

Construction Programs

As the Department of Veterans Affairs (VA) strives to improve the quality and delivery of care for our wounded, ill, and injured veterans, the facilities where that care is provided continue to erode. With buildings that have an average age of 60 years, VA has a monumental task of improving and maintaining these facilities. Since 2004, use of VA facilities has grown from 80 percent to 120 percent, while the condition of these facilities has eroded from 81 percent to 71 percent over the same period of time.¹ It is important to remember that VA facilities are where our veterans receive care, and they are just as important as the physicians and other staff who deliver that care. Every effort must be made to ensure these facilities remain safe and sufficient environments to deliver care. A VA budget that does not adequately fund facility maintenance and construction will reduce the timeliness and quality of care for veterans.

The vastness of VA's capital infrastructure is rarely fully seen or understood. VA currently manages and maintains more than 5,600 buildings and almost 34,000 acres of land with a plant replacement value of approximately \$45 billion. Although VA has addressed a number of critical infrastructure gaps, more than 3,900 gaps remain that will cost between \$54 and \$66 billion to close, including \$10 billion in activation costs.²

With shrinking requests and appropriations from the Administration and Congress, VA is moving further behind in closing known safety, utilization, and access gaps and continues to fail to prevent future gaps from arising. To only maintain VA infrastructure in its current condition, VA's Nonrecurrent Maintenance (NRM) account would need \$1.35 billion per year, based on the estimated plant replacement value *The Independent Budget* veterans service organizations (IBVSOs) have calculated. This account is currently being funded at \$712 million. More funds will need to be invested to prevent the documented NRM backlog of \$19 billion to \$23.3 billion from growing even larger. To address the gaps in safety, access, and utilization, VA will need to invest between \$27 billion to \$33 billion in major and minor construction and leasing.

In addition, the Strategic Capital Investment Planning (SCIP) process is intended to help VA make more informed decisions on capital investments. A key element missing from the gap analysis criteria is a comprehensive assessment of the resources that exist outside of the VA through existing contracts and sharing agreements. Unlike VA-built or VA-leased space, contracts can be amended, cancelled, or sited differently to respond to any geographic changes and health care needs of veterans eligible for this care. This difference is especially relevant in the Veterans Health Administration (VHA) because VA, Congress, and the IBVSOs have increasingly supported leveraging community resources to provide accessible care to veterans in rural and underserved areas. Without a comprehensive understanding of the health care resources that exist within and outside of VA, the Department

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cannot make sound decisions on capital investments and on right sizing its inventory for the near-, mid-, and long-term periods. Another apparent flaw of the SCIP process is the lack of transparency on the costs of VA's future real property priorities, which hinders VA's ability to make informed decisions. This shortcoming was among the findings in a report, titled *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities is Needed*, which the Government Accountability Office (GAO) issued on January 31, 2011.

The IBVSOs fully support the GAO's recommendation in this report that VA must enhance transparency by submitting an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on the costs of future projects. The IBVSOs also support the inclusion of new gap-analysis criteria that consider resources that

are available to the VHA through existing contracts and sharing agreements. We urge a more rigorous gap analysis that informs the priority list of projects in the SCIP process. The IBVSOs, in turn, will be monitoring the level of funding for each of the infrastructure accounts to ensure that all current gaps are met within 10 years and that emerging and future gaps will be closed by sufficient funding.

Quality, accessible health care continues to be the focus for the IBVSOs, and to achieve and sustain that goal, large capital investments must be made. Presenting a well-articulated, completely transparent capital-asset plan, which VA has attempted to do, is important, but funding that plan at nearly half of the prior year's appropriated level and at a level that is only 25 percent of what is needed to close the access, utilization, and safety gaps will not fulfill VA's requirements nor will it serve veterans' best interests.

MAJOR CONSTRUCTION ACCOUNTS

Underfunding major construction has a direct, negative effect on access to care.

Decades of underfunding in amounts of \$19 billion to \$23.3 billion have led to a major construction backlog. Currently, the Veterans Health Administration has 21 major construction projects dating to 2007 that have been only partially funded. In the Administration's budget request for FY 2014, the Department of Veterans Affairs requested funding for only one new project.³ The total unobligated amount for all currently budgeted major construction projects exceeds \$2.9 billion.⁴ Yet the total budget proposal for FY 2014 major construction accounts was less than \$342 million.

To finish existing projects and to close current and future gaps, VA will need to invest at least \$23.2

billion⁵ over the next 10 years. At current requested funding levels, it will take more than 67 years to complete VA's 10-year plan.

In the short-term, VA must start requesting and Congress must start funding major construction at a level that begins to reduce the backlog. The IBVSOs recommend \$2.8 billion be provided for VA for major construction funding in FY 2015. These increased funds will eliminate the most severe safety gaps and complete funding on the longest standing projects. VA must also begin presenting long-term proposals that will outline how it will close all major construction gaps.



MINOR CONSTRUCTION ACCOUNTS

VA infrastructure continues to suffer through lack of funding for minor construction projects.

To close all the minor construction gaps within a 10-year timeline, VA will need to invest between \$6.8 billion and \$8.3 billion.⁶ For several years, VA minor construction was funded at a level to meet its 10-year goal. However, the Administration and Congress have apparently abandoned their long-term commitment to increased appropriations and proposed a drastic funding decrease for minor construction over the past two years. However, the budget proposal for FY 2014 was \$832 million, an increase from the prior year, and coming close the level needed to close all gaps within 10 years.

The Independent Budget veterans service organizations believe that minor construction accounts can

be brought back on track by investing approximately \$831 million per year over the next decade to close existing gaps and to prevent unmanageable future gaps in minor construction.

Additionally, for capital infrastructure, renovations, and maintenance, we recommend \$50 million or more for up to five major construction projects in VA research facilities and \$175 million in nonrecurring maintenance and minor construction funding. This increase would address Priority 1 and 2 deficiencies identified in the 2012 VA research capital infrastructure report (in accounts that are separate from VA's other major, minor, and maintenance and repair appropriations).



NONRECURRING MAINTENANCE ACCOUNTS

Nonrecurring maintenance funding keeps VA properties functioning and sustainable.

Even though nonrecurring maintenance (NRM) is funded through VA's Medical Facilities account and not through a construction account, NRM is critical to VA's capital infrastructure. NRM embodies the many small projects that together provide for the

long-term sustainability and usability of VA facilities. NRM projects are one-time repairs, such as modernizing mechanical or electrical systems, replacing windows and equipment, and preserving roofs and floors. Nonrecurring maintenance is a necessary

component of the care and stewardship of a facility. When managed responsibly these relatively small, periodic investments ensure that the more substantial investments of major and minor construction provide real value to taxpayers and to veterans as well.

VA is moving away from closing current NRM safety, utilization, and access gaps and continues to fall behind on preventing future gaps. Just to maintain in the status quo, VA's NRM account must be funded at \$1.35 billion per year, based on the estimated Plant Replacement Value (PRV). NRM is currently being funded at \$712 million per year. More will need to be invested to prevent the \$22.4 billion NRM backlog from growing larger.⁷

The IBVSOs believe VA should develop a PRV metric and publish its results. Adding the PRV to the SCIP will allow VA to more accurately determine the appropriate amount to request for NRM and objectively decide when a facility becomes more costly to maintain than to replace. Using the PRV as a tool, VA can more accurately determine the annual funding levels needed for NRM by facility, allowing for the reduction in the NRM backlog and fully funding

future needs in a way that would be the most cost effective. The industry goal for NRM is around two percent of the PRV. At that rate facilities can operate for 50 years or more without outspending replacement cost. Knowing what percentage of the PRV is being spent and taking a long view of capital planning would allow Congress and VA to assess when a facility will need to be replaced.

Because NRM accounts are organized under the Medical Facilities appropriation, they have traditionally been apportioned using the Veterans Equitable Resource Allocation (VERA) formula. This formula was intended to allocate health-care dollars to those areas with the greatest demand for health care and is not an ideal method to allocate NRM funds. When dealing with maintenance needs, this formula may prove counterproductive by moving funds away from older medical centers and reallocating the funds to newer facilities where patient demand is greater, even if the maintenance needs are not as great. We are encouraged by actions the House and Senate Veterans' Affairs Committees have taken in recent years requiring NRM funding to be allocated outside the VERA formula, and we hope this practice will continue.



CAPITAL LEASING

*If used properly, leasing can increase accessibility to care.
If misused, it can disrupt the continuum of care.*

The fourth cornerstone to VA's capital planning is leasing. The current lease plan calls for little more than \$2 billion over the next 10 years. VA leases properties to use for each agency within VA, ranging from community-based outpatient clinics (CBOC) and medical centers to research and warehouse space. These leases do not fall under the larger construction accounts but under each Administration and staff office operating accounts.⁸

Since the 1990s, Congress has helped improve VA health-care access and patient satisfaction by authorizing and funding nearly 900 VA community-based outpatient clinics. These facilities have provided local, convenient and cost-effective primary care for millions of veterans. In a 2012 policy shift, the Congressional Budget Office (CBO) changed its accounting practice on how major capital leases

are to be funded, effectively halting Congressional authorization of future leases. Currently, there are 28 major capital leases, totaling nearly \$247 million, for which VA has requested Congressional authorization. As of mid-November 2013, these leases are in limbo. This backlog of leases will only grow as existing leases expire. Lack of reauthorization could result in closures of current clinics, and newly proposed clinics cannot be activated without authorization. Inaction will lead to increased costs associated with longer travel times or the need to provide fee-basis care that otherwise would be provided through CBOCs. Access to care will also decline, as veterans will be forced to travel further and wait longer for the care they need.

Several proposals could solve this problem. One proposal reduced the size and scope of proposed

CBOCs, creating smaller facilities so that individual costs would fall below the need for Congressional authorization. Although this may technically solve the problem, the IBVSOs do not believe this is the best option. Legislation has been introduced that would require VA to record the expected full cost of a lease or record the first-year lease payments plus any fees for cancellation of the lease and to justify a chosen course of action for each such lease. We are hopeful this legislation will remedy this challenge.

VA also has the current authority to enter into a services contract with an outside vendor to bypass the existing CBO-scoring challenges. Services contracts for contract CBOCs have been tested in the VHA and are a proven model for delivering quality care to veterans while enabling VA to retain flexibility and control. The small number of contract clinics operating in VA today has consistently ranked as good or better in patient satisfaction when compared to VA-staffed clinics. Contracting with an outside vendor would provide an immediate fix to the current authorization delays but in our opinion should only be used on an interim basis until a more viable and permanent solution may be found.

This problem and the solution are the responsibility of both VA and Congress. They must actively find and implement a solution that will both resolve the current backlog of leases and ensure future leases can be authorized when VA makes requests congressional approval.

Recommendations:

Congress must dramatically increase funding for NRM to maintain current and future infrastructure as well as invest in reducing the current \$21.5 billion NRM backlog.

VA should add the PRV of all VA facilities into its annual capital plan.

Congress must increase funding for VA's major construction account in an effort to close the gaps in major construction projects within 10 years, starting with \$2.8 billion in FY 2015.

VA must present a long-term plan on how to effectively close all major construction gaps.

VA's minor construction account must be funded at a level over the next decade to close gaps affected by this account, commencing with funds of \$831 million in FY 2015.

VA must continue its transparency in leasing and ensure that veterans' inpatient access needs will not be jeopardized if and when leases expire.

Congress must appropriate an additional \$225 million for research facility infrastructure improvements.

Congress must find a long-term solution for the current leasing paralysis.



EMPTY OR UNDERUTILIZED SPACE AT MEDICAL CENTERS

The Department of Veterans Affairs must use empty and underutilized space appropriately.

The Department of Veterans Affairs maintains approximately 1,100 buildings that are either vacant or underutilized. An underutilized building is defined as one where less than 25 percent of space is used. VA spends from \$1 to \$3 per square foot per year to maintain a vacant building.

Studies have shown that the VA medical system has extensive amounts of empty space that can be reused for medical services or reapportioned for another use. Studies have also shown that unused space at one medical center may help address a deficiency that

exists at another location. Although the space inventories are accurate, the assumptions regarding the feasibility of using this space are not. Medical facility planning is complex requiring intricate design relationships for function as well as the demanding requirements of certain types of medical equipment. Because of this complexity medical facility space is rarely interchangeable, and if it is, the cost is usually at a prohibitive. Unoccupied rooms on the eighth floor used as a medical surgical unit, for example, cannot be used to offset a deficiency of space in the second-floor surgery ward. Medical space has a

critical need for inter- and intradepartmental adjacencies for efficient and hygienic patient care.

When a department expands or moves, these demands create a domino effect on everything around it. These secondary impacts greatly increase construction expense and can disrupt patient care.

Some features of a medical facility are permanent. Floor-to-floor heights, column spacing, light, and structural floor loading cannot necessarily be altered. Different aspects of medical care have various requirements based upon these permanent characteristics. Laboratory or clinical space cannot be interchanged with ward space because of the different column spacing and perimeter configuration. Patient wards require access to natural light and column grids that are compatible with room-style layouts. Laboratories should have long structural bays and function best without windows. Renovating empty space may not be suited to its planned purpose, and such a renovation will create unnecessary expenses and be much less efficient than building new space.

Renovating old space rather than constructing new space often provides only marginal cost savings. Renovations of a specific space typically cost 85 percent of what a similar, new space would cost. Factoring in domino or secondary costs, the renovation can end up costing more than building entirely new space while producing a less satisfactory result. Renovations are sometimes appropriate to achieve functional usefulness but are rarely economical.

As stated earlier in this analysis, the average age of VA facilities is 60 years. Many older VA medical centers that were rapidly built in the 1940s and 1950s to treat a growing war-veteran population are simply unable to be renovated for modern needs. Another important problem with this existing unused space is often location. Facilities are not well located for today's needs; otherwise, they would have been previously renovated or demolished for new construction.

P.L. 108-422 gave new incentive to VA's efforts to properly dispose of excess space by allowing VA to retain in a Capital Asset Fund the proceeds from the sale, transfer, or exchange of certain properties. Furthermore, that law required VA to develop short- and long-term plans for the disposal of these facilities in a required annual report to Congress. VA has identified 494 buildings that have been identified for repurposing. Building Utilization Review and Repurposing (BURR) will focus on identifying sites in three major categories; housing for veterans who are homeless or at risk for being homeless, senior veterans capable of independent living, and veterans who require assisted-living and supportive services. The three planned phases include identifying campuses with buildings and land that are either vacant or underused, visiting the site to match the supply of building and land with the demand for services and availability of financing, and identifying campuses using VA's enhanced-use leasing authority. Under the BURR initiative, if no repurposing for a building is identified, VA will begin to assess its vacant capital inventory by demolishing or disposing of buildings that are beyond their usefulness.

The IBVSOs have stated that VA must continue to develop these plans, working in concert with architectural master plans and community stakeholders, and clearly identify the long-range vision for all such sites.

Recommendations:

VA must develop a comprehensive plan for addressing its empty, underutilized, or excess space in non-historic properties so that they can be used for other purposes if they are not suitable for medical or support functions because of their age or location.

VA must have greater transparency when initiating its BURR plan and must have an earlier, more extensive community involvement when planning for underutilized space and infrastructure needs.

PROGRAM FOR ARCHITECTURAL MASTER PLANS

Each VA medical facility must develop a detailed master plan and delivery models for quality health care that changes because of advances in research, changes in patient demographics, and new technology.

The Department of Veterans Affairs must design facilities with a high level of flexibility in order to accommodate new methods of patient care and new standards of care. VA must be able to plan for change to accommodate new patient care strategies in a logical manner with as little effect as possible on other existing patient care programs. VA must also provide for growth in existing programs based on projected needs through capital planning strategy.

A facility master plan is a comprehensive tool to examine and project potential new patient care programs and how they might affect the existing health-care facility design. This plan also provides insight with respect to growth needs, current space deficiencies, and other facility needs for existing programs and how they might be accommodated in the future with redesign, expansion, or contraction.

In many past cases, VA has planned construction in a reactive manner. Projects are first funded and then placed in the facility in the most expedient manner, often not considering other future projects and facility needs. This short-sightedness often results in construction that restricts rather than expands options for the future.

The Independent Budget veterans service organizations believe that each VA medical center should develop a comprehensive facility master plan to serve as a blueprint for development, construction, and future growth of the facility; \$15 million should be budgeted for this purpose.

VA has undertaken master planning for several VA facilities, and we applaud this effort. But VA must ensure that all VA facilities develop master plan strategies to validate strategic planning decisions, prepare accurate budgets, and implement efficient construction that minimizes wasted expenses and disruption to patient care.

VA MUST EVALUATE USE OF ARCHITECT-LED, DESIGN-BUILD, PROJECT DELIVERY

VA currently employs two project-delivery methods: design-bid-build and design-build. Design-bid-build project delivery is appropriate for all project types. Design-build is generally more effective when the project is of a low complexity level. Evaluating the complexity of the project prior to selection of a method of project delivery is critical.

Design-bid-build is the most common method of project design and construction. In this method an architect is engaged to design the project. At the end of the design phase, that same architect prepares a complete set of construction documents. Based on these documents contractors are invited to submit a bid for construction of the project. A contractor is selected based on this bid, and the project is constructed. With the design-bid-build process, the architect is involved in all phases of the project to insure that the design intent and quality of the project is reflected in the delivered facility. In this project-delivery model, the architect is an advocate for the owner.

The design-build project delivery method attempts to combine the design and construction schedules in order to streamline the traditional design-bid-build method of project delivery. The goal is to minimize the risk to VA and reduce the project delivery schedule. Design-build, as used by VA, is broken into two phases. During the first phase, an architect is contracted by VA to provide the initial design phases of the project, usually through the schematic design phase. After the schematic design is completed, VA contracts with a contractor to complete the remaining phases of the project. This places the contractor as the design builder.

One particular method of project delivery under the design-build model is called contractor-led design-build. Under the contractor-led design-build process, the contractor is given a great deal of control over how the project is designed and completed. In this method as used by VA, a second architect and design

professionals are hired by the contractor to complete the remaining design phases and the construction documents for the project. With the architect as a subordinate to the contractor rather than an advocate for VA, the contractor may sacrifice the quality of material and systems in order to add to his or her own profits at the expense of VA. In addition much of the research and user interface may be omitted, resulting in a facility that does not best suit the needs of the patients and staff.

Use of contractor-led design-build has several inherent problems. A short-cut design process reduces the time available to provide a complete design. This provides those responsible for project oversight inadequate time to review completed plans and specifications. In addition the construction documents often do not provide adequate scope for the project, leaving out important details regarding the workmanship and/or other desired attributes of the project. This method makes it difficult to hold the builder accountable for the desired level of quality. As a result, a project is often designed as it is being built, compromising VA's design standards.

Contractor-led design-build forces VA to rely on the contractor to properly design a facility that meets its needs. In the event that the finished project is not satisfactory, VA may have no means to insist on correction of work done improperly unless the contractor agrees with VA's assessment. A disagreement may force VA to go to some form of formal dispute resolution, such as litigation or arbitration.

An alternative method of design-build project delivery is architect-led design-build. This model places the architect as the project lead rather than the builder. This model has many benefits to VA, including ensuring the quality of the project, since the architect reports directly to VA. A second benefit to VA is the ability to provide tight control over the project budget throughout all stages of the project by a single entity. As a result the architect is able to access pricing options during the design process and develop the design accordingly.

Another advantage of architect-led design-build is in the procurement process. Since the design and construction team is determined before the design of the project begins, the request-for-proposal process is

streamlined. As a result the project can be delivered faster than the traditional design-bid-build process. Finally, the architect-led, design-build model reduces the number of project claims and disputes. This model also prevents the contractor from "low-balling," a process in which a contractor submits a very low bid in order to win a project and then attempts to make up the deficit by negotiating with VA to change orders as construction proceeds.

In addition to selecting the proper method of project delivery, each construction project has unique problems to solve. VA needs to apply these "lessons learned" to future projects.

Recommendations:

Congress must appropriate \$15 million to provide funding for each medical facility to develop a 10-year comprehensive facility master plan. The master plan should include all services currently offered at the facility and should also include any projected future programs and services as they might relate to the particular facility. Each facility master plan must be reviewed every five years and modified accordingly based on changing needs, technologies, new programs, and new patient-care delivery models.

VA must establish a category system ranking design and construction projects by complexity. This ranking system should be used to determine if the project is a candidate for the design-build method of project management.

The design-build method of project delivery should only be used on projects that have a low complexity, such as parking structures and warehouses. For health-care projects, VA must evaluate the use of architect-led, design-build as the preferred method of project delivery in place of contractor-led, design-build project delivery.

VA must institute a program of "lessons learned." This program would involve revisiting past projects and determining what worked, what could be improved, and what did not work. This information should be compiled and used as a guide to future projects. This document should be updated regularly to include projects as they are completed.

PRESERVATION OF VA'S HISTORIC STRUCTURES

The Department of Veterans Affairs must further develop a comprehensive program to preserve and protect its inventory of historic properties.

The Department of Veterans Affairs has an extensive inventory of historic structures that highlight America's long tradition of providing care to veterans. These buildings and facilities enhance our understanding of the lives of those who have worn the uniform, of those who cared for their wounds, and of those who helped to build this great nation. Of the approximately 2,000 historic structures in the VA historic building inventory, many are neglected and deteriorate yearly because of a lack of funding for their upkeep. These structures should be stabilized, protected, and preserved because they are an integral part of our nation's history.

Most of these historic facilities are not suitable for modern patient care but may be used for other purposes. For the past seven years, *The Independent Budget* veterans service organizations have recommended that VA conduct an inventory of these properties to classify their physical condition and study their potential for adaptive reuse. VA has moved in that direction; historic properties have been identified. Many of these buildings have been placed in an "Oldest and Most Historic" list and require immediate attention.

The cost for saving some of these buildings is not very high considering that they represent a part of American history. Once gone they cannot be replaced. For example, the Greek Revival Mansion at the VA Medical Center in Perry Point, Maryland, built in the 1750s, could be restored and used as a facility or network-training space for about \$1.2 million. The Milwaukee Ward Memorial Theater, built in 1881, could be restored as a multipurpose facility

at a cost of \$6 million. These expenditures would be much less than the cost of new facilities and at the same time would preserve history.

The preservation of VA's historic buildings also fits into the VA's commitment to "green" architecture. Materials would be reused, reducing the amount of resources needed to manufacture and transport new materials to building sites.

As part of its adaptive reuse program, VA must ensure that facilities that are leased or sold are maintained properly. VA's legal responsibilities could, for example, be addressed through easements on property elements, such as building exteriors or grounds.

The Independent Budget veterans service organizations encourage VA to use the tenants of P.L. 108-422, the "Veterans Health Programs Improvement Act," to improve the plight of VA's historic properties. This act authorizes historic preservation as one of the uses of the proceeds of the capital-assets fund resulting from the sale or leases of other unneeded VA properties.

Recommendations:

VA must continue to develop a comprehensive program to preserve and protect its inventory of historic properties.

VA must allocate funding for adaptive reuse of historic structures and empty or underutilized space at medical centers.



NOTES

¹ Department of Veterans Affairs, Office of Budget. *FY 2012 Budget Submission Construction*, (Washington: GPO, 2011), vol. 4, chap. 9.3, pp. 11, 12.

² Department of Veterans Affairs, Office of Budget. *FY 2013 Budget Submission Construction*, (Washington: GPO, 2012), vol. 4, chap. 8-1, p. 1.

³ *Ibid.* pp. 2-3.

⁴ *Ibid.* Chapter 2, p. 49.

⁵ *Ibid.*, Chapter 1, p. 4.

⁶ *Ibid.*

⁷ Department of Veterans Affairs, Office of Budget. *FY 2013 Budget Submission Construction*, (Washington: GPO, 2012), vol. 4, chap. 1, p. 4.

⁸ Department of Veterans Affairs, Office of Budget. *FY 2012 Budget Submission Construction*, (Washington: GPO, 2011), vol. 4, chap. 8-2, p. 88.

