**United States General Accounting Office**

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 9:00 a.m. CDT
Monday, July 28, 1997

# VA HEALTH CARE

# Opportunities to Enhance Montgomery and Tuskegee Service Integration

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# VA Health Care: Opportunities to Enhance Montgomery and Tuskegee Service Integration

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our ongoing work on the integration of medical facilities operated by the Department of Veterans Affairs (VA) in Tuskegee and Montgomery. The two facilities' managerial, clinical, and patient support services are to be restructured into a single health care delivery system called the Central Alabama Veterans Health Care System. The system is to provide the same or higher quality services at lower costs; savings are to be reinvested to further enhance veterans' health care.

The Montgomery and Tuskegee integration is a major initiative under way in VA's Atlanta network—one of 22 networks that VA created 2 years ago to help improve the delivery of health care services to our nation's veterans. The Atlanta network operates 10 hospitals and 9 freestanding outpatient clinics, which served over 160,000 veterans at a cost of $782 million in fiscal year 1997. This integration is the only one currently under way in the Atlanta network; other networks have initiated facility integrations in 18 geographic locations nationwide.

We have been monitoring different aspects of the 22 networks' operating policies, procedures, and practices since their inception. Because of your concerns about the impact of possible service changes that the Montgomery and Tuskegee integration may have on veterans, employees, and others, we began to collect information on the integration of these facilities about 3 months ago. Specifically, you asked us to assess the progress of VA's integration planning for these two facilities.

On May 5, we accompanied Chairman Everett on a visit to the two facilities. During that visit, officials from VA's Atlanta network as well as from the Montgomery and Tuskegee facilities told us that they were beginning to implement changes. In general, the officials described several ways that service delivery at the two facilities is to be restructured, including

- unifying management by creating a single team instead of using separate management teams at each facility;
- consolidating clinical services, such as inpatient medicine and surgery, by moving all acute-care patients to the Montgomery facility rather than continuing to provide the service at both facilities;
- centralizing administrative services, such as engineering, by moving most employees to the Tuskegee facility; and

- reengineering some services, such as social work and nursing, by designing more efficient and effective ways to meet veterans' needs.

During this visit, however, VA officials were not prepared to provide detailed information about their proposed service changes. Since then, we have discussed the integration of the facilities with officials in VA's headquarters, Atlanta network, and Montgomery and Tuskegee facilities, and reviewed planning documents. We also discussed integration issues with several private health care providers and consulting firms.

On the basis of our work to date, it appears that both Atlanta network and Montgomery and Tuskegee facility officials have made a lot of progress in planning for this integration, and benefits have already been realized. Planning activities, however, are yet to be completed, including (1) making key decisions on whether and how to restructure certain services, such as nutrition and food services; (2) fully assessing the probable impact of clinical, administrative, and patient support service changes on veterans and employees; and (3) determining how savings will be reinvested to benefit veterans. Moreover, some stakeholders have found it difficult, if not impossible, to assess the reasonableness of VA's decisions and to ultimately "buy in" to them without the benefit of information from completed planning activities facilitywide. Because integrating facilities involves inherently difficult issues and requires careful planning, it seems important for VA to complete its planning in sufficient detail to ensure that benefits are maximized and adverse impacts minimized.

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

Facility integrations are part of VA's nationwide strategy to restructure its health care delivery system to improve access to and quality and efficiency of care provided to our nation's veterans. This is being done in a way that reflects, in large part, changes that have been under way in the private sector for some time. Profound changes in health care brought about by technological advances and the rise of managed health care, among other things, have caused a dramatic shift away from inpatient care and a corresponding increase to outpatient care. Toward this end, VA has been increasing the number of ambulatory care access points, emphasizing primary care, decentralizing decision-making, and integrating facilities to provide an interdependent, interlocking system of care.

Integrations can provide significant benefits to veterans primarily because VA can reinvest the money it saves to further enhance veterans' access and improve service availability and quality. VA estimates that integration of

facilities nationwide has generated over $83 million in annual 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, and (3) make existing services more accessible through longer operating hours or shorter waiting times. VA expects the Montgomery and Tuskegee integration to save several million dollars annually, and expects to reinvest part of these savings to establish and operate an outpatient clinic in Dothan.

While integrating health care facilities can be beneficial, it requires careful planning because it affects veterans as well as other stakeholders, including VA employees and residents of local communities. For example, facility integrations may alter the way veterans receive VA health care. Historically, many VA facilities afforded veterans one-stop service delivery; that is, they provided as many services as possible at a single location. When inpatient medicine and surgery services are consolidated at the Montgomery facility, veterans will receive primary care at Tuskegee and will have to use Montgomery when they need a hospital admission. These changes will generally bring VA service delivery practices more in line with private sector practices.

Integration of VA medical facilities also has significant impacts 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 service area. Nationwide, 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. Also, in some situations, employees have been moved from one medical facility to another or transferred to different positions within their current medical facility, which in some cases required retraining. Like other integrations, VA has used buyouts and attrition to reduce the Montgomery and Tuskegee workforce by over 100 employees since beginning integration planning. VA officials expect that additional integration planning decisions will be made that will further reduce the workforce and affect other employees by requiring them to be retrained for other positions.

## Completing Planning Phase Before Implementing Changes

VA's integration planning approach has many positive features. For example, the Montgomery and Tuskegee facilities currently plan and implement their integrations using work groups composed of both facilities' employees. Involvement of local facility employees in planning activities appears beneficial in that it expedites the process, includes those

most familiar with the operations of each facility, and permits stakeholder involvement in the outcome.

But our work to date also raises concerns about VA's integration planning process. Integration decisions are generally made incrementally, that is, on a service-by-service basis, at varying times throughout the process. Also, planning and implementation activities frequently occur simultaneously, without a detailed, comprehensive plan.

By contrast, private health care providers and consulting firms with whom we spoke appear to approach integrations with a more structured process that places greater emphasis on reaching implementation decisions after comprehensive integration planning is completed. Providers generally told us that they prepare written plans that include detailed analyses of services at each facility, how services can best be restructured, and how the changes will affect patients, employees, and others.

VA's process contains one common decision point—headquarters approval of an initial integration proposal before detailed planning begins. With the September 10, 1996, approval of the Montgomery and Tuskegee integration proposal, VA decided to operate the two facilities as an integrated health care system using a single management team. Following this decision, a governing board was established to direct and oversee the integration planning process. The board established 13 work groups to analyze data and explore integration options. These groups then submitted their integration proposals to the board, and subsequently, the network office authorized the implementation phase of the integration. Soon after, the director of the newly integrated facilities established four task forces to analyze in more detail certain aspects of the proposals, including space and relocation requirements. The director has the authority to implement changes on a service-by-service basis as he determines appropriate.

This incremental approach runs the risk that later work group proposals could affect previously implemented actions or, conversely, may be limited by proposals that have already been implemented. In addition, it is almost impossible to determine the reasonableness of VA's decisions when they are made incrementally.

For example, the cornerstone of the Montgomery and Tuskegee integration is the consolidation of acute care at Montgomery and long-term, rehabilitative, and psychiatric care at Tuskegee. In addition, administrative services are to be centralized at Tuskegee. This decision to

relocate administrative staff now employed at the Montgomery facility was based on (1) a determination that there would not be sufficient space available for the administrative staff at Montgomery once acute care was moved there and (2) a perception that this would be fair to Tuskegee because acute care was being moved to Montgomery. However, the decision was made without adequately (1) exploring other options that could alleviate the space concern, such as relocating the staff in other buildings on the Montgomery campus, or (2) taking into account how future changes in workload might affect the availability of space in Montgomery, in which case it might be more prudent for VA to lease space nearby until space becomes available at the Montgomery facility.

Also, because VA had not yet made decisions on how to integrate a number of other services before implementation, some key questions about the availability of space at Montgomery remained unanswered. VA is still considering, for instance, several options for restructuring the nutrition and food service, which could make more space available at Montgomery. For example, one option is to consolidate food preparation at one facility and transport meals to the other. Another option is to contract for services. Selecting one of these options could help avoid the costs of moving administrative employees to Tuskegee. Consequently, without a decision on these options, VA has a limited basis for knowing whether its overall integration decisions will produce optimal results.

## Providing a Detailed Integration Plan to Stakeholders Before Implementation Begins

Stakeholders' participation in the process, and ultimately their buy-in, could be enhanced if VA provided them detailed information on all aspects of the integration before beginning implementation. Several private providers told us that before implementing integration changes, they provide stakeholders information such as services to be integrated and resources required. VA does encourage local facilities to have early and continued stakeholder involvement in the integration process.

While the Montgomery and Tuskegee facilities have worked hard to involve stakeholders by using such techniques as meetings, letters, briefings, and newsletters, some of VA's integration actions are difficult to understand because insufficient information about the integration is currently available, 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, VA's inability to provide sufficient information raised concerns about VA's decision to centralize administrative services at Tuskegee. VA made this decision before determining how many or which employees would be moved and, as discussed earlier, without weighing other options that could affect the need to move administrative staff. Therefore, VA officials could not answer some important questions about the potential impact of this proposed action.

In addition, VA officials' failure to consider all potential construction and renovation costs needed for the two facilities over the next several years raises questions. Estimates presented by the work groups to the board showed that integration renovation costs would be about $300,000, including over $100,000 to renovate the Tuskegee buildings that would house the administrative staff. But a master construction plan discussed at the same board meeting showed that estimated construction costs for the two facilities over the next few years could approach $8 million, including other possible renovation costs to house administrative staff. VA officials said they do not consider this plan to be part of the integration because they believe that many of the projects in it would be done regardless of whether the facilities were integrated. We believe that VA should consider all potential expenditures for the two facilities over the next several years as integration-related decisions so that it can better demonstrate to stakeholders the reasonableness of the renovation costs as they relate to the overall plan for the integration.

VA's incremental planning approach contributes to 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.

VA is currently considering ways to improve its integration planning and implementation process. Toward this end, VA is developing a more structured process that should increase the availability of information at important decision points. However, our work to date suggests that

stakeholders' interests may be better served if VA completed a comprehensive planning phase and achieved buy-in from those stakeholders before implementation.

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

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