NON-RECURRING MAINTENANCE PROGRAM

1. PURPOSE. This Veterans Health Administration (VHA) Directive establishes VHA policy for the Non-Recurring Maintenance (NRM) Program.

2. SUMMARY OF CONTENT. This Directive provides policy for the Non-Recurring Maintenance (NRM) Program. The NRM Program focuses on projects that exceed the normal scope and funding limitations of the recurring maintenance program, but that do not exceed limitations for the value of Minor Improvements (MI) that are added by the project as defined in other sections of this directive.

a. Funding for the NRM Program is included within the medical facilities component of the VA Medical Care appropriation.

b. Individual NRM projects must be fully functional and beneficial to VA with no dependency to another project. This does not preclude phased projects; however, each phase must stand alone and not be dependent on any other phased project that has not been fully funded or completed for its full function or benefit.

3. RELATED ISSUES. None.

4. FOLLOW-UP-RESPONSIBILITY. The Director, Healthcare Engineering (10NB), is responsible for the contents of this Directive. Questions may be addressed to 202-273-5880.

5. RESCISSIONS. VHS&RA Supplement to MP-3, Part I, Chapter 4.02b is rescinded.

6. RECERTIFICATION. This VHA Directive is scheduled for recertification on or before the last working day of September 2010.

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NON-RECURRING MAINTENANCE PROGRAM

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes VHA policy for the Non-Recurring Maintenance (NRM) Program.

2. BACKGROUND

a. The primary objective of the NRM Program is to maintain the safe, effective, and efficient function of VHA infrastructure. The program focuses on projects that exceed the normal scope and funding limitations of the recurring maintenance program, but that do not exceed limitations for the value of Minor Improvements (MI) that are added by the project as defined in other sections of this directive. Funding for the NRM Program is included within the medical facilities component of the VA Medical Care appropriation.

b. Individual NRM projects must be fully functional and beneficial to VA with no dependency to another project. This does not preclude phased projects; however, each phase must stand alone and not be dependent on any other phased project that has not been fully funded or completed for its full function or benefit.

3. POLICY: It is VHA policy that the NRM Program is used to maintain safe, efficient, and economical operation of VHA facilities.

4. RESPONSIBILITIES

a. **Deputy Under Secretary for Health for Operations and Management (10N).** The Deputy Under Secretary for Health for Operations and Management is responsible for policy and guidance for the NRM Program.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for managing the VISN NRM Program in a manner that achieves obligation of funds within planned fiscal years and results in funding and program integrity, including:

(1) Approving projects required for inclusion in the national NRM operating plan. All NRM projects with MI costs greater than $25,000 or with total project costs greater than $150,000 must be included in the NRM Operating Plan. NRM projects below this threshold will be approved in accordance with VISN policy, and

(2) Implementing management systems to ensure the MI limit is not exceeded. Particular care will be taken to ensure that, during the course of work, change orders do not cause a NRM project to exceed the MI limit. Projects where actual MI costs reported for a project exceed $500,000 will be reported annually to the Assistant Deputy for Under Secretary for Health for Operations and Management (ADUSHOM).

c. **VISN Capital Asset Managers.** VISN Capital Asset Managers are responsible for coordination and validation of the VISN NRM Program including:

(1) Reviewing projects for compliance with NRM Program requirements and this Directive; and

(2) Implementing; monitoring, and evaluating the NRM Program.

d. **The VISN Support Service Center (VSSC).** The VSSC is responsible for:

(1) Maintaining data systems in support of the VHA NRM Program and for compiling data and reports in support of the national program.

(2) Compiling the draft NRM operating plan for the ADUSHOM from applications entered by the VISNs into the VSSC Capital Assets database.

e. **Medical Facility Director.** The Medical Facility Director, or designee, is responsible for:

(1) Ensuring that the NRM Program is not used where the estimated MI cost, including a pro-rated share of the applicable A/E costs, exceeds $500,000. Due diligence must be exercised when developing cost estimates.

(2) Reviewing projects recommended by facility managers and adding other projects to the submission that is forwarded to the network office.

(3) Conducting an annual risk assessment of infrastructure (utility and facility systems and components) in sufficient detail as to define predictable and preventable infrastructure problems that could result in untoward events. Assessment includes consolidation and analysis of data from all facility condition reports, annual workplace evaluations, accrediting body recommendations, the Capital Asset Realignment for Enhanced Services Facility Condition Assessment, as well as other reviews.

(4) Ensuring that NRM funds are not used to:

(a) Purchase real property;

(b) Supplement construction funds (funds appropriated for major or minor construction projects);

(c) Remodel, alter, amend, construct, extend, improve, modify, or change a (Major, Minor) construction project within a year of the project's final acceptance; and

(d) Improve property determined to be surplus to VHA use in anticipation of an enhanced use project.

(5) Ensuring that NRM projects that propose to improve property not owned by the Federal Government, such as in leased space, have individual project approval by the ADUSHOM.

(6) Ensuring that NRM funds or medical center-controlled funds allocated for NRM work (station-level projects) are not obligated without documentation of: specific budget, scope of work and proper authorization of the designated fund control official. ***NOTE:*** *Such projects may not exceed the MI limit.*

(7) Ensuring that NRM project changes that exceed the approved project specific budget or are outside of the approved scope of work are not submitted or processed. ***NOTE:*** *A new project specific budget and/or new scope of work must first be authorized by the designated fund control official.*

(8) Ensuring that NRM expenditures are documented with clear, auditable records.

(9) Ensuring that NRM projects are submitted for funding consideration using the VISN Support Service Center (VSSC) website at VSSC.med.va.gov/CAPASSETS.

(10) Ensuring that NRM projects with MI exceeding $25,000 or total project cost exceeding $150,000 require monthly Project Tracking Reports (PTR). ***NOTE:*** *An electronic VA Form 1193, Project Application, must be entered into the VSSC Capital Assets database for each of these projects. Once the project is approved for funding by the VISN, a PTR report will be automatically generated for that project and which requires monthly PTR updates until the project is substantially completed.*

5. DEFINITIONS

Elements of work permitted within the NRM Program include non-recurring Maintenance and Repair (M&R), Building Service Equipment Replacement (BSER), Building Service Equipment Additional (BSEA) and MI and associated Architectural and Engineering (A&E) services. The definition and typical work covered in each of these elements are:

a. **Maintenance and Repair (M&R).** M&R includes:

(1) Replacement of complete or segments of utility systems, both interior and exterior to buildings, such as:

(a) Electrical systems,

(b) Heating, ventilating and air conditioning systems,

(c) Fire protection systems,

(d) Medical air, oxygen and vacuum systems,

(e) Plumbing systems,

(f) Sanitary sewer systems,

(g) Chilled water systems,

(h) Steam piping and distribution systems, and

(i) Storm sewer systems.

(2) Replacement of major components of building envelopes, such as roofing, tuckpointing, flashings, copings, exterior finish materials (e.g., brick, masonry, stucco, vinyl) water proofing, windows and doors and replacement of complete or segments of building components such as floor coverings, wall coverings and ceilings.

(3) Maintenance and repair of roads, grounds, and structures. Additionally, any work required for bringing infrastructure into compliance with national mandates or codes, including removal of hazardous materials.

(4) Site preparation necessary to support the installation of replacement medical equipment. This typically includes high cost equipment, such as imaging modalities that require dedicated support space.

NOTE: *M&R is not an appropriate classification for work done in changing function or use of space: Such work is properly classified as MI.*

b. **Building Service Equipment Replacement.** Building Service Equipment Replacement includes replacement of fixed equipment serving the facility when it can no longer be economically maintained, has become obsolete, or so energy inefficient as to be uneconomical to operate. Costs to update or improve existing utility service to the equipment will be identified as M&R.

c. **Building Service Equipment Additional.** Building Service Equipment Additional includes fixed equipment serving the facility that is to be added or expanded in capacity to serve larger areas or functions. Costs of labor for installing systems and utilities to or for the equipment should be identified as MI.

d. **Minor Improvement.** MI includes work required in conjunction with changing the functional use of space, structural changes, or new or additional space. In projects that involve renovation and expansion the costs associated with the expansion will be considered MI. MI costs associated with A&E fees for an NRM project will be pro-rated based on the ratio of MI cost included in the estimated cost of the project to the total project cost, including contingencies and impact costs where applicable.