

# 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 that provide that care 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 utilization at 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. It is important to remember that these facilities are where our veterans receive care, and are just as important as the doctors who deliver it. Every effort must be made to ensure these facilities remain safe and sufficient environments to deliver that care. A VA budget that does not adequately fund facility maintenance and construction will reduce the timeliness and quality of care for our veterans.

The vastness of VA's capital infrastructure is rarely fully visualized 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 decreased the number of critical infrastructure gaps, there remain more than 4,000 gaps that will cost between \$51 billion and \$62 billion to close, with an additional \$11 billion in activation costs.

The two categories that most concern *The Independent Budget* veterans service organizations (IBVSOs) are condition and access. To determine and monitor the condition of its facilities, VA conducted a Facility Condition Assessment (FCA). These assessments include inspections of building systems, such as electrical, mechanical, plumbing, elevators, and structural and architectural safety, and site conditions consisting of roads, parking, sidewalks, water mains, and water protection. The FCA review team can grant ratings of A, B, C, D, and F. Assessments of A through C indicate the rating is in new to average condition. D ratings mean the condition is below average and F means the condition is critical and requires immediate attention. To correct these deficiencies, VA will need to invest nearly \$9.8 billion.

To close the gaps in access, VA will need to invest \$30 billion to \$35 billion in major and minor construction and leasing. The residual \$20 billion is needed to close remaining nonrecurring maintenance deficiencies.

In addition, the Strategic Capital Investment Planning (SCIP) process is a tool that is intended to help VA make more informed decisions on capital investments. One key element that appears to be missing from the gap analysis criteria is a comprehensive assessment of the resources that exist outside of VA through existing contracts and sharing agreements. Unlike VA built and 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 is especially relevant in the Veterans

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Health Administration (VHA) as 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, it would be difficult for the Department to make sound decisions on capital investments and right sizing its inventory for the near, mid-, and long term. Another apparent flaw of SCIP is the lack of transparency on the costs of VA's future real property priorities that hinders VA's ability to make informed decisions. This was among the findings in a report that the Government Accountability Office (GAO) issued on January 31, 2011, titled *VA Real Property: Realignment Progressing, but Greater Transparency about Future Priorities is Needed*.

The IBVSOs fully support the GAO recommendation in the January 2011 report to enhance transparency by requiring VA to submit an annual report to Congress on the results of the SCIP process, subsequent capital planning efforts, and details on

the costs of future projects. We also support the inclusion of new gap analysis criteria that considers 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 SCIP; the IBVSOs, in turn, will be monitoring the level of funding for each of the infrastructure accounts to ensure that all current gaps are closed within 10 years and that emerging and future gaps will have sufficient funding.

Quality, accessible health care continues to be the focus of 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 done, 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 mission: "to care for him who shall have borne the battle...."

## MAJOR CONSTRUCTION ACCOUNTS

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

Decades of underfunding has led to a major construction backlog that has reached between \$21 billion and \$25 billion. There are currently 21 Veterans Health Administration major construction projects that have been partially funded dating back to 2007. None of these projects are funded through completion and only four received funding in fiscal year 2013. The total unobligated amount for all currently budgeted major construction projects exceeds \$2.9 billion. Yet the total budget proposal for FY 2013 major construction accounts was less than \$533 million.

To finish existing projects and to close current and future gaps, the Department of Veteran Affairs will need to invest at least \$21.7 billion over the next 10

years. At current requested funding levels, it will take approximately 40 years to complete VA's 10-year plan.

### Recommendation:

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 Independent Budget* veterans service organizations recommend doubling the requested level, providing VA with \$1.1 billion in major construction funding in FY 2014. VA must also begin presenting long-term proposals that will outline how it will address closing 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 their 10-year timeline, the Department of Veterans Affairs will need to invest between \$8.5 billion and \$10.5 billion, up \$1 billion from the previous year. For several years VA minor construction was funded at a level to meet its 10-year goal. However, the Administration and Congress have lost their commitment and proposed a drastic funding decrease for minor construction over the past two years. The budget proposal for fiscal year 2013 was \$607.5 million, an increase from the prior year, but still underfunded to close existing minor construction gaps. At this funding rate, current minor construction gaps will take more than 16 years to close.

### Recommendations:

VA must invest approximately \$880 million per year over the next decade to close existing gaps and to prevent unmanageable future gaps in minor construction and bring minor construction accounts back on track.

Additionally, for capital infrastructure, renovations, and maintenance, **Congress should appropriate** \$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 to address Priority 1 and 2 deficiencies identified in the capital infrastructure report (in accounts that are segregated 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 the VA medical facilities account and not through the construction account, it 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, among other routine maintenance needs. 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.

The Department of Veterans Affairs is moving farther away from closing current NRM safety, utilization, and access gaps, and continues to fall behind on preventing future gaps from occurring. Just to maintain what it has, in the condition that it is in, VA's NRM account must be funded at \$1.35 billion per year, based on *The Independent Budget's* estimated plant replacement value. It 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.

Because NRM accounts are organized under the medical facilities appropriation, it has 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 intense. 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 *The Independent Budget* veterans service organizations hope this practice will continue.

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### **Recommendation:**

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The House and Senate Veterans' Affairs Committees should continue to require nonrecurring maintenance funding to be allocated outside the Veterans Equitable Resource Allocation formula.



## **CAPITAL LEASING**

*If used properly, leasing can increase accessibility to care.*

*If misused, it can disrupt the continuum of care.*

The fourth cornerstone of VA capital planning is leasing. The current lease plan calls for little more than \$2 billion over the next 10 years. The Department of Veterans Affairs enters into two types of leases. First, it leases properties to use for each agency within the department, ranging from community-based outpatient clinics (CBOCs) and medical centers to research and warehouse space. These leases do not fall under the larger construction accounts, but

under each administration's and staff office's operating accounts.

VA has moved to leasing many of its CBOCs and specialty clinics to increase access of primary and specialty care in local communities and as a way to be more modular as veterans' demographics change. The Independent Budget veterans service organizations see the value in providing quick, accessible health

care, but advise caution about a leasing concept that will rely on contracting inpatient care. Not having accessible inpatient care can and has left VA looking for ways to treat veterans in their greatest time of need. As Strategic Capital Investment Planning continues to move forward and more leases are entered into, some of which may have inpatient alternatives, we will continue to be vigilant in ensuring that VA has viable contingency plans for inpatient care.

The second type of lease, called enhanced-use lease (EUL), allows VA to lease property it owns to an entity outside the Department. These leases allow VA to lease properties that are unutilized or underutilized for projects such as veterans' homelessness and long-term care. Proper use of leases provides VA with flexibility in providing care as veterans' needs and demographics changes.

EUL gives VA the authority to lease land or buildings to public, nonprofit, or private organizations or companies as long as the lease is consistent with VA's mission and that the lease "provides appropriate space for an activity contributing to the mission of the Department." Although the EUL can be used for a wide range of activities, the majority of the leases result in housing for homeless veterans and assisted living facilities. Unfortunately, the EUL authority has expired, leaving VA struggling to enter into agreements for underused and unused property. Congress must reauthorize this authority.

## Recommendations:

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

VA should be placing the plant replacement value into its annual capital plan.

Congress must increase funding for the VA major construction account in an effort to close the gaps in major construction within 10 years, starting with \$1.1 billion in FY 2014.

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, starting with \$880 million in FY 2014.

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 \$170 million for research facility infrastructure improvements.

Congress must reauthorize enhanced-use lease authority to VA.



## 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. It costs the Department 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. It has also been 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 assumption regarding the feasibility of using this space is not. Medical facility planning is complex. It requires intricate design relationships for function and must respond to the demanding requirements of certain types of medical equipment. Because of this, medical facility space is rarely interchangeable; if it is, the cost is usually 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 very critical need for inter- and intradepartmental adjacencies that must be maintained 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 spacing 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. When renovating empty space, if an area is not suited to its planned purpose, it will create unnecessary expenses and be much less efficient if simply renovated.

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 while producing a less satisfactory result. Renovations are sometimes appropriate to achieve those critical functional adjacencies 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 simply cannot be renovated for modern needs. Another important problem with this existing, unused space is often location. Much of it is not in a prime location; otherwise, it would have been previously renovated or demolished for new construction.

P. L. 108-422 incentivized VA's efforts to properly dispose of excess space by allowing VA to retain the proceeds from the sale, transfer, or exchange of certain properties in a capital asset fund. Furthermore, that law required VA to develop short- and long-term plans for the disposal of these facilities in an annual report to Congress. VA has documented 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 phases planned include identifying campuses with buildings and land that are either vacant or underutilized, site visits to match the supply of buildings 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 unsuitable for reuse or beyond their usefulness.

*The Independent Budget* veterans service organizations have stated that VA must continue to develop these plans, working in concert with architectural master plans and community stakeholders, and clearly identifying the long-range vision for all such sites.

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## Recommendations:

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VA must develop a comprehensive plan for addressing empty, underutilized, or excess space in nonhistoric properties so that it can be used for other purposes if not suitable for medical or support functions because of age or location.

VA must have greater transparency when initiating its Building Utilization Review and Repurposing plan and 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 are in a constant state of change as a result of factors that include advances in research, changing 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 impact 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. It 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 often results in short-sighted construction that restricts rather than expands options for the future.

*The Independent Budget* veterans service organizations (IBVSOs) 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. We also 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.

VA has undertaken master planning for several of its facilities, and we applaud this effort. But the Department 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.

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### **Recommendation:**

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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 is to be reviewed every five years and modified accordingly, based on changing needs, technologies, new programs, and new patient care delivery models.



## **ARCHITECT-LED DESIGN-BUILD PROJECT DELIVERY**

*The Department of Veterans Affairs must evaluate use of architect-led design-build project delivery.*

The Department of Veterans Affairs 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. It is critical to evaluate the complexity of the project prior to selection of a method of project delivery.

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 are 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 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 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 with 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 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. This 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 has many benefits to VA. One is ensuring the quality of the project, since the architect reports directly to VA. A second benefit is the ability of a single entity to provide tight control over the project budget throughout all stages of the project. 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 commences, 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. It 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 VA change orders along the way.

In addition to selecting the proper method of project delivery, there is much to learn from the design and construction process for each individual project. It is important for VA to apply these "lessons learned" to future projects.

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### Recommendations:

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

VA should use the design-build method of project delivery only 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 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 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 year after year because of a lack of any funding for their upkeep. These structures should be stabilized, protected, and preserved because they are an integral part 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 (IBVSOs) 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 recaptured. For example, the Greek Revival mansion at the VA Medical Center in Perry Point, Maryland, built in the 1750s can 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 simultaneously would preserve history.

The preservation of VA’s historic buildings also fits into 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 IBVSOs encourage VA to use the tenants of P. L. 108-422, “Veterans Health Programs Improvement Act,” in improving 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.

