holding this hearing to consider capital construction matters, and inviting DAV to submit testimony on this important issue.



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 20, 2004

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed is a report entitled CARES Major Construction Projects FY 2004 – 2010. It includes the Department of Veterans Affairs' (VA) highest priority major medical facility construction requirements over the next 5 years. The projects identified in the report support the recommendations included in the CARES Decision report which was released on May 7, 2004. VA will pursue the projects listed in FY 2004 and 2005, as authorized by section 221 of Public Law 108-170, 45 days after the submission of this interim report. As I stated in the CARES Decision report, implementation of CARES will not be instantaneous; however, once Congress approves the FY 2005 budget request, we will have more than \$1 billion available to begin renovating and modernizing VA's health care system, when added to the 2004 funds already available. While we will assess what amounts should be funded in future budgets and evaluate our estimates for out-year funding streams at that time, my decision report indicates that I anticipate the process will require additional investments of approximately \$1 billion per year for at least the next five years in order to improve VA's infrastructure and enhance veterans' access to care.

A more comprehensive 5-year capital plan will be submitted to the Committees in the next several weeks. It will also include other specific capital requirements such as leasing and minor construction.

As always, I appreciate your continued support for VA and the programs we provide for the Nation's veterans. If you have any questions or concerns regarding this interim report, please have a member of your staff contact Ms. Kathleen Sullivan, Congressional Relations Officer, on (202) 273-6068.

Similar letters have been sent to the other leaders of the Senate and House Committees on Appropriations and Veterans' Affairs.

Sincerely yours,

A handwritten signature in black ink that reads "Anthony J. Principi".

Anthony J. Principi

Enclosure

CARES Major Construction Projects FY 2004 - 2010

VA has identified specific major construction capital requirements needed to implement CARES for fiscal years 2004 through 2010. These projects were identified through the CARES planning process in order to meet the challenges of providing veterans' health care in the 21st century and to implement the decisions identified in the Secretary's decision document released on May 7. Over one hundred CARES concept papers and business case applications were submitted and reviewed through VA's capital investment process utilizing criteria approved by the Secretary. The CARES capital criteria comply with Public Law 108-170.

In the next 6 months, the Department intends to make 28 design awards, 1 land purchase, and a construction award for a bed tower at Chicago, IL. VA will utilize available funds (FY 2004 and prior year appropriations) along with funds included in the FY 2005 President's budget request to carry out these awards. These projects are VA's highest priority, and the Department will proceed with planning and construction once Congressional requirements are met. Per Section 221 of Public Law 108-170, the Secretary may carry out the major construction projects specified in the final CARES report 45 days after submittal of this interim report to the Authorization Committees. This authority expires in December 2006.

VA's capital investment planning process and methodology ensures a Department-wide approach for the use of capital funds and ensures all major investments are based upon sound economic principles and are fully linked to strategic planning, budget, and performance measures and targets. The CARES process focused on capital requirements at a macro-level by using projections of beds and inpatient and outpatient services. Once performance gaps were identified in the market plans, business case applications were developed for specific major construction projects in order to fill these gaps. Business case applications were scored and prioritized based on how well they addressed each of the criteria in the capital decision model.

Attachment 1 identifies VA's major capital investment priorities for FY 2004 and 2005. VA is adhering to the rigor of its capital investment methodology by funding projects in priority order except where additional analysis is pending or to maximize utilization of each year's appropriation. A complete list of VA's top 48 priorities is listed in attachment 2 and attachment 3 contains those projects that will be developed for prioritization and consideration in subsequent 5-year capital plan submissions. In order to optimize funding availability and maximize management flexibility, construction projects with a total estimated cost in excess of \$65M are split-funded, meaning design (usually 10 percent) is funded in one year and construction is funded in a subsequent year. Attachment 4 identifies the major criteria of the capital investment decision model that was used to evaluate and prioritize the investments.

It is important to note that this is the first iteration of the CARES-specific project needs. All out-year projects will need to be re-evaluated prior to release of the budget submission, and adjusted annually thereafter. An updated 5-year Capital Plan will

accompany the annual budget request each year and will reflect the most current costs, phasing, and priorities of the Department. A more detailed 5-Year Capital Plan will be submitted in May 2004, which will include other Department projects (including those of the National Cemetery Administration and Veterans Benefits Administration). In addition, the plan will include information pertaining to additional authorization requirements, congressional notification, and other significant capital asset management issues and programs such as leases and minor construction.

ATTACHMENT 1

FY 2004 AND FY 2005 MAJOR CAPITAL INVESTMENTS

FY2004

VISN	Location	Project Title	Priority #	Estimated Cost (\$000)
12	Chicago	IL Bed Tower	*	\$98,500
12	North Chicago	IL Joint VA and Dept of Navy Medical Project	*	\$13,000
21	Palo Alto	CA Seismic Corrections Bldg. 2	1	\$34,000
10	Cleveland	OH Cleveland-Brecksville Consolidation, Ph 1 Design	2	\$15,000
4	Pittsburgh	PA Consolidation of Campuses, Ph 1 Design	3	\$20,000
23	Minneapolis	MN SCI & SCD Center	4	\$20,500
22	Las Vegas	NV New Fed Med Facility, Design and Land Purchase	6	\$60,000
8	Gainesville	FL Correct Patient Privacy Deficiencies, Ph 1-Design	7	\$8,800
11	Indianapolis	IN 7 th & 8 th Floor Wards Modernization Addition	8	\$27,400
18	Tucson	AZ Mental Health Clinic	9	\$12,100
19	Denver	CO New Federal Medical Facility, Ph 1 Design	10	\$30,000
17	San Antonio	TX Ward Upgrades and Expansion	11	\$19,100
8	Orlando	FL Bed Tower, Ph 1-Design	12	\$25,000
8	Tampa	FL Upgrade Essential Electrical Distribution Systems	13	\$49,000
10	Columbus	OH Construction of Outpatient Clinic	14	\$94,800
6	Durham	NC Renovate Patient Wards	15	\$9,100
22	Long Beach	CA Seismic Corrections-Bldgs 7 & 126, Ph 1 Design	16	\$10,300
20	Anchorage	AK Outpatient Clinic and Regional Office, Ph 1 Design	18**	\$11,760
	Various	Line Items		\$64,378
	Subtotal			\$622,738
	Minors			\$265,000
	Total¹			\$887,738

¹ Appropriations	\$417,820
Transfer Authority	\$400,000
Prior Yr Minor Construction Funds	\$59,918
Indianapolis EU Trust	\$10,000
	\$887,738

*Projects approved in the pilot CARES study for Network 12 – Chicago/Wisconsin

**Priority 17 and 18 are reversed to maximize the utilization of the funding requested in the 2004 budget

FY2005

VISN	Location	Project Title	Priority #	Estimated Cost (\$000)
8	Tampa	FL SCI Expansion	5*	\$7,100
16	Pensacola	FL Joint VA and Dept of Navy OPC	17	\$55,500
17	Temple	TX Blind and Psychiatric Beds	19	\$56,000
8	San Juan	PR Seismic Corrections-Bldg. 1, Ph 1 Design	20	\$15,000
2	Syracuse	NY Construct Addition for Spinal Cord Injury (SCI) Center	21	\$53,900
7	Atlanta	GA Wards Modernization	22	\$20,700
21	Menlo Park	CA Seismic Correct –Geropsych NH Replacement (B 324)	23	\$33,239
21	San Francisco	CA Seismic Corrections-Bldg. 203	24	\$41,500
22	Los Angeles	CA Seismic Corrections-Bldgs. 500 & 501, Ph 1 Design	25	\$8,000
8	Lee County	FL Outpatient Clinic Design	26	\$6,510
23	Des Moines	IA Extended Care Building	27	\$25,000
22	San Diego	CA Seismic Corrections-Bldg. 1	29**	\$48,260
	Various	Line Items		\$30,091
	Subtotal			\$400,800
	Minors			\$182,000
	Total¹			\$582,800

¹ CARES Appropriations	\$524,000
Other Medical Construction Appropriations	\$58,800
	\$582,800

*Delayed pending results of further SCI study

**Priority numbers 28 and 29 are reversed to maximize the utilization of the funding as requested in the 2005 budget

VA'S HIGHEST MAJOR CONSTRUCTION PRIORITIES

VISN	Location	State	Project Title	Priority
12	Chicago	IL	Bed Tower	*
12	North Chicago	IL	Joint VA and Dept of Navy Medical Project	*
21	Palo Alto	CA	Seismic Corrections Bldg. 2	1
10	Cleveland	OH	Cleveland-Brecksville Consolidation	2
4	Pittsburgh	PA	Consolidation of Campuses	3
23	Minneapolis	MN	SCI & SCD Center	4
8	Tampa	FL	SCI Expansion	5
22	Las Vegas	NV	New Federal Medical Facility	6
8	Gainesville	FL	Correct Patient Privacy Deficiencies	7
11	Indianapolis	IN	7th & 8th Floor Wards Modernization Addition	8
18	Tucson	AZ	Mental Health Clinic	9
19	Denver	CO	New Federal Medical Facility	10
17	San Antonio	TX	Ward Upgrades and Expansion	11
8	Orlando	FL	Bed Tower	12
8	Tampa	FL	Upgrade Essential Electrical Distribution Systems	13
10	Columbus	OH	Construction of the Chalmers P. Wylie VA Outpatient Clinic	14
6	Durham	NC	Renovate Patient Wards	15
22	Long Beach	CA	Seismic Corrections-Bldgs 7 & 126	16
16	Pensacola	FL	Joint VA and Dept of Navy OPC	17
20	Anchorage	AK	Outpatient Clinic and Regional Office	18
17	Temple	TX	Blind and Psychiatric Beds	19
8	San Juan	PR	Seismic Corrections-Bldg. 1	20
2	Syracuse	NY	Construct Addition for Spinal Cord Injury (SCI) Center	21
7	Atlanta	GA	Wards Modernization	22
21	Menlo Park	CA	Seismic Corrections-Geropsych Nursing Home Replace (B324)	23
21	San Francisco	CA	Seismic Corrections-Bldg. 203	24
22	Los Angeles	CA	Seismic Corrections-Bldgs. 500 & 501, Ph 1 Design	25
22	Los Angeles	CA	Seismic Corrections-Bldgs. 500 & 501, Ph 2 Construction	25
8	Lee County	FL	Outpatient Clinic	26
23	Des Moines	IA	Extended Care Building	27
22	San Diego	CA	Seismic Corrections-Bldg. 1	29
17	Dallas	TX	Clinical Expansion	28**
4	Butler	PA	Construction of a 100 Bed Nursing Home	30
21	San Francisco	CA	Seismic Corrections-Bldgs 1,6,8 & 12	31
20	American Lake	WA	Seismic Corrections Nursing Home Replacement (Bldgs 2 & 3)	32
22	Long Beach	CA	Seismic Corrections-Bldgs 128 & 133	33
15	Columbia	MO	Operating Suite Renovation	34
7	Huntsville	AL	Out Patient Clinic	35
5	Washington	DC	Ambulatory Care Expansion, Ph 1 Design	36
7	Columbia	SC	Renovation/Construction Dx & Ancillary Care/Spec. Care Space	37
21	Fresno	CA	Ambulatory Care Addition	38
16	Fayetteville	AR	Clinical Addition	39
1	West Haven	CT	New Bed Tower and Research Addition	40

ATTACHMENT 2

VISN	Location		Project Title	Priority
12	Madison	WI	Nursing Home Renovation & Expansion	41
15	St. Louis	MO	Building Renovations & Land Transfer to NCA	42
22	Loma Linda	CA	Clinical and Research Addition, Ph 1 Design	43
5	Martinsburg	WV	Ambulatory Care Improvements	44
4	Lebanon	PA	Nursing Home Renovation	45
5	Beckley	WV	Construction of a 120 Bed Nursing Home	46
5	Perry Point	MD	Construction of a 130 Bed Nursing Home	47
3	Northport	NY	Renovation of Residential and Ambulatory Care	48

* Projects approved in the pilot CARES study for Network 12 - Chicago/Wisconsin

** Priority 28 and 29 are reversed to maximize the utilization of the funding as requested in the 2005 budget.

FUTURE POTENTIAL PROJECTS FOR INCLUSION IN SUBSEQUENT REQUESTS

The following are potential projects from which VA will select for inclusion in future requests.

VISN	LOCATION	PROJECT
1	Providence	RI Outpatient Specialties Clinics & Ancillary Services Addition
1	Boston	MA Place Holder for Boston Study, Ph 2 Construction
3	New York	NY Expand Primary Care
3	New York	NY Place Holder for New York Study, Ph 2 Construction
3	Bronx	NY Construct SCI Building
3	Castle Point	NY Psych & NHCU Integration
3	East Orange	NJ Clinical Addition
3	East Orange	NJ VBA-VHA Co-location
3	St. Albans	NY New NHCU Facility
3	Montrose	NY New Outpatient Building
3	Northport	NY Construct Specialty Care Pavilion
4	Philadelphia	PA Expand Parking Garage
4	Philadelphia	PA Behavioral Health Research Bldg
5	Washington	DC Ambulatory Care Expansion, Ph 2 Construction
6	Salisbury	NC Clinical Addition Specialty Care & Ancillary-Diagnostic Svcs
6	Fayetteville	NC Fayetteville Outpatient Addition
6	Durham	NC Outpatient Addition
6	Asheville	NC Outpatient Services Expansion
6	Hampton	VA Ambulatory Care Specialty Clinic Expansion
7	Atlanta	GA Ancillary Care
7	Bessemer	AL Bessemer Outpatient Clinic
7	Birmingham	AL Parking Deck
8	Tampa	FL Fire Safety/Sprinkler Improvements
8	Bay Pines	FL Consolidation of Clinical Services
8	Tampa	FL Construct CARES Supported Infrastructure
8	Tampa	FL Improve Patient Parking
8	Tampa	FL Correct CARES FCA-Identified Deficiencies
9	Louisville	KY Place Holder for Louisville Study, Ph 2 Construction
12	Milwaukee	WI SCI Center
15	Marion	IL Outpatient and Inpatient Clinical Addition
15	Kansas City	MO Ambulatory Care Addition
15	St. Louis	MO Patient Privacy, Acute Med/Surg patients, JC
15	Columbia	MO Expand Ambulatory Care Addition
15	Poplar Bluff	MO HVAC System
15	St. Louis	MO Backfill Bldg 1 JC for Diagnostics
15	Wichita	KS Outpatient Specialty Care/Ancillary/Dx Clinical Additions/Modernizations
16	Shreveport	LA Clinical Addition for Specialty Care & DX Services
16	Biloxi	MS Addition/ Expansion
16	Biloxi	MS NHCU Replacement
16	Jackson	MS Bldg. 7 Addition & Renovation for Med / Surg, NHCU & Specialty Care
16	Houston	TX Outpatient Specialty Care Space
17	Temple	TX Ambulatory Care Addition
18	Tucson	AZ Diagnostic Building
18	Albuquerque	NM Outpatient Building

ATTACHMENT 3

VISN	LOCATION		PROJECT
18	Phoenix	AZ	Amb Care Addition
19	Ft Harrison	MT	Seismic Corrections, Hosp Bldg 154
20	Seattle	WA	B101 Mental Health/Research Bldg. (S)
20	Roseburg	OR	Seismic Upgrade B2
20	Tacoma	WA	Correct Seismic Defs., B81 (A)
20	Seattle	WA	B100, Expansion Floors 3 & 4, D&T (S)
21	Palo Alto	CA	Amb Care/Research (Seismic Replace B 4, 23, 54, MB2, MB3, and MB4)
21	Monterey	CA	VA/DoD Ambulatory Care Center
21	San Francisco	CA	New Parking Garage
21	San Francisco	CA	ADA Upgrade (Entire campus & grounds)
22	Loma Linda	CA	Clinical and Research Addition, Ph 2 Construction
22	San Diego	CA	Research Building
22	Los Angeles	CA	Research Building Replacement
22	Los Angeles	CA	NHCU Replacement
22	West Los Angeles	CA	Construct Clinic Addition / Consolidate Services
23	Iowa City	IA	Primary Care Clinic
23	Iowa City	IA	Construct Parking Garage
23	Fargo	ND	Specialty Care Addition

CARES Capital Criteria - Summary Definitions

Service Delivery Enhancements: This criterion addresses how the capital investment meets CARES market plan implementation. Projects that were replacement (effected by closure or realignment) received top priority.

Safeguard Assets: This criterion addresses how well the capital investment results in a decrease in designated high-risk assets or increases the Department's compliance with patient and employee safety.

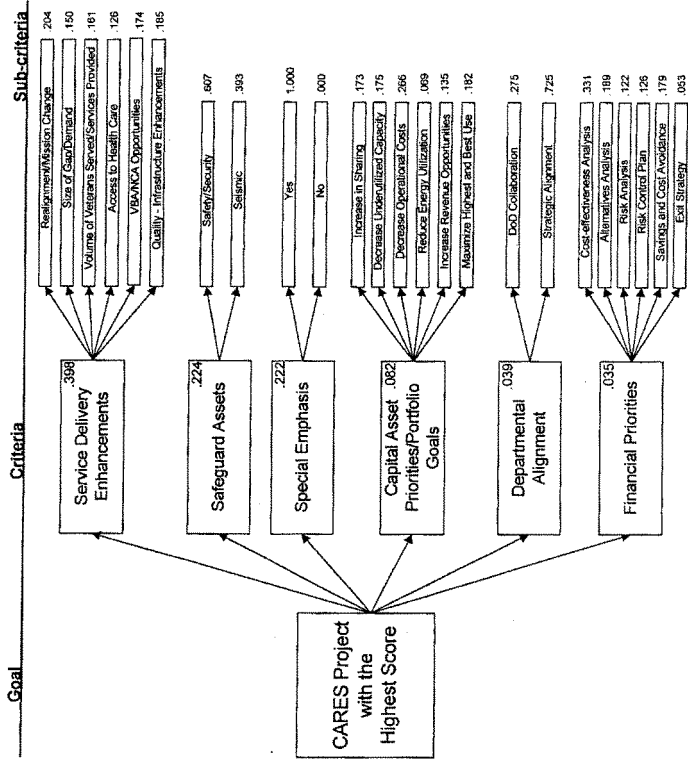
Special Emphasis: This criterion gives preference to those capital investments that substantially support special emphasis programs and services including: spinal cord injury and disorders; blindness; traumatic brain injury; serious mental illness; and post-traumatic stress disorder.

Capital Portfolio Goals: This criterion addresses how the capital investment meets the Department's capital portfolio goals, such as increasing intra- and interagency and community based sharing, and decreasing underutilized assets and operating costs.

Departmental Alignment: This criterion is comprised of priorities from the President's Management Agenda and Secretary's goals for improved management and performance across the Department.

Financial Priorities: This criterion addresses the specific financial metrics, benefits and risks of the selected acquisition when compared to other explored alternatives (e.g., leasing versus construction)

FY 2004-2006 CARES Capital Investment Decision Model





THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
April 5, 2006



The Honorable J. Dennis Hastert
Speaker of the House of
Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

There is transmitted herewith a draft bill, to authorize \$1,606,000,000 for Department of Veterans Affairs (VA) major facility construction projects and \$24,990,000 for major facility leases for fiscal year (FY) 2006 and \$351,966,000 for major facility construction projects and \$26,642,000 for major facility leases for FY 2007. In addition, the draft bill requests an extension of time within which to make contract awards from September 30, 2006, to September 30, 2009, for 18 projects previously authorized under Public Law 108-170. It is requested that the bill be referred to the appropriate committee and favorably considered for prompt enactment.

Title 38, U.S.C., section 8104(a) (2) requires statutory authorization for all VA major medical facility construction projects and all major medical facility leases prior to the appropriation of funds. In accordance with title 38, the draft bill authorizes three projects that are in need of immediate FY 2006 authorization. These projects are located in New Orleans, Louisiana; Biloxi, Mississippi; and Denver, Colorado. Also requiring authorization in FY 2006 are three leases in Baltimore, Maryland; Evansville, Illinois; and Smith County, Texas. For FY 2007, the draft bill authorizes six projects in American Lake, Washington; Columbia, Missouri; Fayetteville, Arkansas; Milwaukee, Wisconsin; St. Louis, Missouri; and San Juan, Puerto Rico, and leases located in Austin, Texas; Lowell, Massachusetts; Grand Rapids, Michigan; Las Vegas, Nevada; and Parma, Ohio.

I would like to begin briefly discussing the projects included in the bill by highlighting those that are in immediate need of FY 2006 authorization. The project in New Orleans, Louisiana, is for construction, renovation, or replacement of the Department of Veterans Affairs Medical Center (VAMC) due to damage from Hurricane Katrina. Likewise, the project to restore the VAMC in Biloxi, Mississippi, and consolidate the services performed in Gulfport Mississippi is necessary because of damage from Hurricane Katrina. The Denver VAMC was constructed in the 1950s and most of the core facilities are deemed to be past or near the end of their useful life.

The Department of Veterans Affairs sees the move of the Denver VAMC to Fitzsimons as an opportunity to create a state-of-the-art medical center to meet veterans' current and future needs.

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The Honorable J. Dennis Hastert

The draft bill also includes 18 major medical facility construction projects that were authorized under Public Law 108-170, but for which it is unlikely that contract awards will be accomplished by September 30, 2006, as required by that law. Therefore, for each of these projects, the draft bill extends the date by which contracts must be awarded from September 30, 2006, to September 30, 2009. A full description of each of these projects is included in the Department's 5-Year Capital Plan, 2004-2009, June 28, 2004.

There are three FY 2006 major medical facility leases included in the draft bill. The Baltimore, Maryland, outpatient clinic lease will provide approximately 132,300 usable square feet of space in proximity to the existing medical center in Baltimore. The lease will meet projected space gaps for the primary care, mental health, and specialty clinics. The lease in Evansville, Illinois, would acquire approximately 126,600 usable square feet of space to replace and expand the existing lease which will expire on November 2008. The lease in Smith County, Texas, is for approximately 72,760 usable square feet for a comprehensive outpatient clinic needed in Smith County, Texas, to provide primary, specialty and mental health care services to veteran enrollees.

The draft bill includes six FY 2007 major medical facility construction projects. The seismic correction and construction of a nursing home care unit project in American Lake, Washington, will correct seismic, fire and life safety deficiencies. In Columbia, Missouri, the project is to construct a 27,000 square feet replacement for the operating room suite and renovate space for surgical support. The project will correct space and infrastructure deficiencies. A project in Fayetteville, Arkansas, for a clinical addition will help address the needs of the growing veteran population and provide a full continuum of patient-centered one-stop quality health care including primary and specialty care. The Spinal Cord Injury (SCI) Outpatient and Inpatient Center in Milwaukee, Wisconsin, is part of the comprehensive Center of Excellence for the physically challenged. Some of the goals of the project are to improve patient care, maximize patient services and quality of life, and meet the demands for SCI physical and recreational therapy. In St. Louis, Missouri, the project will renovate underutilized vacant space located on the Jefferson Barracks (JB) Campus at the VA Medical Center, as well as provide land for expanding the JB National Cemetery. In San Juan, Puerto Rico, the project is for seismic corrections in the main hospital building to comply with VA immediate occupancy standards.

Five FY 2007 major medical facility leases are also included in the draft bill. The lease of approximately 85,000 net usable square feet in Austin, Texas will relocate and expand outpatient specialty care services. The lease in Lowell, Massachusetts, is approximately 35,000 net usable square feet of outpatient clinic space in an area identified in the CARES report as having a significant healthcare gap. The lease in Grand Rapids, Michigan, will maintain outpatient medical care for the veterans residing

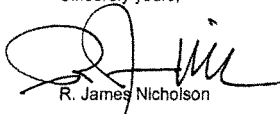
Page 3.

The Honorable J. Dennis Hastert

in Western Michigan. The current clinic is 58 percent under-sized. In Las Vegas, lease space of approximately 109,200 net usable square feet is for up to four primary care and mental health clinics in the metropolitan area. The lease of approximately 74,000 net usable square feet in Parma, Ohio, will replace the current primary care clinic at the Brecksville Division of Louis Stokes Cleveland VA Medical Center.

The Office of Management and Budget advises that the submission of this draft bill is in accord with the program of the President.

Sincerely yours,



R. James Nicholson

Enclosures

A BILL

To authorize major medical facility projects for the Department of Veterans Affairs for Fiscal Years 2006 and 2007 and for other purposes.

*Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,*

**SEC. 1. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS IN
IMMEDIATE NEED FOR FY 2006 AUTHORIZATION**

The Secretary of Veterans Affairs may carry out the following three major medical facility projects in immediate need of fiscal year 2006 authorization, with each project to be carried out in the amount specified for that project :

(1) Restoration, new construction or replacement of the medical center facility for the Department of Veterans Affairs Medical Center, New Orleans, Louisiana, due to damage from Hurricane Katrina in an amount not to exceed \$675,000,000.

(2) Restoration of the Department of Veterans Affairs Medical Center, Biloxi, Mississippi, and consolidation of services performed at the Veterans Affairs Medical Center, Gulfport, Mississippi, in an amount not to exceed \$310,000,000.

- (3) Replacement of the Department of Veterans Affairs Medical Center, Denver, Colorado, in an amount not to exceed \$621,000,000.

SEC. 2. EXTENSION OF AUTHORIZATION UNTIL SEPTEMBER 30, 2009, FOR MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS AUTHORIZED UNDER PUBLIC LAW 108-170

The Secretary of Veterans Affairs may carry out the following major medical facility projects that are authorized under Public Law 108-170 but will not likely accomplish contract award by September 30, 2006, as required by Public Law 108-170. Each of the following projects is to be carried out in the amount specified for that project and the deadline of September 30, 2006, is extended until September 30, 2009, for each project:

- (1) Construction of an outpatient clinic and regional office, at the Department of Veterans Affairs Medical Center, Anchorage, Alaska, in an amount not to exceed \$75,270,000.
 - (2) Consolidation of clinical and administrative functions of the Department of Veterans Affairs Medical Center in Cleveland, Ohio, and the Department of Veterans Affairs Medical Center in Brecksville, Ohio, in an amount not to exceed \$102,300,000.
 - (3) Construction of Extended Care Building at the Department of Veterans Affairs Medical Center in Des Moines, Iowa, in an amount not to exceed \$25,000,000.
-

(4) Renovation of patient wards at the Department of Veterans Affairs Medical Center in Durham, North Carolina, in an amount not to exceed \$9,100,000.

(5) Correction of patient privacy deficiencies at the Department of Veterans Affairs Medical Center, Gainesville, Florida, in an amount not to exceed \$85,200,000.

(6) 7th and 8th Floor Wards Modernization addition at the Department of Veterans Affairs Medical Center, Indianapolis, Indiana, in an amount not to exceed \$27,400,000.

(7) Construction of a new Medical Center Facility at the Department of Veterans Affairs Medical Center, Las Vegas, Nevada, in an amount not to exceed \$406,000,000.

(8) Construction of an Ambulatory Surgery/Outpatient Diagnostic Support Center in the Gulf South Submarket of VISN 8 and completion of Phase I land purchase, Lee County, Florida, in an amount not to exceed \$65,100,000.

(9) Seismic Corrections-Buildings 7 & 126 at the Department of Veterans Affairs Medical Center, Long Beach, California, in an amount not to exceed \$107,845,000.

(10) Seismic Corrections-Buildings 500 & 501 at the Department of Veterans Affairs Medical Center, Los Angeles, California, in an amount not to exceed \$79,900,000.

(11) Construction of a New Medical Center facility in the Orlando, Florida, area in an amount not to exceed \$377,700,000.

(12) Consolidation of Campuses at the University Drive and H. John Heinz III divisions, Pittsburgh, Pennsylvania, in an amount not to exceed \$189,205,000.

(13) Ward Upgrades and Expansion, at the Department of Veterans Affairs Medical Center, San Antonio, Texas, in an amount not to exceed \$19,100,000.

(14) Seismic Corrections-Building 1, Phase 1 Design at the Department of Veterans Affairs Medical Center, San Juan, Puerto Rico, in an amount not to exceed \$15,000,000.

(15) Construction of a Spinal Cord Injury Center at the Department of Veterans Affairs Medical Center, Syracuse, New York, in an amount not to exceed \$53,900,000.

(16) Upgrade Essential Electrical Distribution Systems at the Department of Veterans Affairs Medical Center, Tampa, Florida, in an amount not to exceed \$49,000,000.

(17) Expansion of the Spinal Cord Injury Center addition at the Department of Veterans Affairs Medical Center, Tampa, Florida, in an amount not to exceed \$7,100,000.

(18) Blind Rehabilitation and Psychiatric Bed renovation and new construction project at the Department of Veterans

Affairs Medical Center, Temple, Texas, in an amount not to exceed \$56,000,000.

SEC. 3. AUTHORIZATION OF FISCAL YEAR 2007 NEW MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS

The Secretary of Veterans Affairs may carry out the following fiscal year 2007 major medical facility projects in the amount specified for each project :

- (1) Seismic Corrections: NHCU & Dietetics at the Department of Veterans Affairs Medical Center, American Lake, Washington, in an amount not to exceed \$38,220,000.
 - (2) Replacement of Operating Suite at the Department of Veterans Affairs Medical Center, Columbia, Missouri, in an amount not to exceed \$25,830,000.
 - (3) Construction of a new clinical addition at the Department of Veterans Affairs Medical Center, Fayetteville, Arkansas, in an amount not to exceed \$56,163,000.
 - (4) Construction of Spinal Cord Injury Center at the Department of Veterans Affairs Medical Center, Milwaukee, Wisconsin, in an amount not to exceed \$32,500,000.
 - (5) Medical facility improvements and cemetery expansion of Jefferson Barracks at the Veterans Affairs Medical Center, St. Louis, Missouri, in an amount not to exceed \$69,053,000.
 - (6) Seismic Corrections-Building 1 at the Department of Veterans Affairs Medical Center, San Juan, Puerto Rico, in an amount not to exceed \$130,200,000.
-

SEC. 4. AUTHORIZATION OF FISCAL YEAR 2006 MAJOR MEDICAL FACILITY LEASES

The Secretary of Veterans Affairs may carry out the following fiscal year 2006 major medical facility leases at the locations specified, in an amount not to exceed the amount shown for that location:

- (1) Baltimore, Maryland, Outpatient Clinic, \$10,908,000.
- (2) Evansville, Illinois, Outpatient Clinic, \$8,989,000.
- (3) Smith County, Texas, Outpatient Clinic, \$5,093,000.

SEC. 5. AUTHORIZATION OF FISCAL YEAR 2007 MAJOR MEDICAL FACILITY LEASES

The Secretary of Veterans Affairs may carry out the following fiscal year 2007 major medical facility leases at the locations specified, in an amount for each facility lease not to exceed the amount shown for that location:

- (1) Austin, Texas, Outpatient and Specialty Care Clinic, \$6,163,000.
 - (2) Lowell, Massachusetts, Outpatient Clinic, \$2,520,000.
 - (3) Grand Rapids, Michigan, Outpatient Clinic, \$4,409,000.
 - (4) Las Vegas, Nevada, up to four Outpatient Clinics, \$8,518,000.
 - (5) Parma, Ohio, Outpatient Clinic, \$5,032,000.
-

SEC. 6 AUTHORIZATION OF APPROPRIATIONS

(a) IN GENERAL – There is authorized to be appropriated to the Secretary of Veterans Affairs for Fiscal Year 2006 or the year in which funds are appropriated—

(1) for the Construction, Major Projects Account,
\$1,606,000,000 for the projects authorized in paragraphs 1,
2, and 3 of Section 1.

(b) IN GENERAL – There is authorized to be appropriated to the Secretary of Veterans Affairs until Fiscal Year 2009—

(1) for the Construction, Major Projects, account
\$1,750,120,000 for the projects authorized in paragraphs 1
through 18, of Section 2;

(c) IN GENERAL – There is authorized to be appropriated to the Secretary of Veterans Affairs for Fiscal Year 2007 or the year in which funds are appropriated—

(1) for the Construction, Major Projects, account
\$351,966,000 for the projects authorized in paragraphs 1
through 6 of Section 3;

(d) IN GENERAL – There is authorized to be appropriated to the Secretary of Veterans Affairs for Fiscal Year 2006, 2007 or the year in which funds are appropriated—

(1) for the Medical Care account \$24,990,000 for the leases
authorized in paragraphs 1 through 3, of Section 4; and

(2) for the Medical Care account \$26,642,000 for the leases authorized in paragraphs 1 through 5, of Section 5.

(e) LIMITATION – The projects authorized in sections 1, 2, and 3 may only be carried out using —

(1) funds appropriated for fiscal year 2006 or fiscal year 2007 pursuant to the authorization of appropriations in subsections (a), (b), (c), and (d) of this section;

(2) funds available for Construction, Major Projects, for a fiscal year before fiscal year 2006 that remain available for obligation;

(3) funds available for Construction, Major Projects, for a fiscal year after fiscal year 2006 or fiscal year 2007 that remain available for obligation; and

(4) funds appropriated for Construction, Major Projects, for fiscal years 2006 or 2007 for a category of activity not specific to a project.

SEC. 7 OBLIGATION AND EXPENDITURE OF UNOBLIGATED BALANCES

Notwithstanding any other provision of law, the Secretary of Veterans Affairs may obligate and expend unobligated balances of the "Construction, Major Projects" appropriation to purchase a site for, and the construction of, the new Department of Veterans Affairs Medical Center, Denver, Colorado, and the new construction, restoration or replacement of the Department of Veterans Affairs Medical Center, New Orleans, Louisiana, and purchase a site for, and construction of the new medical center facility in the Orlando, Florida, area.

SECTION-BY-SECTION ANALYSIS

Section 1 authorizes the Secretary of the Department of Veterans Affairs (VA) to carry out three major medical facility projects for which there is an immediate need for fiscal year 2006 authorization. The projects are as follows: the construction, renovation, or replacement of the medical center facility for the Department of Veterans Affairs Medical Center (VAMC) in New Orleans, Louisiana, due to hurricane damages from Hurricane Katrina in an amount not to exceed \$675,000,000; restoration of the VAMC in Biloxi, Mississippi, and consolidation of services performed at the VAMC in Gulfport, Mississippi, in an amount not to exceed \$310,000,000; and replacement of the VAMC in Denver, Colorado, in an amount not to exceed \$621,000,000.

Section 2 extends the date for contract award from September 30, 2006, to September 30, 2009, for 18 major medical facility construction projects that were authorized under Public Law 108-170 but will not likely accomplish contract award by September 30, 2006, as required by P.L. 108-170.

The projects are: construction of an outpatient clinic and regional office, at the VAMC, Anchorage, Alaska, in an amount not to exceed \$75,270,000; consolidation of clinical and administrative functions of the VAMC, Cleveland, Ohio, and the VAMC, Brecksville, Ohio, in an amount not to exceed \$102,300,000; construction of extended care building at the VAMC, Des Moines, Iowa, in an amount not to exceed \$25,000,000; renovate patient wards at the VAMC, Durham, North Carolina, in an amount not to exceed \$9,100,000; correct patient privacy deficiencies at the VAMC, Gainesville, Florida, in an amount not to exceed \$85,200,000; 7th and 8th floor wards modernization addition at the VAMC, Indianapolis, Indiana, in an amount not to exceed \$27,400,000; construction of a new medical center facility at the VAMC, Las Vegas, Nevada, in an amount not to exceed \$406,000,000; construction of an ambulatory surgery/outpatient diagnostic support center in the Gulf South Submarket of VISN 8 and completion Phase I land purchase, Lee County, Florida, in an amount not to exceed \$65,100,000; seismic corrections-Buildings 7 & 126 at the VAMC, Long Beach, California, in an amount not to exceed \$107,845,000; seismic corrections-buildings 500 & 501 at the VAMC, Los Angeles, California, in an amount not to exceed \$79,900,000; construction of a new medical center facility in the Orlando, Florida area, in an amount not to exceed \$377,700,000; consolidation of campuses at the University Drive and H. John Heinz III divisions in Pittsburgh, Pennsylvania, in an amount not to exceed \$189,205,000; ward upgrades and expansion, at the VAMC, San Antonio, Texas, in an amount not to exceed \$19,100,000; seismic corrections-building 1 at the VAMC, San Juan, Puerto Rico, in an amount not to exceed \$15,000,000; construction of a Spinal Cord Injury Center at the VAMC, Syracuse, New York, in an amount not to

exceed \$53,900,000; upgrade essential electrical distribution systems at the VAMC, Tampa, Florida, in an amount not to exceed \$49,000,000; expansion of the Spinal Cord Injury Extended Care addition at the VAMC, Tampa, Florida, in an amount not to exceed \$7,100,000; and blind rehabilitation and psychiatric bed renovation and new construction project at the VAMC, Temple, Texas, in an amount not to exceed \$56,000,000.

Section 3 authorizes the Secretary of VA to carry out 6 major medical facility construction projects to be authorized in fiscal year 2007. The projects are as follows: seismic corrections: NHCU & dietetics at the VAMC, American Lake, Washington, in an amount not to exceed \$38,220,000; replacement of operating suite at the VAMC, Columbia, Missouri, in an amount not to exceed \$25,830,000; construction of a new clinical addition at the VAMC, Fayetteville, Arkansas, in an amount not to exceed \$56,163,000; construction of Spinal Cord Injury Center at the VAMC, Milwaukee, Wisconsin, in an amount not to exceed \$32,500,000; medical facility improvements and cemetery expansion of Jefferson Barracks at the VAMC, St. Louis, Missouri, in an amount not to exceed \$69,053,000; and seismic corrections in the main hospital building of the San Juan VAMC, San Juan, Puerto Rico, in an amount not to exceed \$130,200,000.

Section 4 authorizes the Secretary of VA to carry out major medical facility leases to be authorized in fiscal year 2006 and carried out at Baltimore, Maryland, outpatient clinic, in an amount not to exceed \$10,908,000, Evansville, Illinois, outpatient clinic, in an amount not to exceed \$8,989,000 and Smith County, Texas, outpatient clinic, in an amount not to exceed \$5,093,000.

Section 5 authorizes the Secretary of VA to carry out major medical facility leases to be authorized in fiscal year 2007 and carried out at Austin, Texas, outpatient and specialty clinic, in an amount not to exceed \$6,163,000, Lowell, Massachusetts, outpatient clinic, in an amount not to exceed \$2,520,000, Grand Rapids, Michigan, outpatient clinic, in an amount not to exceed \$4,409,000, Las Vegas, Nevada, up to four outpatient clinics, in an amount not to exceed \$8,518,000, and Parma, Ohio, outpatient clinic, in an amount not to exceed \$5,032,000.

Section 6 authorizes for appropriations for Fiscal Years 2006, 2007 or the year in which funds are appropriated, \$1,606,000,000 from the Major Construction Projects account for the projects authorized in paragraphs 1, 2 and 3 of Section 1; and \$1,750,120,000 from the Major Construction Projects account for the projects authorized in paragraphs 1 through 18 of Section 2. In addition, Section 6 authorizes for appropriations for Fiscal Years 2006, 2007, or the year in which funds are appropriated, \$51,632,000 from the Medical Care account for the leases authorized in paragraphs 1 through 3 of Section 4, and paragraphs 1 through 5 of Section 5. Section 6 also authorizes for appropriations \$351,966,000 from the Major Construction Projects account for the projects authorized in paragraphs 1 through 6 of Section 3. Section 6 allows the projects

authorized in sections 1, 2, and 3, to be carried out by using only 1) funds appropriated for fiscal year 2006 or 2007 pursuant to the authorization of appropriations in subsections a, b, c, and d; 2) funds available for Construction, Major Projects, for a fiscal year before fiscal year 2006 that remain available for obligation; 3) funds available for Construction, Major Projects, for a fiscal year after fiscal year 2006 or 2007 that remain available for obligation; and 4) funds appropriated for Construction, Major Projects, for fiscal years 2006 or 2007 for a category of activity not specific to a project.

Section 7 authorizes the Secretary to obligate and expend unobligated balances of the Construction Major Projects appropriation to purchase a site for, and the construction of, the new VAMC, Denver, Colorado, and the new construction, restoration or replacement of the medical center facility for the VAMC, New Orleans, Louisiana, and purchase a site for, and construction of the new medical center facility in the Orlando, Florida area.



Collaborative
Opportunities
Study Group

VA Southeast Louisiana Veterans
Health Care System

Louisiana State University
Health Care Services Division

April 2006

Interim Report

**Collaborative Opportunities Study Group
New Orleans
April 30, 2006 Interim Report**

In February of 2006, the United States Department of Veterans Affairs (VA) and the Louisiana State University (LSU) Health Care Services Division agreed to establish a mutually beneficial relationship to foster discussions regarding the future of VA and LSU medical care delivery in the New Orleans region. A joint Collaborative Opportunities Study Group (COSG) was formed by the Veterans Affairs Under Secretary for Health and the Vice President of the LSU System to conduct an analysis to determine what, if any, mutually beneficial sharing could occur between the two organizations. The group is co-chaired by, and comprised of, subject matter experts of both organizations. The study encompasses demographics of the region including current data and the predicted impact of Hurricane Katrina on the regional demand for health care, a review of future service needs, consideration of existing VA collaborations as potential models, the possible sites of future facilities, and the potential for the region to support health care advancement. The group was charged to consider quality, access, practicality, and efficiency in developing options for shared facilities and/or services, to review related information management systems and logistics, and to coordinate related communication.

In the aftermath of Hurricane Katrina, both the Southeast Louisiana Veterans Health Care System's (SLVHCS) and Louisiana State University Health Care Services Division's (LSU HCSD) inpatient services in New Orleans are closed due to the devastation their facilities experienced. Renewed access to high quality health care services is critical to the region's revitalization. Options developed for the delivery of these services must also include storm hardening to minimize the impact of any future disasters. The needs in Louisiana are great and hospital construction is tremendously expensive. The construction options being developed by the COSG include some common, shared infrastructure that can mitigate some of the expense associated with building state-of-the-art health care facilities that can benefit the veterans and indigent and uninsured residents of the New Orleans region for decades to come.

To accomplish the detailed analysis for this study, workgroups were formed to define clinical services and to review the financial and legal or sharing considerations associated with co-located services and joint use of common space. Shortly after those groups began their reviews it was evident that an ad hoc group was needed to provide a detailed review of options for making electronic clinical information readily available to service providers. The COSG clearly articulated the need to provide identifiably separate inpatient bed services, so construction models were conceived with separate bed towers, with a potential adjoining area that could house common structures such as a cafeteria. These workgroups are intensively involved in their analyses and the study oversight group holds weekly virtual and monthly face-to-face meetings to guide, coordinate, and review the workgroups' progress.

This interim report describes the foundational work of the New Orleans COSG and its component workgroups. As will be noted throughout, there is much work remaining for the group to complete in order to describe well-developed sharing options with associated cost estimates. The final report will include a great deal of additional information. Most significantly, the Financial Workgroup has yet to develop and analyze the costs associated with any potential collaborative efforts that will be needed to estimate potential savings. Their extensive work to this point has involved developing methodologies to assure that two very different accounting systems, based on very different funding mechanisms can create "costs" that are, in fact, comparable. While the opportunities outlined in this interim report, especially in the clinical section, are considered reasonable based on current clinical expertise and on the assumption that "sharing," particularly in high cost, low volume areas, could potentially yield cost savings, they may change before the final report.

Additionally, the delineation of a timeline describing the sequence of key activities will be an important component of the group's development of options for collaboration. Maximizing the potential benefits that this collaboration affords will require coordinated timing of planning, construction and activation. In its presentation of options, it is the intent of the COSG to outline an optimal timeframe for achieving the greatest return on health care investments in the region. The work of the COSG has been constructive, is progressing well, and is on schedule to complete the assigned study by June 1.

Clinical

**Clinical Services Workgroup
Interim Report April 2006**

Focus and Scope: In conducting an analysis to determine, what, if any, mutually beneficial sharing should occur between the Southeast Louisiana Veterans Health Care System and the Louisiana State University Health Care Services Division, the Clinical Services Workgroup, a subcommittee of the COSG, undertook three areas of study:

1. The present and future need for LSU and VA primary, tertiary, specialty and emergency health care services in the City and Region;
2. The present and future need for LSU and VA medical research and medical education in the City and Region; and
3. How VA/LSU collaboration can contribute to the National and Louisiana advancement of health care services, in cooperation with medical education.

Consideration was given to service, quality, access, practicality and efficiency. The COSG Clinical workgroup utilized findings from the *Report to Congress on Plans for Re-establishing a VA Medical Center in New Orleans* in their assessment. Imperative to the deliberations of the Clinical Service workgroup are the historical partnerships between the SLVHCS, LSU and Tulane University Medical School, as well as many other allied health professional schools. The magnitude of destruction and sustained damage to New Orleans from Hurricane Katrina opens many opportunities for entirely new approaches to shared health care services between the SLVHCS and LSU. Since there is almost no remaining infrastructure, the two institutions are conceptually beginning with a clean slate and a wide range of possibilities was considered.

Preliminary Analysis: Workgroup members agree that collaboration between the SLVHCS and LSU is a very positive and exciting prospect that will enhance patient care outcomes and efficiencies for both institutions. The focus of the discussion has been on those opportunities in alignment with Option 4 described in the *Report to Congress on Plans for Re-establishing a VA Medical Center in New Orleans* (a shared physical plant with separate bed towers).

The following assumptions were made:

1. The two facilities (towers) will be built in close proximity to each other,
2. Collaborative opportunities are maximized if the two facilities are able to activate at, or near, the same time,
3. "Sharing" of services is defined as the use of the VA Affiliate Sharing Authority. Specifically, this means services will be originated and managed by one of the parties and sold to the other party. Separate and distinct SLVHCS or LSU staffing will exist in the service area with the possible exception of a joint nursing pool,
4. Each party must be able to pay for and provide services as agreed upon,
5. A fundamental issue affecting every aspect of collaboration between SLVHCS and LSU is the ability to share patient information electronically.

Clinical

An ad hoc workgroup was formed to develop mechanism(s) to address this critical need.

6. The Medical Center of Louisiana New Orleans (MCLNO) will continue to provide health care services through contractual relationships with faculty from LSU School of Medicine and Tulane School of Medicine.

Present and future need for LSU and VA health care services

The following clinical services were identified as ongoing needs that would more appropriately be delivered separately:

Activity	Planning Assumption
Inpatient Beds (Med, Surg, Psych)	To remain separate within each organization
Outpatient Clinics	To remain separate within each organization
Pharmacy	To remain separate within each organization
Pathology/Lab (point of care testing)	To remain separate within each organization
Radiology/Imaging (core imaging including CT & general)	To remain separate within each organization
Operating Rooms or Suites (general)	To remain separate within each organization
Endoscopy Suites	To remain separate within each organization
Ambulatory Surgery	A single Ambulatory Care Center with a common entry point. Surgical suites to remain separate and outpatient surgery accomplished within each organization

The following are the needed clinical services that could potentially originate in one organization and be sold to the collaborative partner. Regardless of the service "owner", full support for the teaching missions of both the LSU and Tulane Medical Schools will be given priority consideration. Ownership assumptions are preliminary concepts for planning purposes and do not represent recommendations. Fully developed options with associated costs will be used to refine these planning assumptions. The MCLNO will continue to provide health care services through contractual relationships with faculty from the LSU and Tulane Schools of Medicine.

Activity	Planning Assumption
Rehab/PT/OT Speech Pathology	Shared rehabilitation center with separate staffs and each entity caring for its respective patients
Audiology	Shared hearing center with separate staffs and each entity caring for its respective patients
ER/Trauma	Owned by MCLNO and sold to SLVHCS in a single ER/trauma center. Provides a single point of entry for all patients. Care would be structured in three tiers – ER, Urgent Care and Fast Track.

Clinical

Activity	Planning Assumption
Trauma Surgery	Trauma center will have separate OR
Radiation Oncology	Owned by MCLNO – sold to SLVHCS
Dialysis	Owned by SLVHCS – sold to MCLNO
OBGYN/Women's Services	Owned by MCLNO – sold to SLVHCS
Cardiovascular Surgery	Owned by MCLNO – sold to SLVHCS
MOHS Surgery	Owned by MCLNO – sold to SLVHCS
Hyperbaric	Owned by MCLNO – sold to SLVHCS
Core Lab and Reference Lab (Toxicology, Virology, Special Stains, & Genetic Markers)	Owned by MCLNO – sold to SLVHCS Quality control is considered a major benefit of a single lab.
Surgical Pathology	Owned by SLVHCS – sold to MCLNO
Morgue/Autopsy	Owned by SLVHCS – sold to MCLNO
Eye Care Ophthalmology Optometry	Owned by MCLNO – sold to SLVHCS Optometry – contracted
Neurology (EEG, EMG)	Owned by SLVHCS – sold to MCLNO
Respiratory Therapy & Pulmonary Lab	Owned by MCLNO – sold to SLVHCS
Sleep Lab	Owned by SLVHCS – sold to MCLNO
Dental (General & Specialized Dentistry, Oral Surgery)	Owned by SLVHCS – sold to MCLNO
Radiology/Imaging (MRI, PET, Interventional)	Owned by SLVHCS – sold to MCLNO A major consideration is capital investment of high-tech, high-cost equipment and the ability to maintain same
Operating Rooms or Suites (specialty)	Common rooms to be used by both institutions on separate days
Cardiac Cath Lab	Common rooms to be used on separate days

Present and future local/regional need for LSU and VA medical research

Research is a core mission within the Department of Veterans Affairs and its LSU and Tulane affiliates. It is indelibly intertwined with the clinical practice and education programs based in the LSU HCSD hospital system. Historically, there have been rich, ongoing research interactions between all the parties and many fresh opportunities are created by the current prospects to create economies and improve access to patients and core equipment by expanded collaboration.

Historically, MCLNO supported clinical studies on its patient base, but housed the basic science initiatives of its clinical staff, including animal care, at the affiliated medical schools. The VAMC housed all research activities from basic science, through animal care, and clinical trials largely in the main hospital, with some clinical trial components in VA community based outpatient clinics. The

Clinical

VAMC used Tulane's institutional review board for human studies. Both LSU and Tulane maintained basic science laboratories, animal care facilities, human studies compliance programs, and clinical trial offices in the elements of their medical schools. Within six city blocks there was duplication of resource intensive activities such as animal care facilities, human studies compliance oversight committees, and regulatory offices. Additionally, there was duplication of core scientific equipment which, in many cases, led to underutilization.

The conjoint use of new research facilities makes sense scientifically and administratively. Scientifically, the cost of instrumentation for core facilities continues to rise at a rapid rate, and the increasing pace of development of new generation instrumentation is accelerating the need for upgrades in order to remain state-of-the-art. Sharing core facilities would foster access to cutting edge equipment for investigators and promotes fiscal accountability of technical support and infrastructure. The volume of regulatory compliance activity has also risen dramatically. Combining resources will create efficiencies of scale, and lead to improved streamlining and quality in regulatory processes.

How VA/LSU collaboration can contribute to advancement in health care services, in cooperation with medical education

Graduate Medical Education (GME) is a priority mission within the Department of Veterans Affairs and its LSU and Tulane affiliates. These institutions have a rich history in support of medical education with many shared successes. The Associate Deans from LSU and Tulane met with the COSG Clinical Workgroup and expressed a very strong commitment to continuation of GME programs and affiliated health sciences training. Currently, the most significant obstacles to continuation of pre-Katrina residency levels are space and an adequate patient base to insure volume, diversity and complexity of patient care experiences for the students. During the FY06/07 academic year, 18 slots have been relinquished by the Southeast Louisiana Veterans Health Care System and placed at other VA facilities. The SLVHCS has been assured by the Office of Academic Affairs that all existing resident slots will be maintained in VISN 16 until such time as they can be returned to New Orleans. This issue will be closely monitored and reevaluated annually.

Any collaboration between the VA and MCLNO must fully support medical education and training programs at LSU and Tulane. Regardless of "ownership" of the function within the new facilities, primary consideration must be given to the shared teaching mission between all entities.

Information Technology

**COSG Information Technology Workgroup
Interim Report April 2006**

The following documents three weeks of intense joint VA/LSU meetings and discussions focused on opportunities for joint information technology (IT) sharing. Two broad categories of opportunity for IT sharing emerged:

1. Clinical electronic health record (EHR) sharing and
2. Non-clinical operational focused sharing.

To date, the group's effort has centered on the clinical EHR applications. The less developed findings related to non-clinical/operational IT sharing follow.

The following scope and assumptions cross all models developed as potential solutions. The initial findings support four potential solution models for EHR deployment. Additional costing and informatics analysis will be needed before selection of a final solution. Within all four models, the VHA has less variability because of the VHA decision to continue to use its existing, enterprise-wide EHR, thus selection of a model will reside predominantly with LSU.

Scope and assumptions

The ad hoc Information Technology (IT) workgroup of the New Orleans COSG project focused on the potential for collaborations between the VA and LSU in areas of information technologies. To accomplish this review, the IT group members determined potential options for sharing patient data through the implementation of an electronic health record and identified the issues associated with sharing information technology.

Given the existing VA EHR system based on the Veterans Health Information Systems Technology Architecture (VistA), the group assessed various options for LSU to integrate its data with VistA. All options considered would uphold separate and distinct patient databases for the organizations. Neither organization would be able to use or access the other's database in accordance with their data security and privacy rules.

The options developed by the IT group are presented as Models A through D. Further study of each model will be needed in order to select the one that best fits the environment. The group has tried to provide as much high-level data as possible until a single direction is chosen. Any operational collaboration involving information technology will require a robust infrastructure as well as cabling and networking equipment to allow pass-through for all types of data. Technologies throughout the building(s) will need to communicate on a regular basis in order to assure quality and continuity of patient care. The enormous level of interdependency will demand intense management of the data infrastructure and "out of the box" network management. Successful IT collaboration will require review of many rules and policies of both organizations as well as development of common data standards between the two entities. A number of assumptions have been documented by the group and are available for review.

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purchasing, inventory management, dictation, human resource, payroll, telemedicine, satellite communication, telephone, and PBX systems. However, the VA would lead in the development of approved API's (Application Programming Interfaces) to provide clinical data that is useful or required in any of the above systems.

Advantages of Model A include interoperability, decreased learning curves for clinicians already familiar with VA systems, and reduced costs through the economies of scale. Clinicians who have used CPRS in the VA medical care setting would easily transition to a CPRS-LSU version. Standard data elements, messaging and storage would assure that VA and LSU data would be interoperable. Since the VA is investing in a standard approach throughout the spectrum of government health IT interoperability, LSU would be assured of having the broadest interoperable dataset. Consequently, with the VA managing the computing environment, its expertise gained from years of experience could be leveraged to help LSU accomplish the goal of having a computerized health electronic record system (EHR). LSU would avoid a capital outlay for software since VistA is available at nominal cost. As VA develops its next generation of products, LSU would be a participant and a developmental partner. Specifically, as VA develops the services layer of its Service Oriented Architecture (SOA), LSU would play a role in verifying that the services provided can create seamless entry into a proprietary database while allowing shared use of the GUI. In addition, VA's effort to assure full disaster recovery within a very short performance window would benefit LSU as it addresses the security of its EHR.

Disadvantages include limitations of VistA and CPRS. For example, nurse flow charts from ICU systems are not a feature of CPRS. A rigorous accounting of what is available and not available in VISTA and CPRS would be necessary not only to control expectations among clinicians, but also to set the stage for shared partnership in software development. One risk of this model is that LSU may feel like less of a partner in the development of software; thus, LSU may perceive the VA to be "holding all the cards".

Since Model A would require LSU to develop a sizable IT infrastructure to manage the programs excluded in this effort, some effort towards defining and maintaining scopes and boundaries between the two shops would be necessary. VistA is an integrated architecture and few modular interfaces have been fully implemented. At this point, it is difficult to answer with certainty how successful LSU might be if a different clinical system were desired. For example, a proprietary Lab system might require significant work to accomplish full interface with the other components of VistA. LSU has invested significant effort in developing some local IT clinical solutions, little of which could be leveraged in this effort.

Clinician Impact: Least impact on clinical environment due to similarities of the EHR applications (same as B). Unknown – ability of clinicians to suggest configuration changes to system.

Information Technology

The information presented is intended to serve as a foundation for building and developing a solid technology base to foster the VA and LSU collaboration. The next step will be to identify the IT model(s) that should be developed to fit with the identified collaborative clinical options.

Several important systems were identified as beyond the scope of this review. Business systems such as patient accounting, human resources, general ledger, cost accounting, and materiel management are unique to each organization and should be considered in the next stage of the collaborative endeavor. It should also be noted that informatics and information technology exist solely to support the care delivery and operational environments. Ongoing analysis from this initial phase through deployment will need to be informed by the decision making regarding clinical service delivery. For example, at this time it appears that pharmacies remain separate, but dialysis is to be a single service provided in shared space. The implications for informatics include minimizing the impact on the work flow of a single clinician in a single health care environment while supporting the information handling needs of dual billing, pharmacy formularies and record storage for example. If any of these factors is changed, the informatics solution will need to be recreated. Ongoing inclusion of sharing opportunities, discovery and analysis of opportunities and incorporation of opportunities within the more advanced 'models' section will continue as the IT workgroup completes its review.

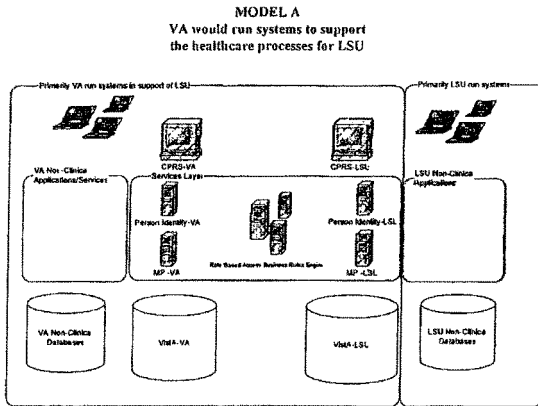
Clinical EHR Applications

Model A - VA would run systems to support health care processes for LSU

Under Model A, LSU would use a customized version of VA's Clinical Patient Record System (CPRS) as its primary graphical user interface (GUI) with VistA as the background database providing CPRS support. The SLVHCS would maintain a separate instance of the VistA database and a separate version of the CPRS GUI executable file. However, the LSU database could be hosted in a VA Regional Data Processing Center (RDPC) in Houston, TX, rather than in New Orleans, LA. VA would deploy and maintain the databases, services, and files for LSU's system, as well as performing software upgrades and regular hardware maintenance. VA would assume responsibility for all aspects of the performance of CPRS. LSU would collaborate with VA staff to customize CPRS for unique application within LSU. VA and LSU would develop a memorandum of understanding (MOU) to describe the roles and expectations of each party. While the MOU would specify the scope of clinical services to be outsourced to the VA, any clinical data accessed through CPRS would be the subject of this effort and the MOU.

The scope of the cooperative effort would include clinician order entry for most clinical services and consult requests, radiology and PACS imaging, lab ancillary system (including transfer of information to reference labs), pharmacy ancillary system, results reporting, disease management, and performance measures reporting. This effort would exclude VA requirements to host and maintain LSU's registration, billing, accounts payable, accounts receivable, cost accounting,

Information Technology

**Model B - LSU would run (VistA) LSU healthcare system.**

As in Model A, LSU would use a customized version of VA's Clinical Patient Record System (CPRS) as its primary graphical user interface (GUI), with VistA as the background database for providing CPRS support. However, in Model B, an IT operations center at LSU would maintain a separate instance of the VistA database and a separate version of the CPRS GUI executable file.

This model would include all of the services noted in Model A (clinician order entry for most clinical services and consult requests, radiology and PACS imaging, lab ancillary system - including transfer of information to reference labs, pharmacy ancillary system, results reporting, disease management and performance measures reporting). As in Model A, the VA would not provide LSU's registration, billing, accounts payable, accounts receivable, cost accounting, purchasing, inventory management, dictation, human resources or payroll systems, telemedicine, satellite communications, telephone and PBX systems. However, assistance in interfacing clinical data that is useful or required could be the subject of joint development provided through an MOU.

Advantages of Model B include a greater level of autonomy in LSU HCSD's development prioritization. Whereas a disadvantage to Model A was the possibility that LSU might perceive the VA to be "holding all the cards" in terms of development scheduling and prioritizing, in Model B, LSU would take on development responsibilities and burdens. Due to its unique mission, the direction that LSU HCSD wishes to take in the development of its IT systems will undoubtedly be different than VA.

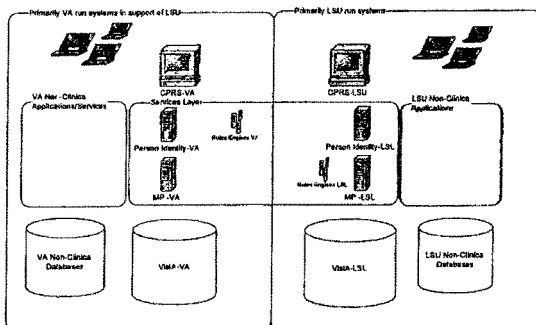
Disadvantages include those noted for Model A. Model B would also require having or contracting for an IT development organization with scope and

Information Technology

expertise parallel to that of the VA. The LSU IT organization would need to master the unique skills required to run the VA systems, such as system administration and knowledge of M and Delphi programming languages.

Clinician Impact: Least impact on clinical environment due to similarities of the EHR applications (same as A). Unknown – ability of clinicians to suggest configuration changes to system.

MODEL B
LSU would run (VistA) LSC
healthcare system



Model C - LSU would run a different vendor user interface and database; clinical data is shared electronically with VA.

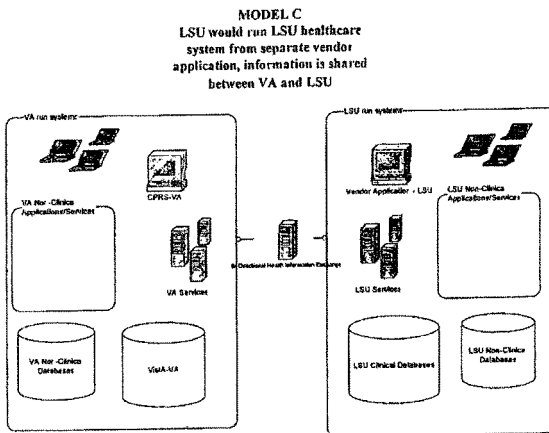
This model differs substantially from the other three in that it features LSU's use of one or more vendor or "home grown" electronic medical record(s), and describes the mechanism for the two health care entities to share clinical data. Model C would present challenges similar to other VA interoperability efforts where the VA seeks to share clinical data with non-VA health systems. Federal Health Information Exchange (FHIE), Bidirectional Health Information Exchange (BHIE), and Remote Data Interoperability (RDI) through the Clinical Health Data Repository (CHRD) are examples of projects involving data transfer between VA and non-VA sources.

Advantages of Model C include LSU's ability to pursue a full complement of vendor or homegrown products which might address its unique needs more completely than VA's software. Furthermore, an initiative to build an environment in which data is shared between VA and LSU would be smaller and more manageable in scope than other Models. Such work could leverage existing VA development efforts in this area and enhance the likelihood of small, consistent improvements.

Information Technology

Disadvantages include all of the advantages cited in the other models. Medical staff moving between the two environments would need literacy in both systems. Any shared services among the two environments would require intensive work on interfaces during development. Model C would require a potential capital outlay of millions of dollars by LSU to review and choose vendor products to complement its own systems and to accomplish its mission.

Clinician Impact: Increased impact on clinical environment due to dissimilarities of the EHR applications. Unknown – ability of clinicians to suggest configuration changes to system.



Model D - LSU creates a “hybrid”.

Model D is a hybrid model that realizes the advantages in Models A and B while providing a level of autonomy more consistent with Model C. Even if LSU were to choose VA’s CPRS/VistA as its long term electronic medical record, it would likely serve both entities’ interests to plan for homegrown and/or vendor products to fill the gap of features not offered in VistA (e.g. obstetrics, pediatrics). The most salient feature of this model is that it features a comprehensive development approach with a shared Service Oriented Architecture (SOA) capable of handling the interface with current CPRS/VistA as well as future products. This SOA is complex and would require significant planning and development on the part of both VA and LSU. This model’s success would depend on the use of open standards and non-proprietary code as well as the political will to carry the development approach through the lifecycle of this joint effort.

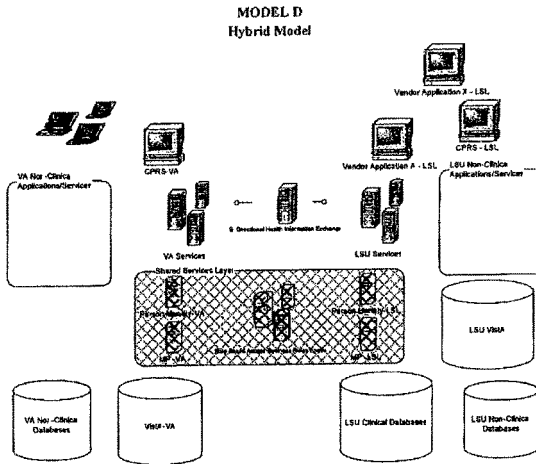
Advantages of Model D are that it may be the most realistic approach and should produce a satisfactory outcome. LSU would be able to begin adapting a proven EHR suite (CPRS/VistA) while also laying the infrastructure for its future

Information Technology

comprehensive mission-critical information system. This system would likely be a superset of CPRS/VistA and other software, databases, and services. However, these systems might be built within a common framework of standards and practices to assure interoperability with future government and private health care systems.

Disadvantages include Model D's complexity, which would require a long-term relationship to ensure that interoperability between LSU and VA systems continues to be a guiding principle throughout the lifecycle of this project. Model D would be expensive to sustain and would require rigorous controls to mitigate risk and manage scope.

Clinician Impact: Increased impact on clinical environment due to dissimilarities of the EHR applications. Unknown – ability of clinicians to suggest configuration changes to system.



Non-clinical Operational Applications or Technologies

Many opportunities for health information technology exist outside of the scope of the clinical EHR applications. These opportunities are more diverse in their nature, spanning hardware infrastructure, software and devices. The operational applications which are contained within the facility and are not associated with larger-enterprise activity (such as automatically generated enterprise-wide reporting) provide more opportunity for joint sharing. These items require additional analysis to develop scope, and assumptions and to incorporate them into models. The applications will be minimally impacted by models and can be incorporated into the any option. Additional review by the ad hoc IT workgroup will be driven by the clinical and business options developed.

Sharing

Sharing Workgroup Interim Report April 2006

Due to extent of the damage incurred by both VA and LSU medical facilities in New Orleans, authorities have deemed it unfeasible to remodel the existing structures. The focus of the Sharing Workgroup is a collaborative model, with VA and LSU each having a bed tower joined by a corridor that may contain facilities for services to be provided to both organizations, with clear ownership lines drawn for the connecting space. LSU and VA would retain autonomy with regard to their own operations. All relationships between the two entities would fundamentally be buy/sell arrangements governed by established contract law, regulations and policy. This would provide the means/authority for addressing many of the legal issues that would arise from a "joint operation" model.

The following areas were considered in identifying the broad issues involved in enacting the sharing model: organizational overview, legal/contracting issues, external accreditation issues, human resources issues pertaining to contracted services, and operations models.

Organizational Overview

The Southeast Louisiana Veterans Health Care System (SLVHCS), formerly known as the VA Medical Center, New Orleans, LA, is part of the Department of Veterans Affairs and is an agency of the federal government. VA provides medical care to eligible beneficiaries as authorized by Title 38 USC.

"LSU" refers to the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College, on behalf of Health Care Services Division. The Board of Supervisors of Louisiana State University and Agricultural and Mechanical College is a public constitutional board created to supervise and manage the institutions under its authority. The Health Care Services Division (HCSD) is an institution under the supervision and management of the LSU Board. All of its assets, including the Medical Center of Louisiana and University Hospital are ultimately under the supervision of the LSU Board. The Louisiana State University Health Sciences Center in New Orleans is a separate institution also under the supervision and management of the LSU Board.

Legal/Contracting issues

The legal tasks involved analyzing the models for future collaboration between the SLVHCS and LSU developed by the COSG, identifying existing legal authorities under which the models may be implemented and, where existing authority is inadequate to implement any aspect of a proposal, determining what legal authority would be required to permit implementation. Additionally, the legal experts advised the other workgroups on any questions relating to legal issues that arose in their reviews.

Most of the VA authorities to provide services to veterans and obtain the tools for providing such services (including acquisition and construction of hospitals,

Sharing

entering into sharing agreements for services, leasing space, etc) derive from Title 38.

Land: Due to time limits for land leases on which VA or LSU owned structures are built, the COSG has limited its review to options where VA would own the land for the VA structure and LSU would own the land for the LSU structure. Both VA and LSU may purchase land subject to their respective legislative authorities. Both organizations may receive donated land as well as engage in swaps for land either not suitable for construction or not needed for state purposes (Title 38 USC § 8103, La. R.S. 17:3351(A)(9)). La. R.S. 52:2 contains authority for a state agency to donate or convey to the United States any lands for use in connection with hospitals though policy issues would need to be considered by the LSU Board. VA does not have statutory authority to donate personal property directly. Property deemed in excess or surplus to a federal agency's needs is referred to the General Services Administration (GSA) in accordance with the Federal Property and Administrative Services Act of 1949, as amended, 40 USC § 101.

Both organizations have the authority to acquire land through either expropriation (La. R.S. 19:141 et seq) or via another agency through condemnation (38 USC § 8103 and 40 USC §3113). However, VA does not have the authority to obtain land through condemnation and then transfer the land to a third party. Likewise, if LSU owns or expropriates land without waivers of the right of refusal obtained in the act of acquiring the property, LSU must offer the land back to the original owner before transferring any land to the VA under La. R.S. 41:1338.

Construction: VA and LSU are required to obtain legislative authority (federal and state, respectively) for construction projects over a certain threshold. Legislative authorization and appropriation are required for any major VA construction project over \$7 million. The capital outlay process for the State of Louisiana is the process by which expenditures for the acquisition of land, buildings and other permanent properties are approved (La. R.S. 39:101 et seq) if the expenditure exceeds \$350,000 (La. R.S. 39:128).

The VA may not expend or obligate funds for other than the scope of the project for which authorized and appropriated. In the instance of the New Orleans medical center, there is nothing in the present legislative proposal that would permit the scope of any A/E or construction contract to include design or construction of any portion of LSU's facilities or LSU's portion of the shared space. Legislation to effect these options may be necessary.

The federal government routinely uses the design-build approach for its construction projects. This is the traditional delivery method where design and construction are sequential and contracted for separately with two contracts (an architect-engineer (A/E) services contract and a construction contract) and two contractors (A/E and construction contractor). VA may not contract for a firm to perform design services or for the construction of any portion of LSU facility.

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However, VA may include in its advertisement for A/E services a requirement for the VA A/E coordinate with the LSU A/E firm. LSU would procure A/E services under a separate contract. VA may procure the construction in the same manner as the A/E services, i.e. advertise that the construction contractor may be called upon by another entity to construct the remainder of the corridor.

With respect to choosing an architect/engineer, LSU would submit the name of its proposed architect (which could be the same as the VA architect) to the Division of Administration for consideration and approval by the Louisiana Architects Selection Board (or Louisiana Engineers Selection Board) but the selection board may not accept the referral and a committee would solicit bids for the requested service under La. R.S. 38:2310, et seq. There does not appear to be a way to deviate from this procedure without legislation.

While no Louisiana statutes specifically prohibit LSU from using the same contractor as the VA, pursuant to La. R.S. 38:2211, et seq, a contract for any project in excess of \$100,000 would have to be awarded pursuant to Louisiana's statutory public bid process. However, the very nature of one contractor for the entire project would necessarily restrict the competitive process integral to Louisiana public construction projects. Louisiana legislation would be needed to authorize this method of constructing the proposed facility.

Common Area/Linking Corridor: There are three scenarios for construction of the area connecting the bed towers. Each of these scenarios incurs issues that must be addressed through contract and/or legislation.

In scenario 1, either the VA would construct the connecting corridor with joint funding by the VA and LSU, or the VA and LSU would each construct its part of the corridor. The practical approach to scenario 1 would be for VA to construct a portion of the corridor from VA's bed tower up to VA's property line. LSU would complete the corridor from there to its bed tower. The parties would grant each an easement permitting access. The caveat for scenario 1 would be that VA does not have the authority to "overbuild" with the intention of sharing services or space (such as education facilities) in its part of the corridor.

Under the second scenario, the connecting corridor would be constructed and funded by VA and a portion of the space leased to LSU pursuant to traditional VA lease authority (38 USC § 8122). Scenario 2 would require legislative authority for VA to build with the intent to lease space to LSU. VA's authority to out-lease medical or medically related space is set forth at 38 USC § 8122. The term of the lease is limited to 3 years, and proceeds received by VA, minus expenses for the maintenance, operation, and repair of buildings leased for living quarters, must be deposited into the Treasury as miscellaneous receipts.

Under the third, the connecting corridor would be constructed and funded by VA and a portion of the space provided to LSU via a use of space agreement pursuant to 38 USC § 8153. VHA policy allows use of space selling agreements

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for up to 20 years with an early cancellation clause required for any agreement exceeding 10 years.

LSU would obtain the use of VA space under La. R.S. 39:1705, one of the few statutes under the Cooperative Purchasing section that does not authorize an activity independent of the competitive or public bid process. Therefore, some level of approval by the Division of Administration would be required.

VA Provide Services to LSU: 38 USC § 8153 authorizes VA to sell its resources "that are not or would not be used to the maximum effective capacity" with the requirement that veterans receive priority and that such sharing arrangements are certified necessary to maintain the quality of services or to improve services to veterans. LSU, through statutes including La. R.S. 17:1519, et seq and La. R.S. 39:1481, et seq, is authorized to contract with the VA for professional, social, consulting, and personal services without proceeding with a competitive bid or negotiation process.

LSU Provide Services to VA: To the extent that it can be established that LSU is an entity associated with an affiliate of VA, VA may enter into sharing agreements (contracts) for health care resources on a noncompetitive basis under 38 USC § 8153. The Federal Acquisition Streamlining Act, 41 USC § 254c, gives VA multiyear contracting authority for up to 5 years. VA buys services using medical care appropriations, which expire within one-year of the appropriation. Pursuant to La. R.S. 39:1706, LSU/HCSO can supply personnel and informational, technical or other services to the VA, provided that the VA's request for such personnel and services does not interfere with HCSO's needs.

Joint Acquisition of Equipment: The Secretary has authority to enter into agreements with VA's affiliates for the joint acquisition of medical equipment under Title 38, § 8157. Although there is no statutory authority for LSU to jointly own equipment with the VA, there are vehicles by which LSU can purchase or lease equipment to allow LSU to utilize the most recent, maintained medical technology. For example, LSU might lease space to a third party to construct and install the equipment.

External Accreditation

JCAHO reserves the right to inspect both the leased space and the contractor if space is shared through a lease arrangement. With the tracer methodology, the surveyors will travel the route of the patient and visit/inspect the locations the patient has visited. JCAHO, and possibly CARF, will have the authority to inspect clinical service areas. Generally, contracting language states that the organization providing the service will have JCAHO accreditation or meet JCAHO standards. Monitors must be spelled out in the contract and reports submitted to the organization.

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Human Resources Issues for Contracted Services

The VA is considering how 38 USC §8110(a)(5) may limit its authority to conduct studies regarding outsourcing of services.

In Louisiana, Civil Service enjoys constitutional status. Neither the legislature nor the governor can negate Department of Civil Service actions with respect to employment matters. Outsourcing has been accomplished in some instances, but it has been necessary to work through plans with the Department of Civil Service and to modify initial proposals to satisfy the Department with respect to employees.

Operations Models and Issues

Any operations model developed would have to consider the following:

- Focus on a long-term relationship that benefits both organizations
- Strengthening the existing strong affiliation
- Serve in an advisory capacity so as not to undermine the authority of the VAMC or LSU executive leadership

VAMC and LSU should consider a structured and phased approach for effective management of collaboration efforts. The phases of the collaboration would include planning, implementation, evaluation, and support/maintenance.

Texas Medical Center model: The Sharing Group examined the Texas Medical Center model in exploring viable options for a collaborative operating model. The Texas Medical Center model is based on a very sophisticated, mature consortium of organizations with access to generous resources such as land and funding. However, the Texas Medical Center model may be applied on a smaller scale to meet the emerging needs for a health care organization consortium in New Orleans.

Operations Council: An Operations Council could provide a forum to encourage communication, oversee the evaluation and support/maintenance of shared programs/services, and facilitate implementation of an adapted Texas Medical Center model.

Operations Opportunities for Sharing: While VAMC and LSU would operate two independent facilities, opportunities may exist for the organizations to share policies and procedures (e.g. dress code and parking), training and education, and process improvement initiatives. For example, by pooling resources the parties would be able to offer more expanded educational programs and utilize the expertise of the other's facility. This could result in enhanced education programs, a better trained workforce, improved efficiency in utilization of resources, and more cost-effective utilization of computer-based training programs and video conference training programs.

Police and Security: As stand-alone facilities, VA and LSU would continue to operate separate Police and Security operations. In the event that the

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organizations build connecting facilities, the close proximity would invoke a need for both organizations to understand the other's police and security operation and clarify any restrictions or limitations such as VA's restricted jurisdictional boundaries.

Prisoner Care: VA may enter into agreements to provide medical care to prisoners of state or local jurisdictions. In no case may VA agree to take responsibility for the security of such a patient-prisoner. Procedures for assuring the safety and well-being of VA patients and staff while maintaining custody of the prisoner during treatment must be in place.

Emergency Preparedness: As stand-alone facilities, VA and LSU would continue to operate separate emergency preparedness programs. However, should the organizations build in close proximity to each other, it would be imperative for them to collaborate in developing a joint emergency preparedness plan and to conduct joint exercises.

Access Ramp to I-10: The construction of a ramp is not within the authority or jurisdiction of VA. However, VA may include easy access to the I-10 ramp in the site requirements when soliciting expressions of interest in acquiring land through purchase or donation. Those entities having jurisdiction are the Louisiana Department of Transportation and the Federal Department of Transportation, Federal Highway Administration.

Finance

COSG Finance Workgroup Interim Report April 2006

Scope

The COSG Finance Workgroup is charged with developing cost estimates for varying levels of collaboration between LSU and the VA. In addition the group is charged with estimating potential cost savings for the VA over the 30 year life of collaboration options. To understand the costs of operating a potential hospital shell with contracted services between the two organizations the following items are considered:

1. The present and future demographics of the City of New Orleans ("City") and the metropolitan New Orleans area ("Region")
2. Proposed sites and locations for future LSU and VA health care facilities, research and educational facilities in the City and Region, including analysis of sites for joint and collaborative facilities
3. Cost of various options studied by the COSG

Finance Group Assumptions

The following list of assumptions was jointly developed and agreed upon by COSG Finance Workgroup members from both the VA and LSU.

- All financial decisions will be based upon sound actuarial and financial principles.
- Both organizations will use a long term planning horizon (10 to 20 years) to determine regional demographics and patient demand.
- Both organizations are regional referral centers and in the long term expect workload to return to pre-Katrina levels. LSU is still determining patient demand and will use the demographic analysis developed for the Site and Facility Master Plan for the Consolidation of Charity and University Hospitals at Medical Center of Louisiana at New Orleans until new demographic data is available.
- VA laundry services will not be located within the new hospital shell and will be provided by LSU in a recently updated laundry facility in New Orleans or through another VA facility in VISN 16.
- Both the LSU and VA components of the hospital will meet or exceed all Federal Energy use guidelines.
- Each organization will operate separate police services.
- The option of sharing physical space staffed by both LSU and VA will not be evaluated.
- The VA will build and operate the majority of the administrative space such as staff education, conference centers, and business center.

Demographics

LSU and the VA will use different methodologies for calculating demographics for the patient catchment areas of their respective hospital systems. While the

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Center for Disease Control (CDC) is coordinating federal demographic analysis in New Orleans, the next CDC demographic update will not be available in time for use in this analysis. The CDC recommends using currently available demographic data. Since each organization serves as a regional referral center and draws many of its patients from outside of the flooded areas, both project that workload will return to pre-Katrina levels.

VHA

The VA will use VA Enrollee Health Care Projection Model (EHCPM) – 20 Year Projection figures. This is the same workload estimate used for the VA CARES hospital replacement analyses. Highlights of those findings are listed below:

- Demand will be similar to pre-Katrina levels by 2013.
- Veterans are still residing within the New Orleans VAMC catchment area even if they were displaced from their homes due to flooding.
- While population is declining, enrollment will actually increase due to those newly eligible because of economic hardship and veteran population trends that began pre-Katrina.
- Orleans Parish accounted for only 24% of projected 2023 beds and outpatient clinic visits.
- Even if only 60% of VA users return to Orleans Parish, minimal impact on the demand for VA services is projected.

LSU

LSU is still finalizing patient demand data and will use the demographic analysis developed for the Site and Facility Master Plan for the Consolidation of Charity and University Hospitals at Medical Center of Louisiana at New Orleans until new demographic data is available. Factors analyzed in the study include:

- population size and composition,
- employment rates,
- rate of uninsurance, number of individuals eligible for Medicaid,
- and the Medicaid DSH system.

The key takeaway from the study is that the heightened rate of those uninsured in Louisiana post-Katrina will likely increase the number of people dependent on the LSU safety-net hospital system, despite a reduced overall population. Other key demographic findings from the study are:

- The uninsurance rate is higher in Louisiana and in the New Orleans region in particular.
- Rates of uninsurance vary widely by employment sector.
- Areas of job loss correlate with jobs that offered insurance.
- Job growth since Katrina has occurred in sectors that do not offer health insurance, such as service areas and debris removal.
- Fewer residents living in the immediate New Orleans area, but more uninsured residents, will increase demand for care.

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Facility Construction

General Construction Assumptions

The following assumptions were developed and agreed upon by both LSU and VA representatives during weekly COSG Finance Construction work team conference calls.

- The first operational floor designated for patient usage will be constructed 15 feet above sea level.
- Both LSU and VA components of the hospital will meet or exceed all federal energy use guidelines.
- The hospital complex (VA and LSU) will have one energy plant to supply steam, chilled water, generators, and medical gases. All utilities generated in the energy plant will be produced in accordance with VA security and emergency preparedness standards regardless of whether the VA or LSU is the end user of the utility.
- Neither the VA nor LSU are required to adhere to local zoning and height requirements.
- Two helicopter pads are necessary to meet VA security and trauma center designation requirements. One helicopter pad will be for sole use by only trauma center operations and the other for sole use by the VA to meet VA security requirements.

Site analysis

A site fit test is being conducted to determine the feasibility of co-locating a VA Medical Center and replacement MCLNO hospital on adjacent parcels of land. One proposed site currently under review is proximate to Interstate 10 and consists of approximately 37 acres. Preliminary analysis shows that the proposed site will be large enough to meet the long term workload projections of both LSU and VA while still meeting VA security requirements. There are other similarly sized locations that could be utilized for the construction.

Initial plans call for an eight to ten story bed tower on the VA side of the facility and a nine to twelve story bed tower on the LSU side of the facility. A shared services corridor connecting the two bed towers would be between four to six stories in height. The shared service corridor would house contracted clinical services such as operating rooms, an imaging center, and the emergency department. In addition, contracted support services such as administrative conference rooms, an atrium, and cafeteria would also be located within the shared corridor. The number of required stories in each section is determined by the location of the clinical and support services within the new facility. LSU would also operate a freestanding outpatient clinic on the proposed site. A central energy plant detached from the hospital structure would also be located on the proposed site and serve the energy needs of both organizations and all common space.

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VA Hurricane and Flood Planning Requirements

- Power, water, sewer, and HVAC will be contained in a central energy plant, hardened and elevated to protect against Category 5 hurricane damage
- A “Defend in place” philosophy providing 100% of the power, water, fuel, and waste retention required for 8 days following a disruption in the City’s infrastructure
- Helipad – to provide emergency evacuation by air if necessary
- Elevation of the perimeter of site to repel post-Katrina flood levels
- Current elevation assumption is 15 feet above sea level (see the Flood Analysis section below for more detail)
- Vehicular ingress and egress ramps for emergency access to state or federal highway system - elevated above the 100-year flood event
- Inclusion of all VA standards (CD-54) and pilot study of emergency power and water supply during natural disasters

VA and Federal Infrastructure Issues

- Commissioning concentric levels of control and protection
- Site size, entry control, road designs, parking, etc.
- VA Hospital Building System
- Sustainability (LEED Silver Rating)
- Energy Performance
- Stand Off Distance (50 ft)
- Main Entrance Lobbies
- Loading Docks
- Mail Handling Rooms
- Ballistic & Forced Entry Resistance Construction
- Functional Interrelationships and Adjacencies
- Crime Prevention through Environmental Design
- Modularity
- Redundancy
- Building Envelope Blast Resistance
- Progressive collapse and column protection
- Access control systems (site, building, and critical areas)
- Intrusion detection systems
- CCTV Monitoring, Surveillance, and Alarms
- Communication Systems
- Security Control Center
- Site Distribution for Utilities
- HVAC Building Systems
- Plumbing and Fire Protection Building Systems
- Electrical Building Systems
- Emergency Power
- Telecommunications Systems

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Space Plan

The VA and LSU will be using different space driver methodologies within the model for their respective space requirements. The VA will be using space drivers developed for the CARES process and LSU will use the same space drivers used in the Site and Facility Master Plan for the Consolidation of Charity and University Hospitals at Medical Center of Louisiana at New Orleans Study. Common space in requirements will be developed using a consensus process between the two organizations. The space plan is scalable allowing for the addition or subtraction of clinical and support services as needed.

Ownership assumptions have been developed. Options for the provision of support services are still under development and, barring any legal or regulatory exclusions, will be based solely upon which organization can provide the service most cost effectively.

Options on which clinical services would be located in the new hospital shell are still not complete. LSU is also analyzing what outpatient clinical services to house on-site. The VA is determining the size of the primary care clinic to be housed within the new hospital shell, based on workload breakdown between this and a VA outpatient primary care clinic at another site in the City of New Orleans. In addition, LSU is in the process of determining where the organization's ambulatory support services will reside. Options for ambulatory support services include the new hospital shell and another building, on-site or off-site. Building costs per square foot within the new hospital shell and maximum square footage with the footprint that can be accommodated on any proposed site will determine the placement of LSU ambulatory support services.

Construction costs per square foot in the new hospital shell are still being calculated. VA security and emergency hardening provisions, listed above, will greatly impact both the total construction price and the capacity of the site.

Flooding analysis

VA facilities management personnel and LSU engineers met with Army Corps of Engineers representatives regarding the required height above sea level for the first patient functioning floor. All organizations agree that given current flooding data the first patient functioning floor will be 15 feet above sea level. New flooding requirements are being developed by the Army Corps of Engineers and the Federal Emergency Management Agency (FEMA). When new flooding requirements are released, the proposed height of the first patient functioning floor will be reevaluated with the Army Corps of Engineers.

Parking

Each organization will determine its parking space requirements using separate methodologies. Once final parking space requirements are calculated, several options to meet the parking space needs will be developed. The reuse of

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currently existing parking structures adjacent to the proposed site will also be analyzed.

Economies of Scale

Economies of scale will be achieved through standardization between the two organizations in the following areas: mechanical, electrical, plumbing, elevators, fire alarm, nurse call, telephone systems and IT components wherever possible to minimize spare parts, service contracts, and overall maintenance costs. Having one architect design both the VA and LSU sides of the co-located facility or requiring all architects to work collaboratively can also maximize economies of scale through standardization.

Costing of Clinical and Support Services

Clinical

An initial cohort of clinical services currently being explored for contracting in the new hospital structure was selected for costing methodology development. Services selected include diagnostic imaging including interventional radiology, and GI services. These services must be compared line by line to ensure that each organization is including like costs related to a procedure to allow for a true cost comparison. Most recently, the development of a methodology to incorporate actual LSU professional fee costs into the cost comparisons has replaced the previously used estimate. This enhancement will increase the accuracy of the costing. Due to the intricacies of each organization's financial systems, every department's cost comparison will require slight customization.

Support Services

Support costs were calculated for each organization at a unit cost level. This was accomplished by deriving the total cost of labor, supplies, and services and dividing by a mutually agreed upon unit cost driver. Support services selected for initial comparison for cost comparison methodology development include: housekeeping, laundry services, and patient nutrition and food services.

Support costs for each organization are being compared at a line item level of detail to ensure an exact cost comparison for the operation of a support service. An example of the preliminary review of a cost comparison between the two organizations appears in the following table.

Organization	Housekeeping cost per square foot
LSU	\$4.58
VA	\$4.34

A costing methodology for the comparison of patient nutrition and food services is still being developed. The barriers to overcome in developing a methodology are that VA and LSU use different unit cost drivers and classify their costs differently in their respective cost accounting systems. Specifically, LSU patient

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nutrition services include operating costs for the employee and visitor's cafeteria as well as administrative catering services while the VA does not. A method for backing out LSU employee visitor cafeteria and administrative catering costs is still being developed to allow for a true comparison of patient nutrition services operational costs across the organizations.

Other support services that will be compared are energy plant operation, facilities management services, and business support services including: mail, reproduction, messenger, and printing services.

Continuing Work

- The use of a local utility cooperative is being investigated. Should it be determined that the utility cooperative meets all VA security and emergency preparedness requirements including infrastructure, its use will be considered as a viable option in lieu of a new, central energy plant.
- Analysis of cost of construction per square foot is ongoing.
- Determine life cycle costs and complete a cost effectiveness analysis of all options upon the receipt of final demographic and operating cost data.
- Finalize scope and operating costs of administrative and clinical contracted services between the two organizations based upon the developed methodology.

New Orleans Collaborative Opportunities Study Group Membership	
VA members	LSU members
<p>VHA Co-Leader Michael Moreland, Director, VA Pittsburgh Healthcare System</p> <p>Michael Finegan, Director, Western New York HCS Timothy Shea, Director, Little Rock VAMC Robert Wiebe, Director, Network 20 Julie Catellier, Dep. Director for Disaster Recovery John Church, Director, SLVHCS Walt Hall, VACO Group 3 Lead Counsel Carla Sivek, Exec to Director/Planner VA Pittsburgh</p>	<p>LSU Co-Leader Michael Kaiser, MD Deputy Chief Medical Officer LSU HCSD Patrick O'Connor, Dir. Research & Development LSU HCSD Cathi Fontenot, Medical Director MCLNO Don Elbourne, Consultant LSU HCSD Willie Hawkins, Dir. of Institutional Relationships LSU Charles Hilton, Assoc Dean of Academic Affairs, LSUHSC Robert Plaisance, Deputy CEO, LSU HCSD Nathan J. Daigrepoint, Project Manager</p>
Sharing Workgroup Membership	
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Clinical Workgroup Membership	
<p>VHA Co-Chair, Robert Wiebe, Director, Network 20 Julie Catellier, Deputy Director for Disaster Recovery Jim Tuchs Schmidt, Director, Portland VAMC Stephen Ezeji-Okoye, ACOS Palo Alto Paul Hastings, Director of Surgery, NOLA</p>	<p>LSU Co-Chair, Cathi Fontenot, Medical Director MCLNO Jimmy Cairo, Dean and Prof, School of Allied Health, LSU HSC Tom Nolan, Chair of Department of OB/GYN Rhonda Green, Director of Medical Services, LJCMC Jeff Wiese, President of MCL Medical Staff Joyce Majonos, Lab Manager, Charity Hospital</p>
Finance Workgroup Membership	
<p>VHA Co-Chair, Michael Finegan Chris Stomberg, CFO Minneapolis Lynn Ryan, CFO Jackson Steve Hopkins, FM VHA Jill Powers, VSSC Jimmie Tyus, Staff VSSC Steve Jones, VISN 16 Staff Jimmy Murphy, CFO New Orleans VAMC Cindy Jwainat, VISN 16 CAPS Manager Josh Malecki, Administrative Fellow</p>	<p>LSU Co-Chair, Don Elbourne, Consultant HCSD Mike Carter, Account Mgr, Reimbursements, HCSD Bob Arnold, Facility Management, MCLNO Danny Mahaffey, Facility Planner, LSUHSC Art Landry, Director of Financial Services, HCSD Nita Chambers, Chief Fiscal Officer, HPLMC Lanette Buie, Director of HR, HCSD Nathan Daigrepoint, Lab Tracker Project Coordinator</p>