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Health, Education and Human Services Division

B-271514

August 30, 1996

The Honorable Christopher S. Bond
Chairman, Subcommittee on VA, HUD,
and Independent Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

With its fiscal year 1996 health care budget exceeding $16 billion and the Congress looking for ways to balance the budget, the Department of Veterans Affairs (VA) faces increasing pressure to contain its health care costs. As a result, improving the efficiency of VA's health care operations while maintaining services to veterans is receiving much emphasis.

This letter responds to your request that we examine VA's progress in implementing management improvement initiatives to its health care system. These initiatives stemmed from three draft reports prepared between February 1994 and August 1995 by a Management Improvement Task Force composed of senior VA managers.[1]

VA expects the management improvement initiatives to achieve considerable savings. In this regard, it expected to be able to absorb $385 million of OMB-imposed reductions in its budget requests for fiscal years 1995 and 1996 by providing more efficient health care as a result of the initiatives.[2] In fiscal year 1996, the Congress appropriated $397 million less than VA requested expecting that VA could find even greater efficiencies.

[1]The task force did not issue a final report. Each draft report had recommendations addressing expected budget shortfalls. The reports varied significantly in their savings estimates, ranging from $209 million to over $1 billion. We used all three draft reports in conducting our analyses.

[2]VA stated it would achieve $49.6 million in management improvement savings in its fiscal year 1995 budget submission and $335 million in fiscal year 1996.

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Our work focused on determining

- the extent to which the task force's recommendations have been implemented and measurable savings achieved and

- how, if initiatives have not been implemented, VA plans to manage the reductions in its budget while maintaining patient care.

On May 24, 1996, we briefed your staff on the results of our work. This letter documents and provides additional details on the information provided at that briefing. The scope and methodology of the work is described in enclosure 1.

RESULTS IN BRIEF

VA has concentrated its efforts in implementing the task force's recommendations on those initiatives aimed at reducing centrally funded activities. It has deferred decisions on most of the more significant recommendations (that is, to achieve administrative efficiencies by streamlining and realigning facilities) to the directors of its newly implemented Veterans Integrated Service Networks (VISN) and done little to track initiatives that have been implemented. Of the recommended initiatives under way, the integration of the management structures of 18 medical facilities into 8 is the most significant to date.

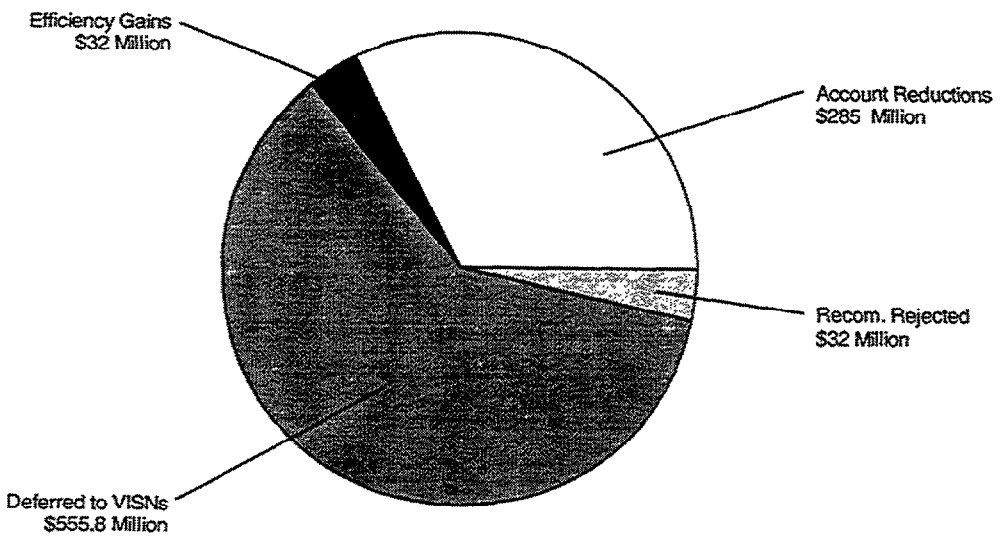
To meet the budget reductions, in addition to reducing centrally funded activities, VA cut facilities' budget allocations across the board. Our work suggests that this approach to cost cutting will not allow VA to achieve cost efficiencies nor will it ensure that patient care will be maintained. For these reasons, in prior reports we recommended ways that VA could (1) improve its budget requests to the Congress by better tracking implemented management improvement initiatives and associated savings and (2) use its resource allocation system to more equitably distribute resources to its medical facilities.

VA'S IMPLEMENTATION OF TASK FORCE RECOMMENDATIONS HAVE FOCUSED ON REDUCING CENTRAL ACCOUNTS

VA has concentrated its efforts in implementing the task force recommendations on those initiatives aimed at reducing centrally funded activities. In fiscal year 1996, for example, VA reduced facility activations by $170 million; equipment purchases by $26 million; and other headquarters-managed accounts, such as national training programs, recruitment and retention, and community nursing home programs, by about $89 million.

VA also expects to save $32 million or more per year through eight facility integrations recommended by the task force that were recently completed or are under way. VA officials told us that these integrations, approved in early 1995, were not scheduled for completion until March 1997. Nonetheless, on the basis of actions taken or planned at the affected facilities as of May 1996, facility directors have estimated associated annual savings ranging from $1.3 million to $11.5 million per facility. Estimated reductions in the number of full-time equivalent positions have ranged from 1.3 to 6.2 percent. To some extent, facilities have used the savings from efficiencies achieved through the integrations to help offset budget cuts. Facility directors also indicated that they have redirected savings to improve patient care. Figure 1 summarizes the implementation status of the most recent (August 1995) task force recommendations. Enclosure 2 details the status of the recommendations in the August 1995 draft report. Enclosure 3 details the integrated facilities, their expected savings, and how facility directors indicated they have redirected funds.

Figure 1: Implementation Status of Management Improvement Task Force Initiatives–August 1995 Report



The task force recommendations with the highest estimates of predicted savings–those for streamlining and integrations–have for the most part been deferred pending the full implementation of VA's reorganization into VISNs.[3] VA officials indicated that VISN directors had received a copy of the task force's most recent report and that decisions on implementing most initiatives would be left to them. Generally, because all 22 VISNs were not operational until June 1996, VA headquarters officials indicated that expecting results from VISN directors was premature. Some facility and VISN directors, however, have been taking steps to streamline certain services and programs. For example, the Portland, Oregon, and Ft. Lyon, Colorado, facilities have reorganized to combine certain services and focus more on patient care. One VISN has consolidated all fiscal activities within one of its medical facilities, which officials have estimated could result in reducing full-time equivalent employees by 50 to 60.

VA also deferred decisions on most of the recommended facility integrations to VISN directors. In all, the task force recommended 45[4] different facility integrations in its draft reports. VA has approved 11–8 in March 1995 and 3 in May 1996.[5] Savings from not-yet-implemented recommended integrations could possibly be greater than those expected from integrations under way or completed. VA officials from some of the integrated facilities (approved for integration in March 1995) indicated that the potential for additional efficiencies from their integrations was less than what might be expected from others because (1) the facilities had been informally integrating services before the integration was formally approved or (2) the facilities initially chosen for integration often had different missions or were geographically dispersed. The potential for efficiency gains is likely to be greater for unintegrated larger facilities that may have duplicate services within close proximity–for example, facilities in urban areas. Enclosure 4 shows the status of additional recommendations made in earlier task force draft reports.

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[3]The reorganization effort began in October 1995 after the task force had already prepared its initial streamlining and efficiency recommendations. The VISNs were generally operational by June 1996.

[4]This does not include five recommendations for consolidating independent outpatient clinics with other facilities.

[5]The eight integrations approved in early 1995 were for facilities in Palo Alto and Livermore, California; Newington and West Haven, Connecticut; Baltimore, Fort Howard, and Perry Point, Maryland; Buffalo and Batavia, New York; Marion and Fort Wayne, Indiana; Temple, Waco, and Marlin, Texas; San Antonio and Kerrville, Texas; and Seattle and American Lake, Washington. The three integrations approved in May 1996 were for facilities in Lyons and East Orange, New Jersey; Pittsburgh (University Drive and Highland Drive), Pennsylvania; and Hot Springs and Fort Meade, South Dakota.

In line with VA's effort to decentralize responsibility and authorities to field managers, VA deferred action on many recommendations in part so that it could lay the groundwork for field managers to act. For example, VA delegated authority to reduce staff to VISN directors in January 1996 for title 5 staff and in March 1996 for title 38 staff.[6] VA also delegated authority to reorganize facilities to facility and VISN directors–necessary for realignments of both clinical and administrative functions–and issued guidance on contracting–necessary to assist facilities in developing contracts in line with National Performance Review objectives. Examples of such contracts, which have subsequently been entered into, include those for fire protection and for laundry services.

As VISNs begin realigning and integrating their facilities and personnel, determining savings will not be possible without better information on actions planned and taken. VA Budget Office officials said that VA has no formal plan or program for achieving the specific management improvement savings cited in its fiscal year 1995 and 1996 budget submissions. Officials acknowledged that those savings estimates were derived from the difference between the budget request that VA submitted to the Office of Management and Budget (OMB) and that which OMB approved. VA officials also said that they had done little to track information on the initiatives under way and completed. To measure the savings achieved and better assess its budget needs, VA would need to collect such information, especially because facilities have been allowed to redirect savings to other uses.

To address this problem, in our July 1996 report[7] to you on ways in which VA could operate more efficiently, we recommended that the Secretary include in future budget submissions (1) information on savings achieved through improved efficiency and (2) plans to either reinvest savings in new services or programs or use the savings to reduce the budget request. The information in this letter further supports the need for a tracking system to obtain this information.

As VISN directors begin to evaluate their facilities, it is not clear at this point whether tracking of VA management improvement initiatives will improve in the near future. VA officials indicated that a critical element of their plan to improve efficiency through the new VISN organization is to hold VISN directors accountable for performance and for

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[6]Title 38 generally governs employment actions for VA physicians, dentists, nurses, physician assistants, and other medical personnel. Title 5 governs such actions for clerical and administrative personnel. Field reorganizations involving significant staff reductions are governed by title 38.

[7]VA Health Care: Opportunities for Further Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996).

strategic planning and resource allocation decisions.[8] VISN director contracts signed in May 1996 laid out 15 performance measures intended to move VA toward a more efficient, outpatient-oriented system. None of the measures or planning requirements, however, calls for the accounting of management improvement initiatives and associated savings. Regarding facility integrations, VA has recently initiated a tracking effort. The Under Secretary for Health directed the VA Management Decision Research Center in April 1996 to develop a plan for evaluating integration benefits. Such a plan, although not developed as of June 1996, would be a step in the right direction.

VA ADDRESSED THE BUDGET REDUCTION MAINLY THROUGH ACROSS-THE-BOARD CUTS

VA, in fiscal years 1995 and 1996, cut each medical facility's budget across the board to compensate for most of the difference between VA's budget proposal to OMB and the amount ultimately appropriated to VA for veterans health care. In fiscal year 1995, for example, VA reduced facilities' budgets by $49.6 million, claiming it as management improvement savings. In fiscal year 1996, after reducing central program accounts by several hundred million dollars as previously discussed, VA addressed the remaining budget reduction of about $414 million by reducing facilities' budgets by this amount.

VA applied this approach to facilities that differ widely in their ability to absorb such reductions. A February 1996 report found that workload costs vary significantly by facility, even after facility size, mission, and geographic cost differences are considered.[9] For example, costs among comparable VA facilities typically varied 30 percent or more between the highest cost and lowest cost facilities. Furthermore, inequities in the way money is allocated to facilities has resulted in some facilities rationing care (for example, by not serving certain categories of veterans) while others are not. For example, fiscal year 1994 data indicate that although up to 13 percent of some facilities' patients were veterans in a discretionary category because they had nonservice-connected conditions and higher incomes, other facilities had treated no discretionary patients.

Because of their differences in cost and workload, facilities vary greatly in their options for managing budget cuts. Therefore, in our view, VA's across-the-board approach to cost cutting does not ensure that efficiencies will occur or that patient care will be maintained.

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[8]On July 8, 1996, VA issued guidance for VISN directors on preparing network plans for achieving VHA's goals and objectives. The first network plan for each VISN is due on September 30, 1996.

[9]Veterans' Health Care: Facilities' Resource Allocations Could Be More Equitable (GAO/HEHS-96-48, Feb. 7, 1996).

Facilities with considerable opportunity for efficiency could reduce their costs by increasing efficiency. Facilities already operating at a relatively high level of efficiency, however, may have to manage budget reductions by cutting services or rationing patient care. Our February 1996 report contained several recommendations for changes needed to improve the equitability of VA's facility allocations. These recommendations included considering within VA's resource allocation system differences in facilities' ability to provide discretionary care and instituting a systematic formal review and evaluation process to examine reasons for cost variations among facilities and VISNs. These recommended improvements to VA's resource allocations should also provide VA a better basis for managing budget reductions while maintaining patient care.

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AGENCY COMMENTS AND OUR EVALUATION

We obtained comments on a draft of this letter from VA (see enclosure 5). VA cited that it is making considerable progress in implementing initiatives that are still appropriate, citing 12 of 14 initiatives under way or completed from those noted in the August 1995 task force report. VA added that it has implemented many other systemwide efficiencies and that it is in the process of implementing others, such as integrating administrative functions resulting from medical center reorganizations; consolidating laundry services; contracting for outside fire coverage and golf course maintenance; and restructuring the mental health program to emphasize outpatient rather than inpatient substance abuse treatment. As our letter points out and VA's own examples demonstrate, however, VA's management improvement initiatives have thus far been targeted toward those projects that are the easiest to implement. Most of the significant work remains to be done.

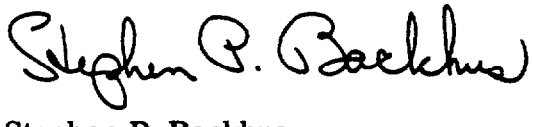
VA indicated that the agency's move to a capitation-based system should correct problems associated with its historical budgeting practices and address the concerns we raised about VA's cutting facilities' budgets across the board to manage budget reductions. We agree that a move to a capitated system would provide more incentives for efficiency in VA's system, but VA will still need to address many issues and information needs before such a system can be equitably implemented. VA's resource allocation system–in place since 1993–was intended to be capitation based, but VA has done little to use the system's data to correct problems with its historical budgeting problems. Our 1996 report had several recommendations for changes needed to improve the equitability of VA's facility allocations, which we believe still apply as VA transitions to a capitation system.

Finally, in response to our view that VHA needs a systematic, centrally directed assessment of major initiatives undertaken and outcomes and savings achieved, VA said that such accountability will be secured through its many ongoing monitoring processes.

For example, VA cited its implementation of the Government Performance and Results Act of 1993 and the development of performance indicators to measure program efficiency and effectiveness. Although we support VA's efforts, we believe that, until these systems are fully developed and operational, VA needs to account for savings achieved so that it can more accurately present its annual budget submissions.

We are sending copies of this letter to the Secretary of Veterans Affairs. We will also make copies available to others on request. The information contained in this letter was developed by Frank Pasquier, Assistant Director; Katherine Iritani, Evaluator-in-Charge; and Linda Bade, Senior Evaluator. Please contact me on (202) 512-7111 if you or your staff have any questions about this correspondence.

Sincerely yours,



Stephen P. Backhus
Associate Director, Veterans' Affairs
and Military Health Care Issues

Enclosures - 5

Enclosure 1

SCOPE AND METHODOLOGY

To assess the extent to which the Management Improvement Task Force-recommended initiatives have been implemented, we interviewed many VA officials and obtained available documentation. Officials interviewed include leaders and staff analysts of the task force and its work groups; the VHA Chief Financial Officer and Budget Office Director; Chiefs of the Medical Programs Formulation Office, Budget Execution Office, and Construction Formulation Office; the Chief Network Officer; and program officials responsible for affected programs. We also interviewed and obtained documentation from several VISN, regional, and facility directors, including the directors of the eight facilities that had begun integrating in March 1995.

To quantify the savings associated with the initiatives undertaken, we relied on (1) estimates developed by the Management Improvement Task Force or, (2) in cases in which VA officials had documented more recent estimates, estimates and support provided by knowledgeable VA officials. We obtained documentation to the extent available but did not independently verify the savings estimates provided.

To determine how VHA planned to manage the potential budget shortfall if initiatives had not been implemented, we analyzed VA budget formulation and execution data showing the basis for VA's requests for budget increases and the fiscal year 1996 initial facility and headquarters program allocations. We discussed the basis for VA's savings estimates with the Office of Management and Budget official responsible for assessing VA's health care budget.

We reviewed various VHA documents on VA's reorganization into VISNs and discussed the status of strategic planning and performance measurement efforts with representatives of the Office of Planning, Policy and Performance Measures.

Our field work was conducted between January and July 1996 in accordance with generally accepted government auditing standards.

Enclosure 2

VHA IMPLEMENTATION OF MANAGEMENT IMPROVEMENT INITIATIVES FROM THE AUGUST 1995 MANAGEMENT IMPROVEMENT REPORT

Dollars in thousands

	Implementation measures undertaken			
Recommended management improvement initiatives	**Account reductions taken in FY 1996**	**Efficiency gains obtained through implementation**	**Initiative deferred to VISN for possible implementation**	**Initiative rejected**
Reduce activation funding	$169,664			
Reduce Central Office managed program accounts	79,058			
Hold capital equipment to FY 1996 account restriction level	26,363			
Decentralize Funding for Prosthetics				Cost shift
Decentralize Community Nursing Home funds to VISN/Medical Centers and/or limit length of contracts	7,103		$142,897	
Reduce Readjustment Counseling Service regional staff at 33% and/or align Vet Centers to Medical Centers and reduce by same percentage as on Target Allowance	2,488			
Eliminate funding for Resident Engineers from Medical Care budget; contract for expert consultants through Major or Minor Construction appropriation	268			
Eliminate funding for Distinguished Physicians program (as vacancies occur)	257			
Eliminate central funding for Recruitment and Retention	182			
Integrate Medical Centers and services where appropriate		$32,062	347,437	
Review and suspend inpatient dental care where applicable			37,000	
Establish national contracts for transplant services			17,500	
Decentralize permanent change of station reimbursements to VISNs; have facilities absorb some costs			11,000	
Limit Beneficiary Travel payments				$32,000
Total	**$285,383**	**$32,062**	**$555,834**	**$32,000**

Note: Analyses based on VHA estimates.

STATUS OF FACILITY INTEGRATIONS AND ESTIMATED SAVINGS

In addition to the major reorganization to replace its regional office structure with Veterans Integrated Service Networks (VISN), the Secretary of VA announced in early 1995 authorization for the organizational integration of 18 VA medical centers into 8 facility management structures. The effort was intended to expand services to veterans, while increasing operational efficiency by eliminating duplicative administrative services and otherwise improving the management of VA's health care facilities.

Because VA did not establish measurement criteria or baseline data that could be monitored to show the progress and savings occurring from the integrations, comparable information on savings achieved from each integration is not available. Instead, VA relied on facility directors to assess how to measure the progress and success of the integrations. To date, this has resulted in the development of measurement data that are neither consistent nor complete. The limited information provided by facility directors indicates, however, that the integrations show significant potential for improving patient care and saving funds.

TRACKING OF INTEGRATION OUTCOMES AND SAVINGS IS LIMITED

A number of factors prevented us from thoroughly assessing the outcomes and savings achieved from the integrations. First, VA headquarters has not established central measures for assessing the progress of the integrations or the efficiencies achieved nor has it directed facilities to compile baseline data with which to measure changes in workload, staffing, and budgets. Facilities were told they could (1) develop their own integration plans as well as the criteria for tracking progress toward the integration goals and (2) retain any integration-related savings[10] and redirect them to patient care activities. The extent to and manner in which facilities have conducted such tracking vary widely. Also, most of the integrations were still in various stages of completion at the time of our review.

The limitations in the available data on facility integrations further support the need for a systematic, centrally directed assessment of major initiatives undertaken, outcomes, and savings achieved and redirected to patient care or other activities. Without tracking

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[10]This was to apply to savings beyond those budget reductions made to all facilities' budgets. As discussed earlier, VA made across-the-board reductions to all facilities' expected budgets in fiscal years 1995 and 1996 to account for a large part of the management improvement savings claimed in its budget submissions and expected by the Congress.

savings from major management initiatives, such as facility integrations and realignments, accurately determining future resource needs is impossible as is accounting for resource expenditures to the Congress and the taxpayers. Furthermore, without identifying measurement criteria and data for assessing progress, it is difficult to assess the initiatives' affect on patient care and ensure that patient care is being maintained. Finally, without a tracking process, VA cannot make resource allocation decisions that target resources to facilities according to their workloads and costs–a goal VA has been trying to meet in making facilities allocations more equitable.

We recommended in a July 1996 report[11] that in future budget submissions the Secretary of Veterans Affairs include (1) information on savings achieved through improved efficiency and (2) plans to either reinvest savings in new services or programs or use the savings to reduce the budget request. If it were to implement this recommendation, VA would need to determine what data are needed to measure progress in meeting the goals of each initiative being undertaken and to ensure that facilities or VISNs are consistently collecting such data and providing them to headquarters on an ongoing basis.

INTEGRATIONS SHOW POTENTIAL FOR IMPROVING PATIENT CARE AND ACHIEVING EFFICIENCIES

On the basis of actions to date, facility directors estimated annual savings from the integrations to equal between $1.3 million and $11.5 million each. Because facility directors used their own–rather than objective–criteria to assess integration outcomes, savings and full-time equivalent employee (FTE) estimates provided may not be directly comparable. Furthermore, because of some facility directors' concerns that identified savings could be removed from future budgets, some estimates are probably conservative.[12] Nonetheless, the information from facility directors shows significant potential for integrations to improve patient care and save money. For example, facility directors provided us with many specific examples of actions to achieve savings, such as eliminating duplicate management and administrative positions, reducing contract hospital

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[11]VA Health Care: Opportunities for Further Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996).

[12]The Management Improvement Task Force Workgroup on Consolidations, in its attempts to outline how dollars and FTEs could be withdrawn from facilities' budgets, found that "many directors feared that any savings they offer now will be swept up without any return to the facility. In addition, those facilities who offered negative replies might not lose any staff or dollars." In contrast to how VA has accounted for savings by uniformly reducing facilities' budgets, the task force recommended that any FTE and dollar cuts as a result of the integrations be distributed to the field on the basis of criteria such as workload.

costs, eliminating costs for duplicate high-technology equipment, and eliminating duplicative services such as radiology or laboratories. Facility directors' estimates of dollar and FTE savings, information on the changes in the number and type of patients served, and the savings redirected to patient care activities are shown in table 3.1.

Enclosure 3

Table 3.1: VA Facility Directors' Estimates of Savings, Workload Changes, and Redirected Funding Resulting From Facility Integrations Approved January - March 1995

State	Affected facilities	Estimated annual savings (as of May 1996)	Estimated related/ other savings[a]	Estimated annual FTE savings[b]	Estimated change in patients served[c]	Change in eligibility criteria	Redirected funds to patient care[b]	Redirected funds for access points[d]	
		Dollars in millions		Percent of preintegration		Categories of veterans served	Dollars in millions	Savings used for access points	Number funded[b]
California	Palo Alto/Livermore	$3.23	$0	1.3	+32	Unchanged	$0	No	0
Connecticut	Newington/West Haven	7.48	3.94	6.2	+4.9	Increased access: Westhaven[e]	1.30	Yes	3
Maryland	Baltimore/Ft. Howard/ Perry Point	3.43	3.00	1.3	+2.2	Unchanged	0.21	No	0
New York	Buffalo/Batavia	2.38	0.25	2.2	Unchanged[f]	Unchanged	0.30	No	0
Indiana	Marion/Fort Wayne	1.70	0.20	2.7	+21.3	Under consideration for change	0.60	No	0
Texas	Temple/Waco/Marlin	2.50	0	6.0	+11.2	Increased access: Temple[e]	2.53	Yes	5
Texas	San Antonio/Kerrville	2.69	0	1.6	Increased[g]	Decreased access: Kerrville[e]	0.75	Yes	3
Washington	Seattle/American Lake[h]	1.26	0	2.8	Unchanged[f]	Unchanged	1.26	No	0
Subtotals		**$24.67**	**$7.39**				**$6.95**		**11**
Total estimated savings		**$32.06**							

[a]Savings that facility directors (1) did not directly attribute to the integration but felt would not have occurred without it or (2) expected to occur in the immediate future.

[b]Based on preliminary information provided by facility directors to the VHA Chief Network Office.

Enclosure 3

[c]Estimates based on available data for (unduplicated or projected unduplicated) unique patients, fiscal year 1995 to 1996 (actual to date or projected year).

[d]Access points are primary care clinics located apart from existing facilities. They are one of the primary means by which VA facilities have recently been improving veterans' access to care.

[e]In cases in which access was increased, the facility began serving higher income, nonservice-connected veterans (Category Cs) that it had not before the integration. In cases in which access was decreased, the facility stopped serving Category C veterans.

[f]Change in projected unique patients for fiscal year 1996 (postintegration) was less than 1 percent.

[g]Data to calculate the percentage increase in workload at the San Antonio/Kerrville facilities (now called South Texas Veterans Health Care System) were unavailable at the time of our review.

[h]The director of the Seattle/American Lake facilities (now called the Puget Sound Health Care System) felt it was too soon to estimate integration savings. The savings shown is the amount the facility indicated to VA headquarters that it had redirected due to the integration from administrative to patient care accounts.

Some facility directors believed that improved patient care services, rather than administrative efficiencies and lower costs, were the main success story for the integrations. All directors interviewed cited examples of ways in which the integrations had allowed them to redirect funds to patient care positions, increase services to veterans, or otherwise improve veterans' access to quality care. For example, with a combined patient database, referrals among facilities were streamlined and the administrative burden associated with referring patients among facilities eliminated. The director of the integrated Palo Alto/Livermore facilities (now called the VA Palo Alto Health Care System) told us that, with the integration, the patients of the smaller Livermore facility had increased access to the wider spectrum of care provided by Palo Alto. Waiting times were also being reduced. Before the integration, Palo Alto had a 6-month backlog of patients waiting to see an ophthalmologist, and Livermore had no backlog. After the integration, the workload was redirected, shortening Palo Alto's backlog without adversely affecting Livermore's patient care workload.

Enclosure 4

STATUS OF VA'S MANAGEMENT IMPROVEMENT TASK FORCE RECOMMENDATIONS MADE IN ALL THREE DRAFT REPORTS

VA's budget submissions for both fiscal years 1995 and 1996 cited management improvement recommendations of its Management Improvement Task Force as examples of how it planned to save several hundred million dollars in its health care budget. Table 4.1 provides information on the status of the recommendations in the task force's three draft reports.

Enclosure 4

Table 4.1: Management Improvement Initiatives Stemming From Task Force Draft Reports

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Activations and capital investments							
Reduce activation accounts as needed to address budget shortfalls (HQ will fund only those clinical or program improvement construction project activations that serve additional unique patients)	Short	512	$83,700,000				**Not implemented**
Reduce activation funding on on the basis of VISN recommendations	Short					$169,664,155	**Account reduction:** FY 1996 budgetary reduction of $169,664,000
Capital equipment and nonrecurring maintenance accounts held to FY 1996 levels	Short					26,363,274	**Account reduction:** FY 1996 budgetary reduction of $26,363,000

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Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Corporate overhead							
Centralized accounts--continue to decentralize and reduce accounts such as the federal telephone system, Federal Employees Compensation Payments and postage/mail accounts for Feb. 1994 report; August 1995 report more comprehensive, dealt with most of the centralized program accounts (see below)	Short	153	14,141,191			3,879,510	**Account reduction:** some centralized accounts reduced in FY 1995; FY 1996 reduction of $79 million exceeded recommendation in total and included accounts for national field units, National Program Office,
	Mid	216	15,955,094				Research Centers, and National
National field units--reduce costs and/or eliminate units, such as National Engineering Service Center, Quality Management, and Information Service Center	Short	55	7,053,427				Training Programs **Account reduction:** see above
	Mid	690	45,239,921				
National program office--minimize staff and use field expertise	Short	4	288,621				**Account reduction:** see above
	Mid	52	3,824,944				

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Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Research centers--fund directors' salary from outside medical care appropriation for AIDS Research Center, Environmental Hazards Research Center, Schizophrenia Research Center, and Alcohol Research Center	Mid	12	1,542,660				Account reduction: see above
National training programs--become self-sustaining; sell service to medical centers for account such as Trainees, Employee Health Care Education Network, Tuition Support, National Training Program, and Academic Affiliations Support	Short	100	10,389,249	49	$7,140,000	7,000,000	Account reduction: see above
	Mid	51	8,448,179	36	2,082,000		
Permanent Change of Station reimbursements--decentralize to VISNs	Short					11,000,000	Deferred to VISNs
Terminal Leave funding--to VISNs	Short					Cost shift	Deferred to VISNs
Management reductions/consolidations							
Abolish Assistant Chiefs in Administration/Support Services	Short	148	8,486,857				Deferred to VISNs
	Mid	1,036	59,407,999				
	Long	296	16,973,714				

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Abolish all Assistant Director and one clerical support position	Short	8	437,944	20	1,520,000		**Efficiency gain:** 28 Assistant Director positions are being abolished; others, as the positions are vacated; no new trainee programs initiated in FY 1996; no tracking or monitoring undertaken to determine savings
	Mid	56	3,065,608	20	1,520,000		
	Long	16	875,888				
Integrate Readjustment Counseling Service (RCS) Outreach into VAMC management as a product of integrations	Short	7	288,494	21	945,000	945,000	**Account reduction:** separate GAO initiative looking at RCS (see GAO/HEHS-96-113); budget reduction of $2.5 million in FY 1996
	Mid	46	2,019,457			1,935,030	
	Long	13	576,988				
Consolidate and/or realign services							
Combine Recreation Therapy and Voluntary Service	Short	20	770,297				Deferred to VISNs
	Mid	140	5,392,077				

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Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
	Long	40	1,540,594				
Combine Engineering and Environmental Management with Plant Management Services	Short	121	4,350,249				Deferred to VISNs
	Mid	847	30,451,743				
	Long	242	8,700,498				
Realign Medical Administration Service and reassign functions	Short	60	1,726,454				Deferred to VISNs
	Mid	420	12,085,175				
	Long	120	3,452,907				
Service Integrations	Short			124	5,991,000		**Deferred to VISNs:** reorganization directive issued in FY 1995 placed responsibility for reorganization onto Medical Center and VISN Directors
	Mid			290	13,979,000		
Assign all independent outpatient clinics/domiciliaries to parent medical centers	Mid	125	6,250,000				Deferred to VISNs

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Medical Center consolidations	Mid	1,457	72,850,000	287	0		**Partially deferred to VISNs:** eight recommended facility integrations begun in FY 1995; three additional authorized in FY 1996; see enclosure 3 for additional details
	Mid			671	44,247,000		
Administrative function consolidations	Short			657	30,718,000		**Deferred to VISNs:** reorganization authority delegated to medical centers and VISN Directors in 1995
	Mid	1,066	53,300,000	657	30,718,000		
	Long			1,314	61,436,000		
Combined administrative/facility integrations	Mid					379,499,000	**Partially deferred to VISNs:** see above service integrations, medical center consolidations, and administrative function consolidations
Consolidate regional offices and Medical Center Administration when geographically close	Mid	304	10,900,000				Deferred to VISNs

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Laundry consolidations	Short			34	961,000		**Efficiency gain:** 5 of 15 recommended laundry consolidations completed in 1995, 5 being completed in 1996, 4 to be done in 1997 for total savings of $40 million
	Mid			39	1,099,000		
	Long			20	564,000		
Resident Engineers program--10% reduction in FTE with further analysis in Nov. 94 version; fund Resident Engineers from *Major or Minor Construction* Appropriation in August 1995 version	Long			13	870,000	6,395,000	**Account reduction:** budgetary and FTE reductions were taken in both FY 1995 and 1996 **Initiative partially rejected:** funding will not be taken from other appropriation
Eliminate Distinguished Physicians Program as vacancies occur	Long					2,076,000	**Deferred to VISNs:** $257,000 budget reduction taken in FY 1996
Decentralize Community Nursing Homes to VISNs	Short					150,000,000	**Deferred to VISNs:** budget reduction of $7 million in FY 1996

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Decentralize Prosthetics to VISNs	Short					Cost shift	**Initiative rejected:** budget reduction of $11 million in FY 1996
Program/service adjustments							
Reduce and/or eliminate Recruitment and Retention program	Short			78	3,800,000	6,042,000	**Account reduction:** $182,000 cut in 1996
Limit Beneficiary Travel funding	Short		83,779,000				Initiative rejected
	Mid					32,000,000	
Minimize provision of patient clothing	Short		3,690,000				Initiative rejected
Discontinue provision/cleaning of employee uniforms	Short	14	1,607,265				Initiative rejected
	Mid	95	11,250,855				
	Long	27	3,214,530				
Eliminate Chronic Dialysis treatment--reduce costs 25%	Short	12	1,249,139				Recommendation under study
	Mid	87	8,743,974				
	Long	25	2,498,278				

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Shift fire protection to local community	Short	23	880,044	16	408,000		**Efficiency gain:** contracting authority revised; task force established to assist medical centers; contracts being initiated in one location (Palo Alto) in FY 1996
	Mid	159	6,160,307				
	Long	45	1,760,088	46	1,173,000		
Shift Chaplain Service to local community	Short	33	1,980,686				Initiative rejected
	Mid	231	13,864,803				
	Long	66	3,961,372				
Alternative revenue streams[b]	Long						Deferred to VISNs
Contracting							
Contract out Psychology Service	Short	130	7,072,256				Initiative rejected
	Mid	909	49,505,790				
	Long	260	14,144,511				
Other contracting for services such as Dental, Environmental Management, Food Service, Organ Transplants, Laundry, Medical/Dental Residents, Medical Media and Security	Short	3,824	0	4,941	0		Deferred to VISNs
	Mid	10,305	0	2,169	0		

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
	Long	2,943	0	2,724	0		
Contracting flexibility delegated to directors						Cost shift	**Implemented:** authority delegated to VAMC/VISN directors,2/27/95
Veteran Service Area(VSA) VISN initiatives							
Realign surgical workload--for facilities identified in FY 1992 VHA surgical study, where surgical average days of care were less than 15	Mid	1,062	52,576,207				Deferred to VISNs
Restructure Mental Health Services (consolidate)	Short	10	529,618				Deferred to VISNs
	Mid	70	3,707,325				
	Long	20	1,059,236				
Restructure Fiscal/Acquisition and Material Management at medical centers	Mid	60	2,400,000				Deferred to VISNs
Realign workload/adjust mission--allow VSAs to realign inpatient workload; realignment report survey dated May 1, 1992	Long	4,700	300,000,000				Deferred to VISNs
Facility/program restructuring[a]							
Small hospitals							Deferred to VISNs
Small acute care bed sections							Deferred to VISNs
Occupancy rates for acute medical beds							Deferred to VISNs

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Small inpatient psychiatry bed sections							Deferred to VISNs
Small Substance Abuse Treatment programs							Deferred to VISNs
Low occupancy rates for psychiatry beds							Deferred to VISNs
Small surgery programs							Deferred to VISNs
Low volume cardiac surgery programs							Deferred to VISNs
Low volume neurosurgery programs							Deferred to VISNs
Duplicate clinical programs							Deferred to VISNs
Low occupancy for intermediate beds							Deferred to VISNs
Small VA Nursing Home Care units							Deferred to VISNs
Low occupancy for Nursing Home Care units							Deferred to VISNs
Low occupancy rates for domiciliaries							Deferred to VISNs
Hospital-based home care programs							Deferred to VISNs
High-cost and/or low-volume programs[a]							
Contracts for heart/lung, kidney, liver, and bone marrow transplant services						17,500,000	Deferred to VISNs
Spinal cord injury and blind rehabilitation							Deferred to VISNs

Enclosure 4

Management improvement initiatives	Management Improvement Task Force draft reports						Manner of implementation
		February 1994 version		November 1994 version		August 1995 version	
	Term[a]	FTE reduction	Savings	FTE reduction	Savings	Savings	
Inpatient dental care--suspend service where applicable						37,000,000	Deferred to VISNs
Dialysis							Deferred to VISNs
Geriatric Research Education Clinical Center							Deferred to VISNs
Savings total: Short-term/FY 1995 or 1996/tactical		**5,234**	**$232,418,791**	**6,240**	**$52,353,000**	**$370,786,969**	
Mid-term/FY 1996		**19,495**	**$478,942,118**	**3,882**	**$93,645,000**		
Long term/FY 1997-98+/strategic		**8,813**	**$358,758,604**	**4,104**	**$63,173,000**	**$480,512,000**	
Grand total		**33,542**	**$1,070,119,513**	**14,226**	**$209,171,000**	**$851,298,969**	

[a]Definitions of time frames for achieving expected savings varied between the three draft reports. Therefore, for presentation purposes we have categorized the recommendations and the expected savings to reflect the perspective at the time of the draft reports' issuance. Specifically, "short-term" savings in the February 1994 report were for fiscal year 1995, while "mid-term" savings were for fiscal years 1996-97, and "long-term" for fiscal year 1998 and beyond. The November 1994 report cited specific years for its savings estimates, while the August 1995 report presented short-term savings estimates as "tactical" (for fiscal year 1996) and long-term savings as "strategic" for those actions that could take 2 or more years for reductions and efficiencies to materialize.

[b]The Alternative Revenue Stream initiative, as detailed in the August 1995 draft report, was developed to identify revenue streams to be used for the provision of veterans' health care. Stated criteria for this initiative are improvement of utilization of government resources, maximization of sharing agreements, pursuit of other entitlements, and consideration of copayments. Revenues could be obtained from sharing agreements, medical care cost recovery, Medicare/Medicaid, CHAMPUS/TRICARE, nursing home care, and domiciliary care.

[c]The Facility/Programming Restructuring initiative, as detailed in the August 1995 draft report, was developed to evaluate operating beds and programs for realignment or restructuring and to improve operating efficiencies.

[d]The high-cost and/or low-volume programs initiative, as detailed in the August 1995 draft report, was developed to evaluate and compare costs of VA programs with privately operated centers or to review the cost-effectiveness of certain clinical activities that serve a small number of patients.

Enclosure 5

COMMENTS FROM THE DEPARTMENT OF VETERANS AFFAIRS

DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

AUG 2 0 1996

Mr. Stephen P. Backhus
Associate Director, Health Care Delivery and Quality Issues
Health, Education, and Human Services Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Backhus:

The GAO Draft Report: ***VHA's Management Improvement Initiatives***, has been reviewed by Veterans Health Administration (VHA) program officials. Many of the issues identified in this report have been addressed by GAO in previous reports, and VHA provided detailed feedback that is still applicable for this report.

While the identified Task Force initiatives were never officially approved and are not necessarily universally applicable throughout the VA system, we are making considerable progress in implementing those that are appropriate today. Of the 14 initiatives identified on page 9 of the report, we have completed or made progress on 12. The remaining two (decentralization of prosthetics funding; reduction of beneficiary travel funding) have not been pursued due to veteran concerns. Many other systemwide efficiencies have also been implemented or are in the process of being implemented. A few examples of these initiatives include the integration of administrative functions resulting from medical center reorganizations; laundry consolidations; outside contracting of fire coverage and golf course maintenance; and restructuring of the mental health program to emphasize outpatient rather than inpatient substance abuse treatment.

As stated in the report, other administrative efficiencies have been deferred to allow integration with the new Network structure. We believe this approach is logical given our decentralized management strategy and the local variability of numerous factors. Network Directors are in the process of developing formal plans that will outline how they plan to manage their systems within constrained resources. Budgets will force the Directors to maximize the efficiencies within available resources.

The report questions our use of pro-rata budget reductions to facility budgets. We are in the midst of a complex, evolving process to move from an historically-based budget system to a capitation-based resource allocation system. This new system should correct problems associated with the historical budgeting process.

Your report also addresses the need for a systematic, centrally-directed assessment of major initiatives undertaken and outcomes and savings achieved. Such accountability will be secured through numerous other ongoing monitoring processes that VHA has designed to analyze costs across the system and identify opportunities for improvement. As one example, VHA is fully complying with the requirements of the Government

Enclosure 5

2. Mr. Stephen P. Backhus

Performance and Results Act (GPRA) of 1993, and we are actively developing and implementing performance indicators that will measure both effectiveness and efficiency in all of our programs. As we continue to progress in these and other major transition efforts, future budget submissions will necessarily include much more sophisticated information about planning and allocation decisions. Investing fully into the GPRA concept of integrating strategic goals with planning, budgeting and performance will help VHA identify, finance and measure the success of Network actions in the delivery of quality health care.

If additional information is required, please contact Paul C. Gibert, Jr., Director, Management Review Service (105E) at 202.273.8942

Sincerely,

for Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

(406113)

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