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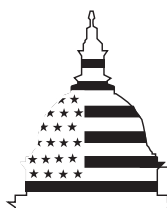
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VA HEALTH CARE

Challenges Facing VA in Developing an Asset Realignment Process

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VA Health Care: Challenges Facing VA in Developing an Asset Realignment Process

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss utilization of health care assets owned by the Department of Veterans' Affairs (VA) and operated by the Veterans' Health Administration (VHA). VHA could spend about one of every four health care dollars operating, maintaining, and improving buildings and land at 181 major delivery locations nationwide—in all, more than 4,700 buildings and 18,000 acres of land.

Four months ago, we reported that VHA's asset plans indicate that billions of dollars might be used operating hundreds of unneeded buildings over the next 5 years or more.¹ This could result because VHA does not systematically

- evaluate how veterans' needs relate to asset needs on a market (or geographic) basis or
- compare assets' life-cycle costs and alternatives, such as purchasing care from other public or private providers, to identify how veterans' needs can be met at lower costs.

We concluded that VHA could enhance veterans' health care benefits if it reduced the level of resources spent on underused, inefficient, or obsolete buildings and reinvested these savings, instead, to provide health care more efficiently in modern facilities at existing locations or new locations closer to where veterans live.

We recommended that VHA systematically develop asset restructuring plans for all medical care markets in a timely manner. From our perspective, such assessments would involve 106 markets, including 66 that have a single VHA delivery location and 40 with multiple locations. Overall, these markets include 165 VHA hospitals.

VHA agreed, in general, with our evaluation and said, at that time, that it would take the steps needed to restructure its portfolio of health care assets. In light of VHA's commitment, you asked us to provide (1) additional information on VHA's hospital utilization and (2) an assessment of efforts to implement an asset realignment process.

¹VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).

My comments this morning are based on our studies completed over the past 5 years that involved

- visits to more than 100 VHA health care delivery locations,
- visits to VHA's headquarters and VHA's 22 regional offices, and
- discussions with more than 500 officials.

Also, we reviewed reports by inspectors general of VA and the Department of Health and Human Services (HHS), as well as private sector consultants regarding hospital utilization.

In summary, VHA's hospital utilization systemwide has dropped dramatically (about 58 percent, or 28,000 patients a day) during the past decade, with most of this decline occurring over the past 3 years. Furthermore, hospital utilization is expected to continue to decline significantly over the next 20 years, primarily because of a projected 36-percent (9 million) reduction in the veteran population. Currently, utilization of individual VHA hospitals varies widely, ranging from an average of 4 to 389 patients per day. About one in three hospitals serves markets experiencing the highest declines in veteran population and lowest utilization among VHA's hospitals (fewer than 50 patients daily in rural hospitals or 150 in urban hospitals).

Over the past 4 months, VHA has made limited progress toward implementing a realignment process. To date, VHA's efforts have focused on discussions of who should lead such a process, how stakeholders should participate, and how decisions are to be made. On the positive side, VHA seems to be leaning toward a process that would allow for stakeholder participation and incorporate asset planning guidelines that are consistent with industry practices. When implementing this process, however, VHA could rely too heavily on local stakeholders who may have vested interests in maintaining the status quo. VHA's past experience suggests that this could result in a protracted decision-making process that continues the expenditure of scarce resources on unneeded buildings, at a rate potentially as high as \$1 million a day.

Background

Within VHA, 22 regional offices, referred to as Veterans Integrated Service Networks, have primary responsibility for health care delivery to more

than 4 million veterans. In each network, a director and a small staff perform a wide range of activities, including asset management.

VHA's 165 hospitals provide a wide range of medical and mental health services. More than three-fourths (125) provide primarily medical and surgical services, whereas the rest provide primarily mental health services—both shorter-term (fewer than 30 days) and longer-term.

In October 1995, VHA began to transform its system from a hospital operator to a health care provider that relies on community-based, integrated networks of VHA and non-VHA providers to meet veterans' needs more efficiently and effectively.² The most notable initiatives involved shifting veterans' care to appropriate outpatient and residential settings, reengineering administrative and clinical processes, and closing services, including medicine or surgery, primarily because of low utilization.

In fiscal year 1999, VHA requested a \$17 billion appropriation to serve veterans' health care needs; VA requested a comparable appropriation for fiscal year 2000. VHA could spend as much as \$4 billion annually for asset operations and maintenance costs, which is generally referred to as the cost of asset ownership. Such ownership costs include utilities and services such as security, grounds care, fire protection, waste collection, pest management, and custodial work. Of note, VHA has more than 5 million square feet of vacant space, which could cost as much as \$35 million to maintain annually.

Most VHA Hospitals Have Low, Declining Utilization

VHA hospital utilization dropped dramatically over the past decade, falling from 49,000 patients a day in 1989 to 21,000 in 1998. Most of this decline has occurred over the past 3 years. During this time, VHA experienced comparable declines in medicine and mental health patients.

These declines stemmed primarily from changing medical practices that reduced inpatient admissions and lengths of stay.³ VHA hospital admissions decreased from about 1 million in 1989 to about 600,000 in 1998, a decrease of about 40 percent. Patients' average lengths of stay per medical admission dropped from 18 days to about 10 days during this time.

As utilization declined, VHA reduced the number of beds that it kept in service. The average VHA hospital size declined from 415 beds in 1989 to

²VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

³VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

158 in 1998. Over the past 3 years, VHA has removed about 24,000 beds from service.

Hospital utilization and operating beds are expected to continue to decline over the next 20 years. Nationwide, the number of veterans (25 million) is declining and their average age (58) is increasing. VHA estimates that the veteran population will number 16 million by the year 2020, a 36-percent decline from today's level. All VHA hospitals project a declining population base for their primary market areas with two-thirds expecting declines greater than 33 percent.

Over the next 20 years, most of VHA's health care buildings will approach or pass their normal useful life expectancy. More than 40 percent, for example, have already operated for more than 50 years, including almost 200 built before 1900. Many organizations in the facilities management environment consider 40 to 50 years to be the useful life of a building.⁴

To gain a perspective on VHA's hospital utilization, we examined hospital closure studies that have been issued annually by the HHS inspector general since 1989.⁵ These studies show that about 600 of 5,400 private hospitals have closed over the past 10 years.

The findings from these studies of hospital closures were similar. Closed hospitals were small, as measured by numbers of operating beds, and had low patient utilization. When the hospitals closed, few patients were affected, primarily because they could get medical care nearby.

The inspector general's latest study, for example, showed that 10 rural hospitals and 28 urban hospitals closed during 1997. Of the rural ones, 6 had fewer than 50 beds. By contrast, 24 of the urban hospitals had 150 beds or fewer.

Our assessment of VHA's 165 hospitals showed that 74 have operating beds comparable, in numbers, to private sector hospitals that closed. Nearly half of VHA's urban hospitals (64 of 136) have fewer than 150 inpatient operating beds and more than one-third of rural hospitals (10 of 29) have fewer than 50 operating beds. As previously noted, VHA's hospitals include longer-term mental health patients, whereas private sector hospitals

⁴Price Waterhouse, Independent Review of the Department of Veterans Affairs' Office of Facilities Management, final report (n.p.: June 17, 1998).

⁵HHS, Office of the Inspector General, Hospital Closure, series 1989 through 1997 (Washington, D.C.: 1991-99).

generally do not. Thus, if VHA's longer-term mental health patients are excluded, a larger number of its hospitals would likely be considered to have low utilization.

On average, VHA's urban hospitals had about 133 patients a day, with 72 percent (89 hospitals) averaging fewer than 150 patients a day. Rural hospitals averaged about 75 patients a day, with about half (15) having fewer than 50 patients a day.

Of note, nearly three-fourths (56) of the 74 smaller urban and rural hospitals serve a veteran population base that is projected to decline more than 33 percent over the next 20 years. In addition, most of these hospitals have health care buildings that are or will soon be more than 50 years old. Over the past 3 years, utilization of those hospitals has dropped by about 50 percent.

VHA's Proposed Realignment Process Faces Implementation Challenges

Over the past 4 months, VHA has worked to design a process for developing asset realignment plans, although progress has been limited. These efforts have focused primarily on discussions between VHA officials and stakeholders. As of last week, VHA officials stated that a decision would be made within 2 months regarding how its asset realignment process will be designed and implemented. They told us that an initiative, referred to as Capital Asset Realignment for Enhanced Services (CARES), had been proposed but that some changes are being considered.

This proposal, as explained to us, appears to be consistent with VA's stated desire to use the Office of Management and Budget's capital asset planning guidelines to systematically develop asset realignment plans. CARES, for example, would direct each region to perform a comprehensive assessment of existing markets that would focus on

- current and future utilization rates;
- asset location, capacity, and condition;
- congruence between need for assets and veterans' demand for services; and
- alternatives to current service delivery modes, including purchasing care from other public or private providers, partnering with such providers, or replacing obsolete assets with modern ones.

As they currently envision it, VHA officials expect locally led steering committees to be established in each of VHA's 22 networks and to serve as the key management entities in the realignment process. They anticipate broad stakeholder membership on these committees, including heads of state veterans' agencies, medical school deans, and representatives of veterans' groups, as well as regional VHA officials. VHA leadership of the committees is not assumed but is to be determined among each committee's members.

VHA officials also expect that each steering committee will (1) independently determine its operating and policy guidelines; (2) use private consultants to collect, verify, and analyze data needed to develop realignment options; and (3) recommend ways that health care assets should be realigned. Officials told us that decisions on recommendations would ultimately be made by top managers in VHA or VA. The steering committees will have the latitude to set their own time periods for completing work, although VHA expects to require periodic progress reports, such as at 6-month intervals.

To be successful, VHA will need to overcome several critical challenges. Foremost, it seems inevitable that the locally led steering committees could struggle to achieve consensus on difficult decisions affecting the status of VHA hospitals and other health care assets. This is because the steering committees could (1) have considerable discretion to make critical decisions concerning how studies will be designed and conducted, (2) be composed primarily of major stakeholders, and (3) not be under the leadership of key VHA managers. In our view, this arrangement could lead to conflict among the various stakeholders sitting on the committees if they attempt to protect their interests at the expense of the overall process.

Our work has shown that VHA's environment contains a diverse group of competing stakeholders, who, quite naturally, could oppose some planned changes that they feel are not in their best interests, even when such changes benefit veterans.⁶ Medical schools' reluctance to change long-standing business relationships, for example, has sometimes been a major factor inhibiting VHA's asset management. Unions, too, sometimes appear to be reluctant to support planning decisions that result in a restructuring of services. This is because operating efficiencies often result in staffing reductions.

⁶Veterans' Health Care: Chicago Efforts to Improve System Efficiency (GAO/HEHS-98-118, May 29, 1998).

Two years ago, we reported on lessons learned from VHA's efforts to integrate the management and services of 36 hospitals in 18 markets.⁷ In general, we noted that objective facility integration planning based on independent judgment and appropriate stakeholder participation was critical to successful integrations. Making decisions to restructure medical facility services when the decisions could adversely affect the planners' own interests presented an inherently difficult situation.

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. We concluded that in such situations VHA integrations might yield less than their full potential benefit to veterans, needlessly limiting savings available for reinvestment.

To overcome this problem, we suggested a more independent planning approach using planners (full-time VA planners or consultants) with no vested interests in the geographic area to develop data and recommend options for improving VHA hospitals' operation, in consultation with stakeholders. We also encouraged VA to provide all stakeholders with sufficient information to understand and support integration decisions.

Another challenge VHA could face involves inherent difficulties in achieving consistent results among the 22 networks without uniform guidelines and criteria on how to conduct market assessments. If steering committees are given wide latitude to develop their own guidelines and criteria, as CARES currently suggests, it seems likely that a variety of approaches to gathering data, assessing information, and decision-making could emerge. As a result, it may not be possible to determine, and therefore ensure, that fair and equitable decisions are made systemwide.

Steering committees may also find it difficult to complete their work in a timely manner. This is because VHA believes that it is essential to use private sector consultants to perform most of the market assessment work, and resources may be available to do only a limited number of markets at one time. VHA estimates, for example, that contracts could cost between \$700,000 and \$1 million for each market that has multiple VHA locations.

As a result, VHA may find it necessary to prioritize its market assessments in order to realize the greatest return on its contracting investment. In this

⁷VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997)

regard, it seems preferable for VHA to establish the 40 multiple location markets as a top priority. Of these, nine have 4 or more delivery locations competing to serve the same veterans; these markets have a total of 46 locations, including 12 with low utilization and rapidly declining veteran populations.

Completing asset realignment plans for these markets first could also help VHA address its financing challenges for conducting other market assessments. This is because such markets should provide an opportunity to dispose of excess or underutilized properties or to develop initiatives that could result in an enhanced use by other public or private organizations. The Congress is currently considering proposals that increase VA's opportunities to retain revenues from the disposal or enhanced use of unneeded buildings. These proposals are compelling because they could provide VA with much needed incentives to make difficult asset realignment decisions in a timely manner.

In recent years, VHA has realized little success with a locally led planning model, like CARES, that relied heavily on stakeholders' involvement. Almost 4 years ago, VHA's New England network began efforts to realign assets among its five delivery locations in the Boston market. Similarly, about 3 years ago, the Great Lakes network initiated efforts to realign services among two of its four delivery locations in the Chicago market.⁸ Both of these efforts were characterized by time-consuming debates among stakeholders that resulted in piecemeal decisions. In neither market has VHA yet reached decisions that are in veterans' best interest.

By contrast, VHA had notable success using a more centralized planning model when assessing the needs of veterans in the Northern California health care market during 1997. In general, a private contractor, in consultation with stakeholders and others, collected data on veterans' needs, existing VA assets, and lower-cost alternatives and presented options to VHA's central office, which also consulted with stakeholders. This approach allowed veterans' needs to be met without building a previously proposed \$200 million hospital addition. These results were achieved in a shorter time than VA experienced in Boston and Chicago.

Of note, VHA has initiated a new asset realignment effort in Chicago that does not heavily involve local stakeholders. A steering committee composed of high-level officials from several regions was established to review data collected by a private consultant and recommend realignment

⁸GAO/HEHS-98-118, May 29, 1998.

options to VHA's central office. However, VA has delayed announcing its decision and therefore the success of this approach is uncertain at this time.

These experiences suggest that constituting steering committees with major local stakeholders may invite protracted conflict. This conflict could delay VHA's realignment progress if entrenched yet opposing interests dominate the workings of the steering committees. In addition, investing stakeholders with decision-making authority could lead to incremental decision-making if consensus cannot be reached on difficult issues. In such cases, conflict could frequently lead to suboptimal decisions.

Prolonging decisions, in our view, is not in the best interest of veterans because it will delay the identification of resources that could be better reinvested to enhance services. Given VA's current and proposed budgets, it seems inevitable that VA's ownership of unneeded assets will eventually compromise veterans' health care services. In contrast, restructuring its capital assets could reduce budget pressures or generate revenues that could be used to enhance veterans' health care benefits.

While it is not possible to say with certainty what the level of operational savings could be, it seems plausible, based on our assessment of VA's Chicago market, that annual savings could reach \$400 million nationally. In Chicago, we found that VA could save \$20 million annually (about 10 percent of asset operations and maintenance costs) if it met veterans' needs in three rather than four hospitals.⁹ As previously stated, VA could spend about \$4 billion annually for asset operations and maintenance nationwide.

Prolonging the completion of market assessments also increases the pressure on VA's capital asset investment process to ensure that scarce resources are not invested in assets that VA will vacate in a few years. VHA's existing plans show that individual locations' needs range between \$4 million and \$38 million, including about 50 with asset needs exceeding \$10 million. Recently, we recommended, and VA agreed, that its capital investment decisions should be subjected to a more rigorous management review.

⁹VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

Concluding Observations

We are concerned that VHA's limited progress toward establishing an asset realignment process needlessly delays the reinvestment of scarce resources to enhance veterans' health care. Furthermore, potential shortcomings in VHA's process as currently proposed—locally led steering committees that have heavy stakeholder involvement—do not instill confidence that VHA will be significantly closer to having a restructuring plan by this time next year than it is today.

Given VHA's past experiences, it seems that a better option for realizing asset realignment decisions in a timely manner would involve a more centralized planning model that is based on consultant or field information and that is free from undue influence from local stakeholders. Without firmer VHA leadership, it seems likely that VHA could take many years to decide on, much less accomplish, systemwide asset realignment. The daily cost of unduly delayed decisions is unacceptably high, given that VA could be spending \$1 million or more a day to operate and maintain unneeded assets.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

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