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VA HEALTH CARE

Lessons Learned From Medical Facility Integrations

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VA Health Care: Lessons Learned From Medical Facility Integrations

Messrs. Chairmen and Members of the Subcommittees:

We are pleased to be here today to discuss preliminary results of our ongoing work on the integration of medical facilities operated by the Department of Veterans Affairs (VA). In general, a VA integration involves a restructuring of the services within two or more medical facilities into a seamless health care delivery system.

VA operates 173 hospitals and over 200 freestanding outpatient clinics nationwide at a cost of about $17 billion a year. Two years ago, VA created 22 networks to help improve service delivery to the 3 million veterans who use its medical facilities each year. Each network is responsible for overseeing between 4 and 11 hospitals. To date, networks have initiated integrations in 18 geographic areas, involving a total of 36 hospitals.[1]

Our work to date has focused primarily on VA's ongoing integrations in Chicago, Illinois, and in Alabama. Our review of the Chicago integration is being done in response to requests by part of the Illinois congressional delegation, including Congressmen Evans and Gutierrez, who serve on the House Veterans' Affairs Committee, and Chairman Bond of the Senate Appropriations Committee's Subcommittee on VA, HUD, and Independent Agencies. Chairman Everett has asked us to review the Alabama integration.

We have visited the four medical facilities being integrated in Alabama and Chicago and their respective network offices. Also, to gain a broader perspective, we discussed VA's other 16 integrations with network officials and others. In addition, we discussed integration issues with several private health care providers and consulting firms.

As you requested, my testimony focuses on (1) the role of facility integrations in reshaping VA's health care delivery system and (2) lessons learned that could help enhance VA's process for planning and implementing ongoing and future facility integrations.

In summary, facility integrations are a critical piece of VA's overall strategy to enhance the efficiency and effectiveness of health service delivery to veterans. VA's strategy is similar to how the private sector health care industry is evolving. In essence, integrations can allow VA to provide the same or higher quality services to veterans at a significantly reduced cost. In just 2 years, by unifying management and consolidating services, VA's

[1]See app. for a list of the 18 integrations.

integrations have produced millions of dollars in savings that can be reinvested in the system to further enhance veterans' care.

But VA also faces inherent difficulties in planning and implementing integrations, primarily stemming from the potential adverse impacts on stakeholders such as veterans, facility and medical school personnel, and members of Congress who represent these groups. For example, while integrations will generally enhance VA's ability to serve veterans, they will likely result in, among other things, fewer, less convenient, or less desirable (1) employment opportunities for VA and medical school employees or (2) training opportunities for medical school residents and students.

With so much at risk, it is imperative that VA plan and implement integrations to maximize their benefits and minimize the adverse impacts. VA's integration planning approach has many positive features. For example, local facilities currently plan and implement their integrations using work groups comprising VA medical facility employees and others, such as affiliated medical school employees. The involvement of local facility employees in planning activities appears to expedite the process, primarily because no two integration situations are alike.

Our work to date, however, indicates areas where improvements could be made. For example, integration decisions are generally made incrementally, that is, on a service-by-service basis, at varying times throughout the process instead of being made on the basis of decisions about all activities across the integrated facilities. Also, planning and implementation activities frequently occur simultaneously, which does not allow for consideration of the collective effect of such changes on the integration. In addition, stakeholders are involved at varying times in different ways but are not always provided sufficient information at key decision points.

Currently, VA is considering ways to improve its facility integration process. With that in mind, our work suggests that VA could achieve better results by

- adopting a more comprehensive planning approach,
- completing planning before implementing changes,
- improving the timeliness and effectiveness of communications with stakeholders, and
- using a more independent planning approach.

Background

Generally, the 18 integrations, with one exception, share some common characteristics. For example, most of VA's integrations to date involve (1) facilities that have complementary missions, such as acute and mental health care; (2) one facility that is significantly larger than the other(s); and (3) only one or no facility(ies) with a strong medical school affiliation. By contrast, Chicago's Lakeside and West Side facilities have almost identical missions, are about the same size, and have strong affiliations with major medical schools.

VA's facility integrations use different ways to improve management, clinical, and patient support services. These include

- unifying management by creating a single team to manage all facilities instead of using separate management teams at each facility;
- consolidating a service by moving all employees and patients to one facility rather than continuing to provide the service at multiple locations;
- centralizing a service by moving some but not all of the employees associated with it to one of the facilities;
- contracting out some services that VA employees have historically provided; and
- reengineering service delivery by designing more efficient and effective ways to do business.

Of the 18 integrations, 5 have reported that all activities have been completed, and they anticipate no additional changes to their management or delivery structure at this time. The remaining integrations are in various stages of planning and implementation, and several anticipate completion within the next few months.

Facility Integrations Play a Key Role in Reshaping VA's Health Care Delivery

Facility integrations are a critical part of VA's nationwide strategy to restructure its health care delivery system to improve access, quality, and efficiency of care to veterans. VA's restructuring plan reflects, in large part, the changes that have been under way in the private sector health care system for some time. Profound changes in the health care environment brought about, in part, by technological advances, economic factors, demographic changes, and the rise of managed care are causing a dramatic shift away from inpatient care and a corresponding increase in outpatient care. Toward that end, VA has been establishing new community-based clinics, emphasizing primary care, decentralizing decision-making, and integrating facilities to provide an interdependent, interlocking system of care. VA's progress to date indicates that integrations are having positive

results, but it remains to be seen whether integrations will reach their maximum potential and accomplish what VA intends and veterans need.

Integrating health care facilities is a complex process that requires careful planning because it can have an adverse affect on many stakeholders, such as veterans, facility employees, and medical school personnel. For example, facility integrations will undoubtedly alter the way veterans receive health care. Historically, each VA facility has generally tried to provide veterans with one-stop service delivery, that is, to provide as many services as possible at a single location. After consolidating services as part of integration, more veterans may have to go to more than one location for care. For example, when acute inpatient care is moved from the Tuskegee hospital to the Montgomery hospital, veterans receiving primary care at Tuskegee will have to use the Montgomery facility when they need a hospital admission. These changes will generally bring VA service delivery practices more in line with those of the private sector.

Integrations nevertheless provide significant benefits to veterans, primarily because VA can reinvest the money it saves in access and service improvements. VA estimates that integration of facilities has generated over $83 million in savings, which has been used, in part, to (1) provide new community-based clinics that expand veterans' access to primary care, (2) offer new services at existing medical facilities, or (3) make existing services more accessible through longer operating hours or shorter waiting times.

Facility integration has also had a significant impact on VA employees. Most savings are achieved by reducing the number of employees providing the same services at multiple medical facilities within the same geographic area. To date, VA has been able, for the most part, to accomplish this reduction through buyouts and routine attrition, although some reductions-in-force were or will be used. In some situations, employees will move from one medical facility to another or transfer to different positions within their current facility, which may require retraining.

In addition, medical school personnel are affected by the integrations. As VA reduces unnecessary duplication of services, medical schools may have to share management of integrated services, which would result in a reduction in the number of physicians employed and residents trained. In addition, some would have to travel to different facilities rather than continue to provide services at their present locations. For example,

medical school employees and others may have to travel between the Lakeside and West Side facilities, a distance of about 6 miles.

Lessons Learned That Could Enhance VA's Facility Integrations

Because of the large reinvestment opportunities potentially available, facility integrations are one of the best ways VA has to improve quality and access to care for veterans while also increasing the efficiency of health care delivery. Currently, VA is considering ways to improve its facility integration process. On the basis of our visits to the Chicago and Alabama facilities and discussions with officials involved with the other 16 integrations, we also believe that improvements can be made to VA's integration process. Our discussions with several private sector health care providers who are involved with major facility integrations have indicated to us that adopting the following changes could bring VA's process more in line with private sector integration practices.

Using a Comprehensive Planning Approach

Integration of VA medical facilities may be more successful if done on a comprehensive planning basis. Such an approach could involve, among other things, a thorough assessment of all potential resources needed to meet the expected workload over the next 5 to 10 years in a geographic service area. At present, VA does not always include these elements in its planning process. Consequently, integration planners do not always consider all viable options, changing conditions, and future investments. This could cause VA to miss better options, which could greatly lower the dollar savings and thus reduce reinvestment opportunities to improve veterans' care.

Comprehensive planning for integration of services that includes all VA facilities within the same geographic service area expands the options available for consideration. For example, in the Chicago area, four VA facilities within 35 miles of each other serve essentially the same veteran population. If veterans' current inpatient needs could be met in three rather than four locations, VA could save about $20 million annually in operating costs, although some of the savings may need to be reinvested to increase outpatient capacity at the three locations or in community clinics. Operating in fewer locations also could generate additional savings by avoiding future renovations and equipment replacement, and possibly through the sale or lease of excess capacity.

VA may realize greater results over the long run if it uses a longer planning horizon. This could enable VA to determine how its current workload will

compare with its future resource needs. For example, as in the private sector, VA's inpatient workload has been decreasing and is expected to continue decreasing over the next 5 to 10 years. If inpatient workload continues to decrease, excess hospital space will increase. Thus, if it uses current workload as a basis, VA may decide that it is not viable to consolidate services, but if it uses future workload estimates, VA may conclude that it is viable to consolidate.

VA may also realize better results if its planning considers all potential resources needed over the next 5 to 10 years. If VA plans for veterans' current needs, it risks using funds for construction, renovation, and equipment that may yield short-term benefits only. For example, in Chicago, VA approved renovations of Lakeside's surgical intensive care unit and emergency room, and the replacement of its cardiac catheterization equipment. For West Side, VA approved the replacement of the angiography suite. If, within 5 to 10 years, the inpatient workload is consolidated at one facility, VA would have realized limited benefits from some of these investments.

Completing Planning Phase Before Implementing Changes

VA's decision-making may be enhanced if it completes all planning for the integrated facilities before beginning to implement the integrations. Each of its 18 facility integrations involved between 2 and 35 work groups to develop proposals to integrate management, clinical, and patient services. VA currently begins implementing proposals as they become available from the various work groups, without first examining all proposals together for an overall perspective.

VA's integration process contains one common decision point—headquarters' approval of the initial proposal to integrate. With this approval, VA essentially decides to operate two or more facilities as a health care system using a single management team. Once an integration is approved, the director for the new system sets up governing boards to direct and oversee the integration process and decision-making. The boards establish work groups to analyze data and explore integration options. Typically, as each work group completes its planning, it submits an integration proposal to the board with recommendations to the director. Once the board approves the recommendations, the director generally begins implementing them.

This incremental approach runs the risk that later work group proposals could affect previously implemented actions. In addition, it is especially

difficult, if not impossible, to assess the reasonableness of VA's decisions when they are made incrementally. For example, VA decided to relocate some administrative staff from the Montgomery to the Tuskegee facility, primarily because VA concluded that sufficient space was not available at Montgomery. But VA had not yet determined how much staffing was needed for a number of other services at Montgomery before implementing these changes. This occurred primarily because, at the time, planning for those services was not completed. VA was still considering, for instance, several options for restructuring Montgomery's and Tuskegee's nutrition and fiscal services, which could greatly affect the availability of space in the Montgomery facility.

VA recognizes the need for a more structured process. Two months ago, it established a team to revise its integration guidance. VA is considering adopting a five-phase process that includes conceptualization, quantitative and qualitative analyses, implementation planning, implementation, and evaluation. These are logical phases in that the end of each phase seems to provide a decision point at which stakeholders may efficiently and effectively participate in VA's process. Moreover, this process suggests that decisions on the proposed integration of services on a facilitywide basis will be made only after planning is completed, because the next phase focuses on the implementation of the plan. As such, this approach should help VA make better integration decisions.

Providing a Detailed Integration Plan to Stakeholders Before Implementation Begins

Stakeholder participation in the process could be enhanced if VA provides a detailed integration plan before implementation begins. VA encourages local facilities to have early and continued stakeholder involvement. The local facilities have worked hard to involve stakeholders by using such techniques as meetings, letters, briefings, newsletters, and videos.

Stakeholders, however, have sometimes found it difficult to understand and support VA's actions because they were not provided sufficient information about the integrations, such as

- how services will be integrated,
- how potential changes will affect veterans and employees,
- why selected alternatives are the best ones available,
- how much the potential changes will cost to implement,
- how much the potential changes will save, and
- how VA will reinvest savings to benefit veterans.

For example, for the Montgomery/Tuskegee integration, VA decided to consolidate administrative services by moving most employees from Montgomery to Tuskegee. However, it made this decision before determining how many or which employees would be moved or what it would cost to renovate the space needed to accommodate the increased number of administrative staff at Tuskegee. Therefore, VA officials could not answer some key questions raised by congressional stakeholders.

VA's incremental planning approach contributes to these communication problems because it limits the amount of information available about the integration before implementation begins. Providing this information would enable VA to communicate more effectively with stakeholders. Moreover, presenting such planning results in a written document that could be shared with stakeholders would further enhance the opportunity for effective communication by allowing VA to obtain stakeholders' views and gain support or "buy-in" for its proposed integration activities.

Using an Independent Planning Approach

Objective facility integration planning based on independent judgment is critical to successful integrations. Making decisions to restructure medical facility services when the decisions could adversely affect the planners' own interests presents an inherently difficult situation. Many competing interests are at stake in VA's integrations, including those of VA employees, medical school personnel, and residents of affected communities. As planners, these groups may not aggressively consider all viable options and may avoid difficult choices by focusing only on marginal changes to the status quo. In such situations, VA integrations might yield less than their full potential benefit to veterans, needlessly limiting savings available for reinvestment.

For example, in the West Side/Lakeside integration, VA uses work groups to study integration of individual clinical services. Medical school faculty chair the work groups that will make proposals for how VA will integrate two of the more important services—surgery and medicine. The work groups are expected to address integration of management and consolidation of services. A potentially divisive issue is whether to consolidate clinical services and, if consolidated, where the services should be located. Because the planners will be greatly affected by the outcomes, it has proven extremely difficult for the competing medical schools to address this issue.

To overcome this problem, a more independent planning approach using planners (full-time VA planners or consultants) with no vested interests in the geographic area could be used to develop data, explore options, and recommend actions to the network director.

In conclusion, VA has only scratched the surface in reaping the benefits of medical facility integrations; the greatest benefits are yet to be realized. Effective integrations involve difficult choices and, as we discussed today, the decisions should be objective and in the best interests of veterans. Toward this end, we encourage VA to continue improving its integration process, because every dollar saved by integrating in a more efficient way can be reinvested to better meet veterans' medical needs or serve veterans who might otherwise not be served.

This concludes my prepared statement. We will be glad to answer any questions you or Members of the Subcommittees may have.

VA's Approved Integrations

VISN[a]	VA health care system	Integrated facilities
1	Connecticut	Newington, CT; West Haven, CT
2	Western New York	Batavia, NY; Buffalo, NY
3	New Jersey	East Orange, NJ; Lyons, NJ
3	Hudson Valley	Castle Point, NY; Montrose, NY
4	Pittsburgh	Pittsburgh (Highland Drive), PA; Pittsburgh (University Drive), PA
5	Maryland	Baltimore, MD; Fort Howard, MD; Perry Point, MD
7	Central Alabama	Montgomery, AL; Tuskegee, AL
11	Northern Indiana	Fort Wayne, IN; Marion, IN
12	Chicago	Lakeside, IL; West Side, IL
13	Black Hills	Fort Meade, SD; Hot Springs, SD
14	Greater Nebraska	Grand Island, NE; Lincoln, NE
14	Central Iowa	Des Moines, IA; Knoxville, IA
17	North Texas	Bonham, TX; Dallas, TX
17	Central Texas	Marlin, TX; Temple, TX; Waco, TX
17	South Texas	Kerrville, TX; San Antonio, TX
20	Puget Sound	American Lake, WA; Seattle, WA
21	Palo Alto	Livermore, CA; Palo Alto, CA
22	Southern California System of Clinics	Sepulveda, CA; Los Angeles, CA

[a]Veterans integrated service network.

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