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Report to the Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate

April 1998

VA HEALTH CARE

Closing a Chicago Hospital Would Save Millions and Enhance Access to Services

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GAO

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Health, Education, and
Human Services Division

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

Dear Mr. Chairman:

The Veterans Health Administration (VHA) currently operates four hospitals—Lakeside, West Side, Hines, and North Chicago—in the Chicago area at an annual cost of approximately $563 million.[1] These hospitals have experienced a significant reduction in inpatient workload over the last decade. This was caused primarily by changes in the health care environment such as a shift from an emphasis on inpatient treatment to an outpatient-based health care system and a declining veteran population. In fiscal year 1996, the four Chicago-area hospitals provided inpatient care to about 18,700 veterans.

In May 1996, VHA began restructuring to improve the efficiency of the Chicago Lakeside and West Side hospitals by integrating management and consolidating or reengineering administrative and clinical services. These hospitals were selected because they are close together and offer essentially the same services. VHA's primary planning assumption is that both hospitals would continue operating because four hospitals are needed to serve Chicago veterans as well as meet VHA's medical education and research goals and the Department of Defense's (DOD) contingency mission. VHA's planning assumption also recognizes the political difficulties inherent in assessing whether to close a hospital.

In November 1996, you expressed concern that this planning assumption may limit VHA's opportunities to save money and improve care to veterans. As agreed with your office, we assessed whether VHA could serve Chicago veterans with three hospitals and, if so, (1) the extent of the resources that could be redirected to improve patient care and (2) the potential impact of one hospital closure on VHA's other missions.

Although we analyzed data regarding all four Chicago hospitals, our viability assessment focused primarily on whether VHA could meet

[1]VHA, within the Department of Veterans Affairs (VA), is responsible for providing medical care to eligible veterans.

veterans' needs if it closed either the Lakeside or the West Side hospital. We examined these two hospitals more extensively because of the analyses VHA had already done to integrate their management and clinical operations. We recognize that a similar assessment encompassing the Hines and North Chicago hospitals would need to be completed before final decisions are made concerning how to best meet veterans' needs in the Chicago area. We performed our work between October 1996 and January 1998 in accordance with generally accepted government auditing standards. (App. I contains a more detailed discussion of our scope and methodology.)

Results in Brief

VHA can meet the health care needs of Chicago-area veterans by operating three hospitals instead of four. VHA began fiscal year 1997 operating 1,665 inpatient medicine, surgery, and psychiatry beds at the four Chicago hospitals, and veterans used 850 beds a day, on average. The large supply of unused beds provides sufficient capacity to meet the needs of veterans now using Lakeside or West Side. For example, during fiscal year 1997, veterans used an average of 145 and 198 beds a day at Lakeside and West Side, respectively, while during the same period Hines Hospital closed 262 beds and North Chicago closed 244 beds. Moreover, veterans' demand for VHA hospital care is expected to continue declining as (1) treatments shift from inpatient to outpatient settings and (2) the Chicago-area veteran population continues to decrease. In addition, other Chicago public and private hospitals have about 5,700 excess beds, which VHA could use on a contract basis to meet veterans' inpatient needs closer to their homes, as VHA does elsewhere. Regardless, veterans would continue to have good access to health care if either Lakeside or West Side hospital is closed because most of the veterans using these facilities live in essentially the same residential areas.

Our analysis showed that consolidating services into three locations could reduce VHA expenditures an estimated $200 million over the next 10 years by lowering facility operating and maintenance costs as well as avoiding $6 million to $27 million in renovation costs. In addition, VHA could potentially generate millions of dollars in revenues through the lease or sale of property from the closed location. VHA would, however, incur one-time costs for relocating some clinical services, but the savings could be used to enhance services to veterans, including adding needed new community-based outpatient clinics and buying new equipment.

VHA would also be able to meet its education, research, and DOD contingency missions by operating three hospitals. This is because the three remaining locations would likely carry the same workload that four locations would have, thereby providing a sufficient number of patients for VHA to maintain a comparable level of education and research opportunities. VHA will also be able to provide a flexible portion of its operating beds for military casualties, if needed, which was set at about 40 percent in 1997.

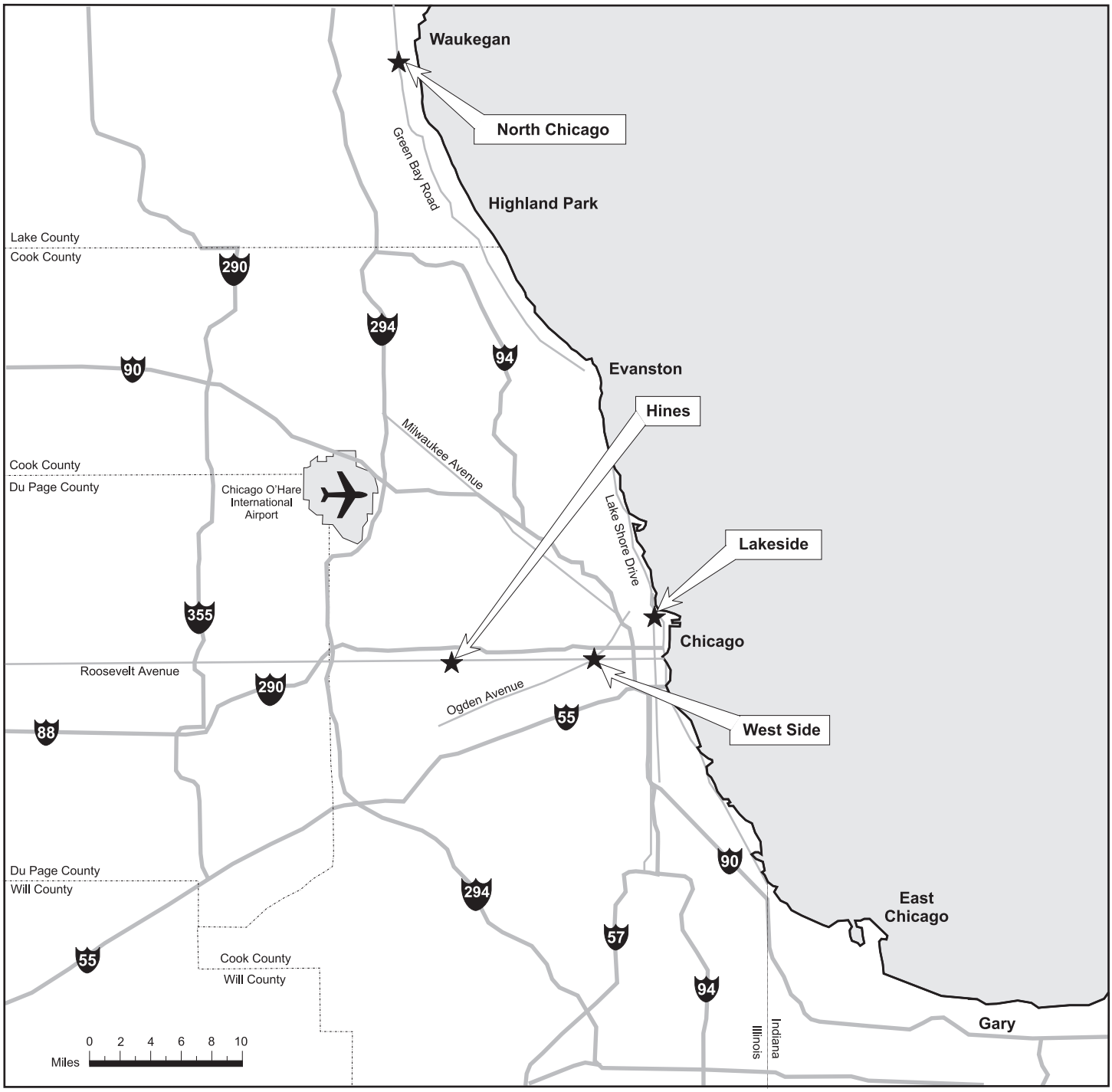
Background

VHA operates one of the nation's largest health care systems, including 173 hospitals and over 400 outpatient clinics nationwide; VHA had about 45,700 hospital beds nationwide in fiscal year 1996. VHA hospitals also purchase health care from other public and private providers under certain conditions, such as during medical emergencies or when they do not provide the services themselves. VHA served about 2.6 million of the estimated 26 million veterans at a cost of approximately $17 billion in fiscal year 1996.

In 1995, VHA restructured its system into 22 service networks covering specified geographic areas that reflect patient referral patterns and the availability of medical services. The Great Lakes network operates eight hospitals that served over 138,000 veterans living in parts of Illinois, Indiana, Michigan, and Wisconsin at a cost of about $915 million in fiscal year 1996. Of these, four are located in the Chicago area (Hines, Lakeside, North Chicago, and West Side). The network also operates 12 outpatient clinics including three in the Chicago area (Evanston, Hyde Park, and Oak Park).

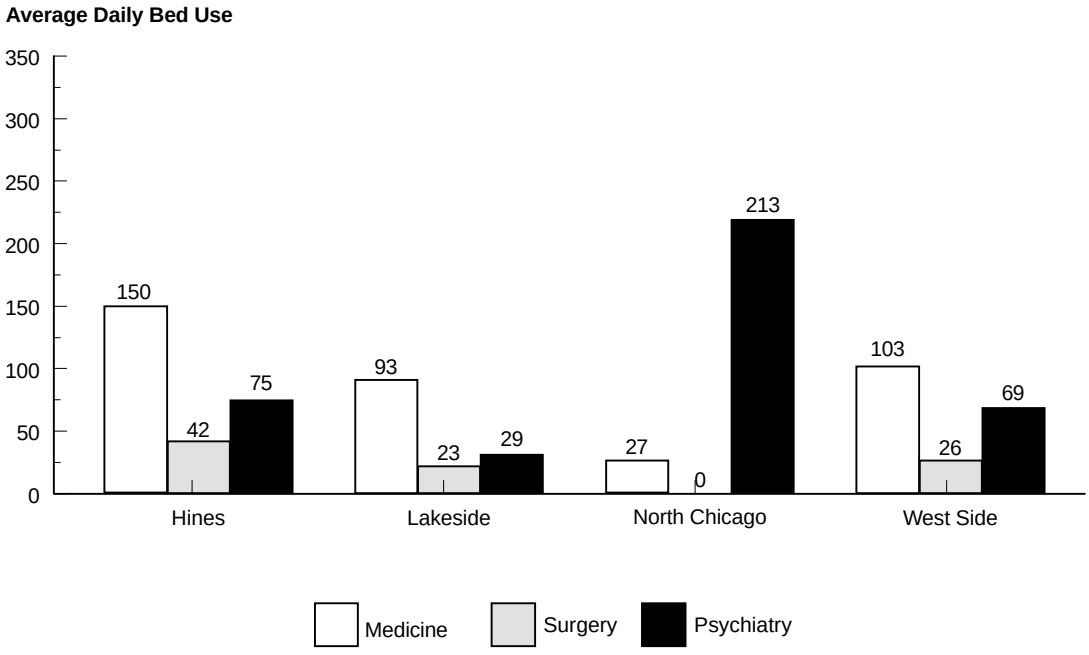
The Lakeside and West Side hospitals are located about 6 miles apart in the city of Chicago (within Cook County). Hines Hospital is also located in Cook County approximately 10 miles west of the West Side facility. North Chicago Hospital is located about 35 miles north of the Lakeside and West Side hospitals. Figure 1 shows the location of the four Chicago-area hospitals.

Figure 1: Chicago-Area VHA Hospitals Are Located in Close Proximity



The four hospitals spent approximately $563 million serving over 78,000 veterans of an estimated Chicago-area veteran population of 722,900. The hospitals operated 1,665 beds for these veterans, who had over 29,200 inpatient admissions and nearly 905,000 outpatient visits. Hines, Lakeside, and West Side are tertiary care hospitals that provide acute inpatient medical, surgical, and psychiatric care; North Chicago, on the other hand, is a psychiatric center, which provides limited inpatient medical care. (Fig. 2 shows fiscal year 1997 average daily bed use for these facilities.[2])

Figure 2: Average Daily Bed Use of Chicago-Area Hospitals, FY 1997



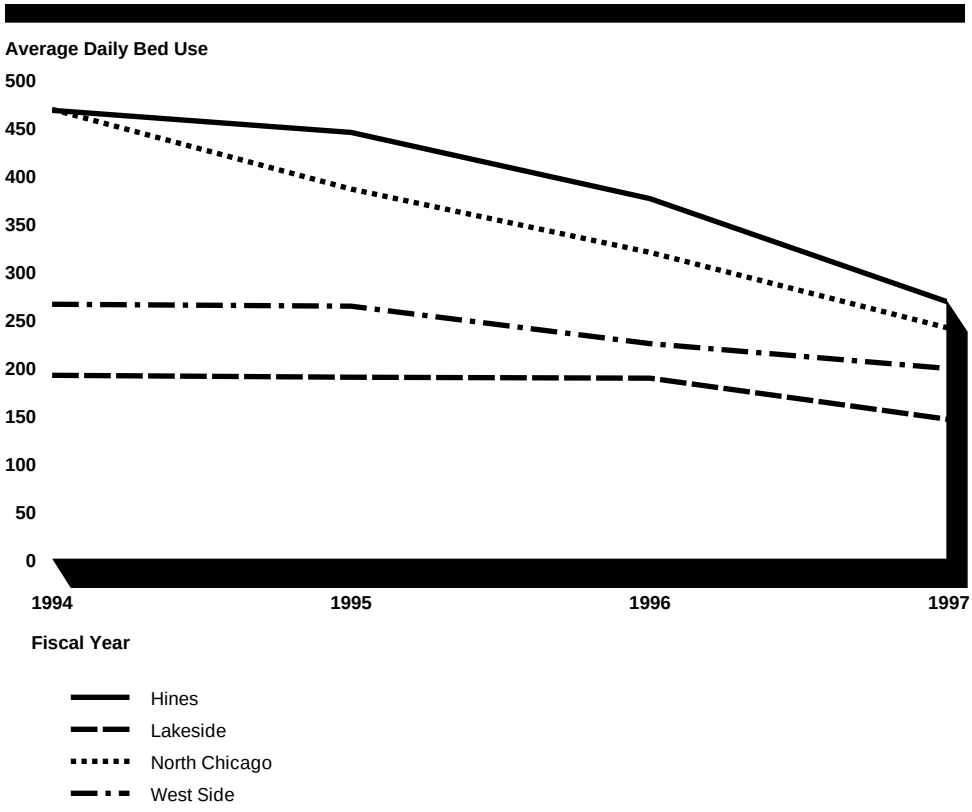
Sources: VHA: Chicago Health Care System Director's Office (Lakeside and West Side); Medical Administration Service (Hines and North Chicago).

Veterans' use of inpatient services has declined in recent years as the Great Lakes network takes steps to meet veterans' needs in the most

[2]Average daily bed use, also referred to as average daily census, represents the total number of beds occupied for a period of time divided by the total number of days in the period (generally 365 consecutive days).

appropriate settings. For example, changes in the delivery of health care have allowed the network to perform more surgeries on an outpatient basis. Also, improved utilization review policies and procedures have reduced inappropriate admissions and lengths of hospital stays. These factors, among others, contributed to a 39-percent decline in average daily bed use among the four Chicago-area VHA hospitals since fiscal year 1994. Hines and North Chicago had the largest declines, as figure 3 shows.

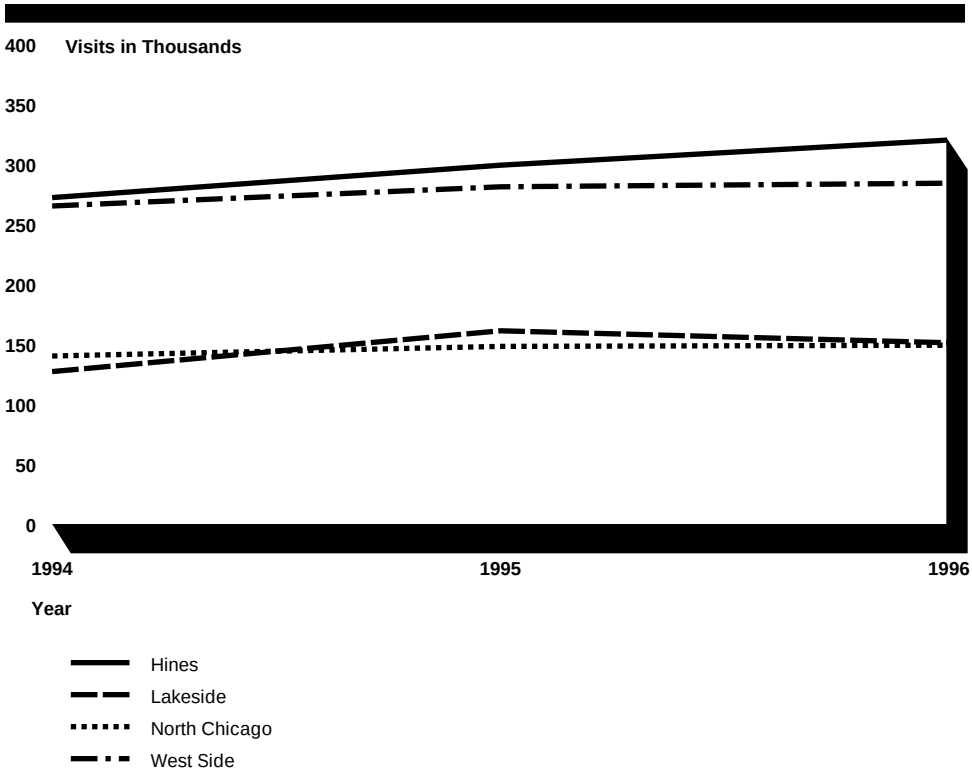
Figure 3: Chicago-Area VHA Hospitals' Bed Use Has Declined



Sources: VHA: Chicago Health Care System director's office (Lakeside and West Side); Medical Administration Service (Hines and North Chicago).

In contrast, veterans' use of outpatient services at the four hospitals has increased by about 13 percent since 1994. Hines Hospital accounted for most of this growth, as figure 4 shows.

Figure 4: Chicago-Area VHA Hospitals Had Varied Growth in Outpatient Usage, FY 1994-96



Source: VA, Summary of Medical Programs, October 1, 1993 Through September 30, 1994, Summary of Medical Programs, October 1, 1994 Through September 30, 1995, and Summary of Medical Programs, October 1, 1995 Through September 30, 1996 (Washington, D.C.: National Center for Veteran Analysis and Statistics).

The Great Lakes network expects outpatient usage to continue growing as it takes additional steps to increase veterans' access to primary care by establishing community-based outpatient clinics (CBOC). The network plans to establish 15 new CBOCs by fiscal year 2000, including 8 in Illinois—2 of which are to be in Chicago. Network officials estimate that it will cost $7.5 million to operate these 15 new CBOCs, which must be financed using existing resources.

In addition to serving veterans' health care needs, VHA has three other medical-related missions: health care education and training, research, and contingency backup to the nation's defense and disaster medical services. First, VHA's health care education and training programs help to ensure an

adequate supply of clinical care providers for veterans and all U.S. citizens. Each year, VHA budgets an amount for resident training; these funds are allocated to networks on the basis of an annual appropriation. Nationwide, VHA has affiliated with 105 medical schools, which annually train about 33,000 residents in VHA facilities. Residents rotate among medical schools' hospitals, VHA hospitals, and other facilities; about 9,100 are working in VA facilities each day. VHA reimburses residents about $350 million for work done in VHA facilities. The four Chicago hospitals serve as training sites for 1,335 residents annually through affiliations with four medical schools (see table 1).

Table 1: Chicago-Area VHA Hospitals Are Source of Training for Residents

VHA hospital	Affiliated medical school	Annual number of residents trained at VHA	Daily number of residents trained at VHA	VHA cost (in millions)
Hines	Loyola University	523	182	$6.0
Lakeside	Northwestern University	297	102	3.9
North Chicago	University of Health Sciences/Chicago Medical School	137	55	2.0
West Side	University of Illinois at Chicago	378	134	4.5
Total		**1,335**	**473**	**$16.4**

Second, the mission of VHA's research program is to contribute to the nation's knowledge about disease and disability. Each year the Congress appropriates money for medical research. VHA allocates monies to researchers based on headquarters' review of research proposals. VHA employees who hold faculty appointments at affiliated medical schools perform nearly all VHA-funded research. Nationwide, in fiscal year 1996, VHA spent $257 million for 1,666 research projects. The four Chicago hospitals spent $11.3 million for 124 projects during fiscal year 1996.

Third, VHA serves as a contingency backup to DOD medical services, and during national emergencies it supports the National Disaster Medical System. In serving as backup to DOD medical services, VHA will provide as many beds as it can make available. For example, in 1997, VHA plans called for providing 10,781 beds within 72 hours of DOD's request for assistance in caring for returning casualties, and a maximum of 13,545 beds—about 30 percent of VHA's total operating beds—available nationwide as soon as possible.

Through its ongoing restructuring effort, VHA has taken over 200 integration actions affecting the Lakeside and West Side facilities.[3] In general, these actions involve three types of changes:

- unifying management of numerous administrative activities instead of using separate management teams at each facility;
- consolidating some services at a single location rather than continuing to provide them at multiple sites; and
- reengineering other services by standardizing operating policies, practices, and databases.

Consolidating Services Into Three Chicago Hospitals Appears to Be a Viable Option for Meeting Veterans' Health Care Needs

Based on the extent of unused inpatient capacity and the decreasing demand for services, VHA can meet veterans' current and future inpatient and outpatient demands by closing one of its four Chicago hospitals. Veterans' access to VHA care would remain essentially unchanged, because most veterans using the Lakeside and West Side hospitals live in the same area now served by three of the four hospitals.

Unused Inpatient Capacity at VHA Hospitals

VHA has sufficient capacity available to meet veterans' needs using three VHA hospitals. VHA's four Chicago hospitals operated 1,665 medicine, surgery, and psychiatry beds at the beginning of fiscal year 1997. Veterans used an average of 850 of these beds a day during 1997. Of the remaining 815 beds, VHA closed (removed) 639 because of a lack of demand. Moreover, 262 of the 639 beds were closed at Hines. In fact, as table 2 shows, more beds were closed at Hines during fiscal year 1997 than the current demand for beds at either Lakeside or West Side.

[3]We are currently studying the impact of VHA's integration actions and will report our results at a later date.

Table 2: Closed Beds at Hines During Fiscal Year 1997 Compared With Current Demand for Beds at Lakeside and West Side

	Medicine[a]	Surgery	Psychiatry	Total
Hines—beds closed in 1997	160	42	60	262
Lakeside—current demand for beds	93	23	29	145
West Side—current demand for beds	103	26	69	198

[a]This category includes general medicine, neurology, rehabilitation medicine, and intermediate care beds.

Source: VHA: Chicago Health Care System director's office (Lakeside and West Side); Medical Administration Service (Hines and North Chicago).

The remaining 377 closed beds afford VHA greater flexibility to close a Chicago hospital.[4] For example, if VHA closed West Side, then it could use 51 beds at Lakeside, 244 beds at North Chicago, and the 262 beds at Hines. In contrast, if VHA closed Lakeside, then it could use 82 beds at West Side, 244 beds at North Chicago, and 262 beds at Hines. (See table 3.)

Table 3: Beds Closed at Lakeside, West Side, and North Chicago VHA Locations, FY 1997

	Medicine	Surgery	Psychiatry	Total
Lakeside	0	11	40	51
West Side	42	20	20	82
North Chicago	38	N/A	206	244
Total	**80**	**31**	**266**	**377**

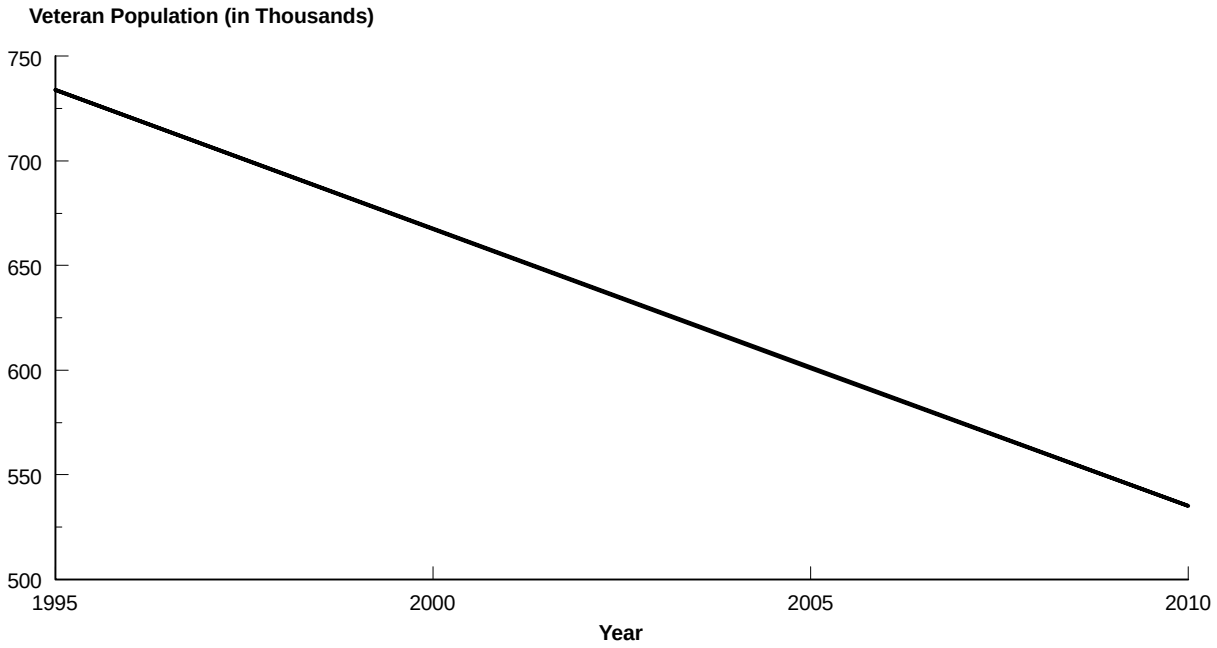
Note: N/A = not applicable.

Source: VHA: Chicago Health Care System director's office (Lakeside and West Side); Medical Administration Service (Hines and North Chicago).

Chicago-area veterans' demand for inpatient care (currently at 850 beds) is expected to decrease, which will further increase VHA's supply of unused beds. This decline in demand for inpatient care is attributable to VHA's actions expected to improve service delivery efficiency as well as to the decline in the veteran population. For example, VHA estimates that the Chicago-area veteran population will decrease by about 27 percent by the year 2010. This decline is expected to occur at a constant rate, as figure 5 shows.

[4]The costs to reopen some of these wards for inpatient use are discussed later in this report.

Figure 5: VHA Projects Steady Decline in Chicago-Area Veteran Population



Source: VHA estimates based on the 1990 National Census as provided by the National Center for Veteran Analysis and Statistics.

VHA should need fewer beds in the future as the veteran population declines and the demand for inpatient care decreases. In fiscal year 1997, veterans used Chicago beds at the rate of roughly 12 beds per 1,000 veteran users, which was about the same as the fiscal year 1996 VHA national average.[5] If veterans' use of Chicago hospitals in future years is at the same rate as the past year, then overall use will decline. In 5 years, at the same bed rate, assuming that a 9-percent decrease in the number of veterans will result in an equivalent decrease in veteran users, veterans will need about 58 fewer beds than are currently used. Moreover, if the Chicago hospitals' efficiency initiatives continue to be successful, further reductions in veterans' bed use are likely. For example, VHA's Southwest network has the lowest bed usage of the 22 networks—6 beds per 1,000

[5]Since beds for patients with spinal cord injury and those for rehabilitation of the blind are included in the nationwide analysis, for comparative purposes, they are added to the operating bed totals for the Chicago-area hospitals.

veteran users. If the Chicago-area VHA hospitals could achieve this use level, they would need 426 fewer beds to support the inpatient workload.

Unused Inpatient Capacity in Non-VHA Hospitals

Like VHA, other public and private hospitals in Chicago have many unused beds. VHA has instructed networks to establish integrated systems where VHA hospitals refer patients to local providers for care where and when appropriate to best meet the needs of those veterans. In October 1996, the Congress relaxed the requirements VHA must follow to contract with such hospitals to better meet veterans' health care needs.[6] This should afford VHA opportunities to meet many veterans' needs more conveniently and potentially at less cost.

Chicago-area hospitals have substantial excess capacity that VHA could use for inpatient services. The Illinois Department of Public Health licensed beds at 71 hospitals to operate in Cook County in 1997. On the basis of the 56 hospitals that responded to a 1995 American Hospital Association survey, these hospitals have more than 5,700 excess beds a day. For example, on any given day, three hospitals located within about six blocks of West Side Hospital—Cook County Hospital, Rush-Presbyterian-St. Luke's, and the University of Illinois at Chicago—could potentially accommodate nearly 640 inpatients for medical, surgical, and psychiatric services. Similarly, excess bed capacity also exists in the areas surrounding VHA's Hines, Lakeside, and North Chicago hospitals.

Moreover, many veterans live closer to other public and private hospitals with excess capacity than they do to VHA's hospitals. For example, about 2,000 veterans reside in an area about 7 miles north of Lakeside and West Side, where there are seven private hospitals with a combined total of over 700 unused beds daily. These veterans currently occupy about 24 medicine and surgery beds a day at Lakeside and West Side that VHA could contract for, thereby providing a more convenient option for veterans than the VHA hospitals. (See app. II for a summary of the number of unused beds in Cook County.)

Maintaining Availability of Outpatient Care

VHA can also meet veterans' outpatient treatment needs while operating three hospitals, but some service delivery changes would be required. VHA currently operates up to 46 different primary care and specialty care clinics located within each Chicago-area hospital. Primary care clinics generally operate 5 days a week, whereas specialty clinics operate less

[6]P.L. 104-262 (1996).

frequently and their schedules vary by clinic. During fiscal year 1996, veterans visited the four hospitals' outpatient clinics about 905,000 times. About half of these visits were made to Lakeside and West Side, as table 4 shows.

Table 4: Outpatient Usage Varied Widely at Chicago-Area VHA Hospitals, FY 1996

Hospital	Outpatient visits	Percentage of outpatient visits
Hines	320,511	35
West Side	284,034	31
Lakeside	151,009	17
North Chicago	149,282	17
Total	**904,836**	**100**

VHA has at least five options for maintaining the current level of services with three hospitals. First, on the basis of estimates from each facility's outpatient service chief, three of the four outpatient treatment areas could absorb at least a 10-percent increase in workload without additional resources such as space and staff. For example, VHA may be able to handle as many as 30,000 additional outpatient visits at Lakeside or 28,000 visits at West Side.

Second, VHA has the option to extend the hours for outpatient clinics located in the hospitals. For example, two service chiefs estimated that by (1) extending operating hours to nights and weekends and (2) increasing the number of staff, workload could be increased by 30 to 50 percent. The increased workload would be handled by shifting staff from the location that would be closed. VHA could handle an additional 200,000 or more visits at the three remaining hospitals.

Third, VHA could convert some inpatient wards into outpatient clinic areas. This could allow the remaining hospitals to handle more of Lakeside's or West Side's visits. As previously discussed, the delivery of health care is shifting from an emphasis on inpatient care to outpatient treatment. As the number of inpatient wards continues to decline, VHA can modify the existing space into outpatient treatment areas. We discuss later in this report the estimated costs to convert inpatient wards into outpatient treatment space and the costs associated with the other options (see "VHA Will Incur Costs in Closing a Hospital").

Fourth, VHA could establish additional CBOCs to provide expanded primary care capabilities. These clinics enable VHA to, among other things,

(1) improve veterans' access to care, (2) shorten waiting times at hospital-based outpatient clinics, and (3) provide treatment in settings more appropriate for outpatient services. Fifth, VHA has the option of building new outpatient capacity for primary care or specialty care on the grounds of an existing hospital location or at a remote location.

Maintaining Accessibility of Care

VHA should be able to maintain veterans' access to care if services are consolidated in three hospitals. This is because the Lakeside and West Side hospitals are about 6 miles apart and, as a result, are competing to attract veterans from essentially the same geographic area. In fact, veterans living in the vicinity of the three hospitals located in Cook County do not rely on any one hospital for their care.

Most veterans in the Chicago area live within 25 miles of the three VHA hospitals, and closing one hospital will not increase that distance. By reopening some wards, VHA can close one of the facilities, shift the workload to the other three hospitals, and continue to provide the same level of inpatient service that is now available to veterans in the Chicago area. As figure 6 shows, three hospitals—Hines, Lakeside, and West Side—are located in Cook County, which accounts for the vast majority of the hospitals' primary service areas, which we defined as a 25-mile-wide area surrounding each facility.

Figure 6: Service Areas for Three Chicago-Area VHA Hospitals

Veterans living in the same vicinity use all three VHA hospitals located in Cook County (see table 5). The veteran population in Cook County was estimated to be 411,000 in fiscal year 1996. Of these, about 49,500 veterans use the three hospitals annually, accounting for about 75 percent of the total veterans served.

Table 5: Cook County Veterans' Usage of VHA Hospitals, FY 1996

VHA hospitals in Cook County	Number of veterans who received services	Percentage of total veterans served
Hines	19,043	38.5
West Side	18,565	37.5
Lakeside	11,903	24.0
Total	**49,511**	**100**

Moreover, city of Chicago veterans' use preferences are not greatly affected by the accessibility of VHA's hospitals. For example, Chicago veterans live in 66 different residential areas as defined by U.S. Postal Service zip codes. During fiscal year 1996, West Side Hospital attracted the largest number of inpatient and outpatient users in 31 of the 66 areas, although these users represented a majority (more than 50 percent) in only 19 areas, as table 6 shows. (See app. III for a breakdown of each Chicago zip code area and the number of veterans residing in these areas who used the three hospitals for inpatient and outpatient services.)

Table 6: City of Chicago Veterans Used All Three Chicago-Area VHA Hospitals in FY 1996

Facility used by most veterans	Number of areas where facility had largest number of users	Number of areas where facility had more than 50% of users
West Side	31	19
Lakeside	18	12
Hines	16	9
Evenly distributed	1	Not applicable

During discussions with us in July 1997, veterans also expressed a willingness to use different hospitals. For example, during interviews we conducted with 190 veterans who received care at either the Lakeside or West Side VHA hospitals, 75 percent indicated that they would use another VHA facility if the one they presently use was closed. Of the remaining 25 percent, 17 percent of the veterans were not certain where they would obtain care, and 7 percent said they would use non-VHA care.

Also, VHA currently operates a shuttle service between the Lakeside and West Side hospitals that runs throughout the day. A more limited service is available between these two hospitals, Hines, and an outpatient clinic in Crown Point, Indiana. VHA could modify this system to minimize veterans' inconvenience caused by the shifting of services if a hospital is closed. Depending on which hospital is closed, VHA could expand its service to (1) include North Chicago; (2) run between any outpatient clinics not already part of the shuttle service, including new clinics that may open in the future; and (3) run more frequently to certain locations. VHA has recognized that making modifications to existing transportation systems was integral in helping veterans adjust to service delivery changes at other locations.

Meeting Veterans' Health Care Needs in Three Rather Than Four Hospitals Could Save Millions

If VHA consolidated services into three hospitals it could reduce expenditures over the next 10 years by about $200 million or more for (1) facility operating and maintenance costs and (2) renovation costs. Additionally, VHA may be able to generate revenues through the lease or sale of the fourth hospital.

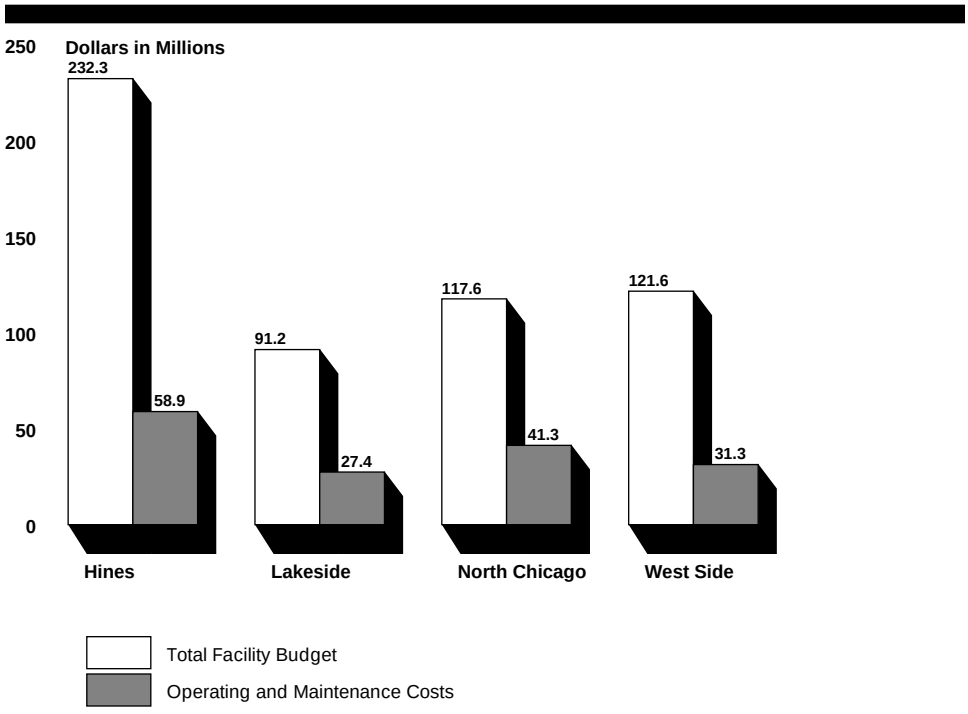
VHA will likely need to use some of the savings from consolidating services to prepare existing or new space for the workload to be relocated, primarily to meet veterans' outpatient treatment needs. In this regard, VHA has many relocation options, and the extent of relocation costs could vary greatly depending on the hospital to be closed and the mix of options VHA determines to best meet veterans' needs. For example, VHA's costs to prepare space to accommodate the smallest hospital's workload could be relatively low—perhaps as little as $5 million—if VHA decides to use existing space to treat the closed hospital's workload. This may involve expanding the hours of operation at the remaining three hospitals' outpatient clinics or converting inpatient space into outpatient treatment areas. VHA may also decide to rely, in part, on new CBOCs to help meet veterans' needs. In contrast, relocation costs could be much higher, as much as $50 million, if VHA decides to construct new outpatient space at one of the existing hospitals or in another location.

VHA would need to develop a more detailed plan to determine which hospital to close and how to meet veterans' needs in the remaining hospitals. Regardless, all of the relocation costs should be incurred within 1 to 2 years, while the savings will continue to accrue indefinitely. The potential savings and costs associated with closing a hospital are described in greater detail in the following section.

VHA Can Save Millions in Facility Operating and Maintenance Costs

Through consolidating services, VHA can save millions by reducing or eliminating facility operating and maintenance costs. VHA spent approximately $563 million during fiscal year 1996 to provide health care services to veterans at the four Chicago-area locations. Of the $563 million, about $404 million was directly related to the delivery of medical care, including direct clinical costs such as surgery and indirect clinical costs such as pharmacy and laboratory. The remaining approximately $159 million was for facility operating and maintenance costs, such as utilities, cleaning, security, and maintenance. These costs generally represent about 25 to 35 percent of a facility's operating budget, as figure 7 shows.

Figure 7: Facility Operating and Maintenance Costs at Chicago-Area VHA Hospitals Are Significant



Source: VHA, VHA/CFO Financial Management Office, Accounting/Reports and Systems Service, Washington, D.C.

By consolidating services in three locations, VHA can realize significant savings from facility operating and maintenance costs. This is because

most of these costs are related to operating at the location, such as utilities, security, and maintenance. Thus, most of these costs would not be shifted, along with patients, to other locations. Facility operating and maintenance costs are primarily devoted to labor, although about 38 percent are for nonlabor expenses.

VHA could save roughly $20 million annually in facility operating and maintenance costs if it closed one Chicago hospital. Specifically, VHA could avoid spending $21 million to $23 million[7] a year to operate and maintain either Lakeside or West Side. However, with the shifting of the closed hospital's workload to other VHA locations, those facilities would incur a relatively small increase in operating costs (possibly about $1 million) for utilities. For example, two VHA engineers estimated that utility costs would increase by 15 to 25 percent if all of the workload from either Lakeside or West Side shifted to one location.

VHA Can Save Millions by Forgoing Renovations

VHA expects to spend significant amounts of resources to renovate and maintain the four hospitals over the next 5 years and beyond. The Lakeside and West Side hospitals began serving veterans over 40 years ago. Although the facilities have been significantly modernized during the intervening years, each remains in need of extensive renovations. VHA could save millions of dollars by consolidating into three locations and avoiding future capital investments at the Lakeside or West Side location.

The Lakeside and West Side hospitals both need renovations. VHA engineers at both hospitals estimate that a total of almost $73 million will be needed to improve these facilities so that VHA can continue to meet veterans' health care needs, about $6 million to $27 million of which will be needed within the next 5 years for West Side and Lakeside, respectively. These capital expenditures include such items as correcting fire safety deficiencies, improving air conditioning, renovating inpatient ward areas, renovating outpatient space, removing asbestos, improving roads, and modernizing elevators.

Additional Revenues Possible Through Lease or Sale of Unused Properties

VHA could also generate revenue through the lease or sale of its excess real property that would result by consolidating services into three locations. The value of real estate leases and sales depends largely on the location of the properties, amount of space available, condition of the buildings, and

[7]These savings estimates were developed jointly by the director's financial staff at the VA Chicago Health Care System and GAO.

local market conditions. Lakeside and West Side are located in areas that seem likely to generate millions of dollars in potential revenues.

Currently, by law, proceeds from the lease or sale of VHA property must be deposited into the miscellaneous receipts account of the U.S. Treasury or into specific designated funds or accounts. For example, all of the net proceeds for leases up to 3 years are deposited into the miscellaneous receipts account. For long-term leases up to 35 years, 25 percent of the revenues are deposited in the medical care account of the VHA facility at which the property is located. The remaining 75 percent of the lease revenues are deposited into a VHA nursing home revolving fund. Proceeds from the sale of long-term leased property valued at more than $50,000 are also deposited into the nursing home revolving fund. Moreover, the proceeds from the sale of nonleased real property are also deposited into the nursing home revolving fund. Legislation would be required to authorize VHA to use any of the revenues generated by lease or sale for another purpose, such as improving hospital or outpatient health care services to veterans.

VHA Will Incur Costs in Closing a Hospital

VHA will incur one-time costs to relocate inpatient and outpatient workload if a hospital is closed. In doing this, VHA has a variety of options. Shifting inpatient workload will involve minimal costs if patients are placed in underused inpatient wards in the other three hospitals. At most, VHA would have to reopen five to seven wards (assuming that inpatient wards consist of about 30 beds), depending on which hospital is closed, in order to meet the veterans' demand for inpatient beds at Lakeside and West Side. VHA may have to spend money to return closed wards to operation. For example, VHA has modified some wards and turned the space into administrative or other medical care areas by replacing the beds with furniture and other equipment. In these instances, no structural changes were made to the rooms, and such things as hook-ups for medical gases are still intact. Consequently, returning these areas to their original purpose involves little expense. VHA engineers estimated, on the basis of how the inpatient areas are currently used and the extent of the changes that would be needed, that to restore a ward to inpatient use could be up to $85,000 or less; but some wards could be restored at little or no cost, especially those closed during fiscal year 1997.

The hospital-based outpatient clinics may also experience an increased workload from closing one hospital. Depending on the amount of the workload, the remaining clinics may be able to absorb the additional

workload in the current space. In doing so, by shifting staff and other resources from the closed location, minimal additional costs would be incurred. However, VHA may need additional outpatient treatment space as a result of closing one hospital. As previously discussed, VHA has several options for obtaining such space. Depending on the option selected, the costs could vary significantly. The least costly option, if space is available, might be converting inpatient wards to outpatient treatment areas. On the basis of previous experience converting inpatient wards into outpatient areas, one hospital engineer estimated that it would cost between $50,000 and $100,000 to modify an inpatient floor and create additional outpatient treatment work space.

In another option, consistent with VHA's long-range strategic planning, VHA could create additional CBOCs. VHA would incur start-up costs to establish new CBOCs. For example, some of the recently proposed clinics have an estimated average start-up cost of approximately $120,000. However, VHA expects that these costs will be recovered and, in the long run, CBOCs can meet veterans' outpatient health care needs at less expense than that currently incurred by hospital-based outpatient treatment clinics.

Finally, VHA could opt to build new outpatient capacity. According to VHA estimates, a freestanding clinic that could provide about half of the outpatient workload of the smallest VHA hospital in Chicago could be built today for between $21.5 million and $26 million. A clinic designed to accommodate all of the outpatient visits from the smallest hospital could be built for an additional $25 million. In contrast, VHA may be able to expand its existing capacity at lower costs. For example, VHA could add to its existing facilities at West Side to accommodate an additional 50,000 to 100,000 outpatient visits. VHA estimates this space could be built for between $13.2 million and $28.8 million, depending on whether one floor or two floors are built on the existing site.

VHA Can Fulfill Its Other Health-Related Missions in Three Hospitals

Closing either the Lakeside or West Side hospital should not hamper VHA's ability to meet its other health-related missions. VHA can continue to provide education and research opportunities to physicians and residents in three locations. Also, closing one hospital should not impede VHA from meeting its DOD contingency mission.

VHA Can Provide Education Opportunities

VHA can meet its educational mission in three hospitals because VHA would have the same level of inpatient and outpatient workload in three locations

that it now has in four. As such, the number of residents should be unaffected by the closing because VHA hospitals would continue to provide care to the same number of patients. However, VHA and its affiliated medical schools would need to make some changes in where residents obtain their education opportunities. In essence, the four medical schools would need to share the workload at three hospitals. For example, two schools could share a single hospital, as is done at VHA hospitals in St. Louis and Washington, D.C.

VHA could also develop a networkwide strategy whereby schools train residents at more than one VHA facility, as medical schools now routinely do with other Chicago-area non-VHA hospitals. The medical schools at University of Illinois at Chicago and Northwestern University train residents at multiple sites. The University of Illinois at Chicago, for example, trains residents at 15 other hospitals, while Northwestern sends residents to 4 other hospitals.

VHA Can Provide Research Opportunities

Likewise, VHA and medical schools will need to make some changes in the way research is conducted, but research opportunities should remain the same or even improve. As with education opportunities, the medical schools would likely need to share research laboratories as well as patients. In this regard, through the consolidation of facilities, VHA could provide improved research opportunities to what currently exist at the four hospitals. Since the inpatient demand for care would probably not decrease as a result of closing a hospital, allocating the workload among three hospitals would increase the number of patients at each location, thereby strengthening the research base. By increasing the number of veterans available for study at each location, VHA physicians could have better opportunities to meet their research mission.

VHA Can Make Beds Available to DOD During National Emergencies

VHA can meet its DOD contingency back-up mission in fewer hospitals, as well. Since 1982, VHA has planned to transfer or divert certain veterans to community hospitals in order to make inpatient beds available for DOD. Moreover, the number of beds VHA plans to make available to DOD has been decreasing in recent years. In 1993, the four VHA hospitals planned to make available 1,003 operating beds to DOD in case of national emergency. But in 1997, these hospitals planned to provide 686 (about 40 percent) of their 1,665 operating beds. VHA expects this number will continue to decline as hospitals reduce their inpatient bed capacity.

Conclusions

VHA faces numerous challenges in meeting veterans' needs while operating on a tighter budget. Toward that end, VHA has achieved some efficiencies within the Lakeside and West Side hospitals, such as unifying management of administrative activities and consolidating some services at a single location. However, operating four hospitals does not give VHA the flexibility to spend its scarce resources in ways that could improve veterans' access to care.

More specifically, consolidating patient workload into three locations is viable. There is sufficient capacity to meet veterans' needs and VHA's other health care missions including medical education and training, research, and backing up DOD's health services. Closing a hospital would allow VHA to avoid spending roughly $200 million on facility operating and maintenance costs over the next 10 years. In addition, the sale or lease of the closed facility could provide substantial additional revenues for VHA.

While we believe that our general estimates are sufficient for assessing viability, we recognize that VHA would need to develop a more detailed plan to meet veterans' needs in three hospitals and to identify which hospital to close.

Recommendation

We recommend that the Secretary of Veterans Affairs direct the Great Lakes network director to develop and implement a detailed plan for meeting veterans' needs in three hospitals. This plan should explore all options available and select those that maximize veterans' access to services while minimizing, to the extent practical, the impact on employees, medical schools, and others. The plan should also identify which of the four VHA hospitals in the Chicago area to close.

Agency Comments and Our Evaluation

We received oral comments on a draft of this report from VHA's Deputy Under Secretary for Health and DOD's Office of the Assistant Secretary of Defense (Health Affairs) for Mobilization. Northwestern University Medical School and the University of Illinois at Chicago Medical School provided written comments. Their comments and our responses are described in the following sections. The comments in their entirety from Northwestern University Medical School and the University of Illinois at Chicago Medical School are in appendixes IV and V, respectively.

Department of Veterans Affairs

VA did not concur with our recommendation that the Great Lakes network director should develop and implement a detailed plan for meeting

veterans' health care needs in three VA Chicago-area hospitals. While acknowledging that we make a credible case that services should be consolidated, VA did not agree that a hospital closure is necessarily the best approach at this time. Rather, VA believed further analysis is needed before making such a decision. Therefore, VA will immediately devise plans for a comprehensive, objective assessment of veterans' needs and resources for the entire Chicago service area. VA plans to use a consultant from outside VA to conduct the analysis, which will consider all available options, including hospital closure. If this comprehensive assessment demonstrates that a hospital closure is needed to best meet the health care needs of Chicago-area veterans, VA will initiate such action, assuming any revenues obtained from the leasing or sale of VA properties may be used by VA to improve services for Chicago-area veterans.

VA's proposed actions meet the intent of our recommendation—namely, that they should result in the development and implementation of a detailed plan to meet veterans' needs in three hospitals if doing so is in the best interest of Chicago-area veterans. We recommend that a plan be developed because we recognize that decisions on which hospital to close and how individual services will be merged among the remaining three hospitals require more detailed information and analyses.

We are concerned, however, about VA's suggestion that a hospital should be closed only if VA can retain revenues resulting from the lease or sale of the properties. While it seems reasonable that VA should try to obtain statutory authority to retain such revenues to further improve services for Chicago veterans, we believe that VA's administrative decision to close a hospital should be linked to whether it needs the hospital, not to legislative decisions on how resulting revenues should be used.

Department of Defense

DOD agreed with our conclusion that VA's ability to meet DOD's contingency needs should not be adversely affected if VA closes one of its four Chicago-area hospitals.

Northwestern University Medical School

The dean of Northwestern University Medical School also disagreed with our recommendation that VA develop a detailed plan to meet veterans' needs by operating three Chicago-area hospitals. The dean contended that our report did not provide sufficient information or data to support a conclusion that closing a VA hospital is a viable option. More specifically, he stated that (1) all relevant factors were not considered and

(2) measurement and analyses of factors considered were significantly flawed.

For example, the dean cited quality of care as a relevant factor that was not considered. More specifically, he implied that Chicago-area VA hospitals and their staffs may not be equally adept at all procedures and, if so, that care could be diminished by closing one VA hospital. We considered quality of care as an important factor but did not specifically address it in our report because we concluded that VA's quality control measures would be appropriate, whatever the treatment setting, to ensure that veterans would receive the same or higher quality of health care in three Chicago hospitals as currently provided in four.

The dean also cited three examples of relevant factors that were inadequately considered. First, the dean said that we based our decision on bed capacity, without sufficient data on the availability of caregivers to absorb additional workloads associated with transferring hundreds of inpatient days or thousands of outpatient visits. We believe that our study provides sufficient data to show how workload could be accommodated if a hospital is closed. Specifically, our report shows that VA has (1) unused inpatient and outpatient capacity and (2) several options for meeting veterans' inpatient and outpatient needs. VA, for example, may opt to recruit new physicians and provide the services at the remaining hospitals or decide to purchase these services from other public or private health care providers. Our work assumes, given the number of hospitals and empty beds throughout Cook County, that sufficient caregivers are available, as needed. In fact, VA may find that purchasing some services is more efficient than directly providing them, especially those that are more specialized or in less demand.

Second, the dean contends that our report does not address veterans' future health care needs. On the contrary, our work shows the extent to which the veteran population is decreasing and is projected to continue declining until the year 2010. Concomitantly, veterans' demand for inpatient medicine, surgery, and psychiatry beds has dramatically decreased over the past several years. Moreover, we discuss VA's efforts to shift from a hospital-based health care system to one that is focused primarily on the delivery of outpatient services. Consistent with this, our report shows the changes in outpatient usage at the four Chicago-area hospitals and discusses options for meeting veterans' demand for such services.

Third, the dean pointed out that our report does not discuss access to public transportation and highways. While our report does not explicitly address veterans' access to local transportation routes or highway systems, it does provide information on veterans' access patterns for the three VA hospitals in Cook County. In summary, our analysis shows that veterans living in the same areas frequently access more than one VA hospital. This suggests that local transportation may not present a significant obstacle to veterans seeking VA care in Chicago-area hospitals. Our report also mentions that VA could consider expanding its existing shuttle system to ameliorate any inconveniences caused by the shifting of services if a hospital is closed.

In addition, the dean stated that our report underestimates the difficulties inherent in closing a facility without losing the benefits of current medical school affiliations. In this regard, he said that VA benefits from uncompensated health care that the Northwestern University Medical School faculty physicians provide to veterans. He believes that such care can only be replicated at significant expense, if at all, if a VA hospital closes.

We agree that VA will need to consider uncompensated care when deciding how to best meet Chicago-area veterans' health care needs. The dean, however, is not able to provide any data to measure the magnitude of the costs of uncompensated care provided at this time. Thus, VA will have to determine the cost and compare it with the potential savings from closing a hospital. Ultimately, if VA cannot obtain the same level of uncompensated care after a hospital is closed, VA will need to spend some of its savings (realized through hospital closure) to purchase the needed services.

University of Illinois at Chicago Medical School

The dean of the University of Illinois at Chicago Medical School disagreed with our recommendation that VA develop a detailed plan to meet veterans' needs in three VA Chicago-area hospitals. In general, he concluded that (1) essential stakeholders are being well served by the present system and (2) a decision to close a hospital should be made only after ongoing efficiency initiatives associated with VA's integration of the West Side and Lakeside hospitals have had sufficient time to work.

The dean pointed out that VA has produced real cost savings by integrating services in 32 clinical and administrative areas. In addition, a joint dean's committee was recently established involving members of both medical schools, which should help VA achieve additional cost savings. While VA

has realized some efficiencies, its operation of four hospitals limits its opportunities to become more efficient. In other words, operating four rather than three hospitals results in annual expenditures of about $20 million a year more than necessary to meet veterans' needs in the Chicago area.

The dean also stated that although it is true the University of Illinois at Chicago Medical School has other affiliated hospitals, none is so integral to its educational program as VA's West Side Hospital. He said that assuming that losses of educational processes in a VA hospital could be quickly replaced by opportunities at other hospitals is incorrect. Such substitutions, while possible, would be qualitatively different from the experience currently afforded at that hospital.

The closing of a VA hospital in the Chicago area does not preclude medical schools from continuing their educational processes in a VA hospital; rather, medical schools would continue to have the opportunity to share education and training at the same VA hospital, as medical schools in St. Louis, Missouri, and Washington, D.C., do now. While such an arrangement in Chicago would obviously necessitate major changes in the structure and management of medical schools' educational processes, the schools could potentially benefit from a broader base of patients, which in turn would enhance their teaching and research.

As agreed with your office, we will send copies of this report to the Secretary of Veterans Affairs, interested congressional committees, and other interested parties. We will make copies available to others upon request.

Please contact me on (202) 512-7101 if you have any questions about this report. Other GAO contacts and staff acknowledgments are listed in appendix VI.

Sincerely yours,

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

Contents

Tables

Figures

Abbreviations

CBOC	community-based outpatient clinics
DOD	Department of Defense
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Scope and Methodology

In considering the viability of VHA meeting Chicago-area veterans' needs with three rather than four hospitals, we relied on most of the same critical factors used (1) in our prior studies that considered service delivery options available to VHA when deciding how to meet veterans' health care needs and (2) by two private consulting firms that VHA used to study the potential for consolidating services among VHA hospitals. These critical factors are (1) the availability of VHA inpatient and outpatient capacity, (2) the magnitude of veterans' health care usage, and (3) the comparability of VHA hospitals' primary service areas.

To assess these factors, we visited the Hines, Lakeside, North Chicago, and West Side hospitals. During our visits, we met with hospital directors and their staffs, including associate directors, chiefs of staff, service chiefs, and facility engineers. To assess the general operating conditions, we visually inspected each hospital's (1) inpatient treatment areas, including beds currently in use; (2) outpatient treatment areas; and (3) administrative areas. We also examined areas currently being renovated and those needing future renovation and/or new construction.

We also reviewed documents obtained from VHA (headquarters, the Great Lakes network, and each of the four hospitals), the American Hospital Association, and the Illinois Department of Public Health. These documents included policy memorandums, reports, studies, facility development plans, hospital floor plans, inpatient workload data, hospital operating cost data, veteran population information (actual and estimates), and inventories of public and private hospital beds and workloads in Cook County, Illinois. (We used the information on public and private sector hospitals in Cook County to determine the availability of potential contract beds to meet veterans' needs.)

To obtain information on why veterans seek health care at VHA medical centers and where they would go for health care if the facility they now use did not exist, we interviewed 190 veterans at Lakeside and West Side hospitals during 4 days in July 1997. We spoke with inpatients on the day of their discharge and with outpatients who had scheduled appointments; the majority of our interviews were with outpatients.

To determine whether VHA can meet the primary care and outpatient treatment needs of veterans with fewer than four hospitals, we interviewed the chief of ambulatory care and facility engineers at each of the four hospitals. We learned, on the basis of their professional judgments, the (1) extent that existing space is used, (2) potential for

providing increased care within the existing space, and (3) various options available to VHA to meet veterans' demand for outpatient treatment with one fewer hospital. In addition, we considered whether outpatient clinics can be used to a greater extent to meet veterans' primary care needs.

We reviewed the Great Lakes network's business plan and other network planning documents. During these reviews, we assessed (1) the current number and capacity of the community-based outpatient clinics (CBOC), (2) VHA's plans to create additional CBOCs, and (3) the costs of providing primary health care through the CBOC initiative. We also reviewed VA's strategic plan for fiscal years 1998 through 2003 and VHA's plan, Vision for Change—A Plan to Restructure the Veterans Health Administration.

To assess potential savings of consolidating services in three hospitals, we developed, with VHA staff at Lakeside and West Side hospitals, estimates for facility overhead costs and potential savings that could be achieved by consolidating each hospital's services into the other three hospitals. This included estimating the number of staff who would transfer to the remaining hospitals in order to manage the increased workload. To derive estimates of potential savings from renovations, VHA staff identified future hospital renovation needs and provided estimates of costs for these renovations. Savings would be achieved by closing one hospital and avoiding future renovation costs. We also discussed with VHA staff other budget impacts or revenue opportunities from closing a hospital such as leasing or sale of the facilities. We relied on VHA estimates on savings and revenues where available.

We also assessed potential costs of relocating services from four hospitals to three. In doing this, we obtained estimates from VHA staff for (1) returning closed beds to operation, (2) converting inpatient wards into outpatient treatment areas, (3) establishing CBOCs, and (4) constructing new outpatient capacity.

To assess VHA's ability to perform its education and research missions using three hospitals, we discussed VHA's education and research requirements with VHA officials and compared these requirements with VHA's capacity when operating fewer locations in the Chicago area.

To determine whether VHA can fulfill its DOD contingency role with one less hospital, we discussed VHA's plans for providing inpatient beds to DOD with VHA and DOD headquarters staff. In addition, we reviewed our prior testimony, which examined VHA's plans for ensuring that veterans who

need care are able to get it during a national emergency.[8] In doing this, we updated the number of operating beds that VHA plans to offer DOD in meeting its contingency backup role.

[8]Health Care: Readiness of U.S. Contingency Hospital Systems to Treat War Casualties (GAO/T-HRD-92-17, Mar. 25, 1992).

Cook County Public and Private Sector Hospitals

Name	Location	Operating beds	Average daily bed use	Unused beds
Northwest Community	Arlington Heights	401	249	152
MacNeal	Berwyn	329	200	129
St. Francis Hospital and Health Center	Blue Island	234	174	60
St. James Hospital and Health Centers	Chicago Heights	348	237	111
Bethany	Chicago	126	72	54
Charter Behavioral	Chicago	123	N/A	N/A
Chicago Lakeshore	Chicago	102	60	42
Columbus	Chicago	284	172	112
Cook County	Chicago	811	523	288
Doctor's Hospital of Hyde Park	Chicago	200	N/A	N/A
Edgewater Medical Center	Chicago	201	151	50
Grant	Chicago	212	114	98
Hartgrove	Chicago	119	92	27
Holy Cross	Chicago	300	196	104
Illinois Masonic Medical Center	Chicago	645	497	148
Jackson Park	Chicago	254	145	109
Loretto	Chicago	222	153	69
Louis A. Weiss Memorial	Chicago	200	115	85
Mercy Hospital and Medical Center	Chicago	487	N/A	N/A
Methodist Hospitals of Chicago	Chicago	189	N/A	N/A
Michael Reese Hospital and Medical Center	Chicago	523	292	231
Mount Sinai Hospital and Medical Center	Chicago	357	268	89
Northwestern Memorial	Chicago	730	421	309
Norwegian-American	Chicago	230	N/A	N/A
Our Lady of the Resurrection Medical Center	Chicago	273	N/A	N/A
Provident Hospital of Cook County	Chicago	86	64	22
Ravenswood Hospital Medical Center	Chicago	321	205	116

(continued)

Name	Location	Operating beds	Average daily bed use	Unused beds
Resurrection Medical Center	Chicago	633	559	74
Roseland Community	Chicago	128	N/A	N/A
Rush-Presbyterian-St. Luke's Medical Center	Chicago	816	574	242
Sacred Heart	Chicago	96	N/A	N/A
Saint Anthony	Chicago	176	86	90
Saint Bernard	Chicago	194	N/A	N/A
Saint Elizabeth's	Chicago	240	190	50
Saint Joseph Health Centers and Hospital	Chicago	492	223	269
Saint Mary of Nazareth	Chicago	305	226	79
South Shore	Chicago	125	70	55
Swedish Covenant	Chicago	282	210	72
THC-Chicago	Chicago	67	46	21
Thorek Hospital and Medical Center	Chicago	144	86	58
Trinity	Chicago	228	134	94
University	Chicago	102	72	30
University of Chicago Hospitals	Chicago	570	482	88
University of Illinois Medical Center	Chicago	431	322	109
Vencor Hospital Chicago—North	Chicago	166	89	77
Forest	Des Plaines	80	N/A	N/A
Holy Family Medical Center	Des Plaines	183	93	90
Alexian Brothers Medical Center	Elk Grove Village	378	238	140
Evanston	Evanston	377	317	60
Saint Francis	Evanston	461	311	150
Little Company of Mary and Health Centers	Evergreen Park	367	N/A	N/A
Riveredge	Forest Park	164	82	82
Glenbrook	Glenview	80	66	14
Ingalls Memorial	Harvey	432	276	156
South Surburban	Hazel Crest	214	156	58
Suburban Cook County TB Sanitorium District	Hinsdale	81	N/A	N/A

(continued)

Name	Location	Operating beds	Average daily bed use	Unused beds
Hoffman Estates Medical Center	Hoffman Estates	193	115	78
Woodland	Hoffman Estates	94	40	54
LaGrange Memorial	LaGrange	231	138	93
Loyola University Medical Center	Maywood	536	358	178
Gotlieb Memorial	Melrose Park	212	125	87
Westlake Community	Melrose Park	239	158	81
Vencor Hospital—Chicago	Northlake	78	63	15
Christ Hospital and Medical Center	Oak Lawn	800	N/A	N/A
Oak Park	Oak Park	176	111	65
West Suburban Hospital Medical Center	Oak Park	273	162	111
Olympia Fields Hospital and Medical Center	Olympia Fields	174	N/A	N/A
Palos Community	Palos Heights	337	210	127
Lutheran General	Park Ridge	587	406	181
Rush North Shore Medical Center	Skokie	251	168	83
CPC Streamwood	Streamwood	100	N/A	N/A
Total				**5,716**

Note: N/A = Not available. These hospitals did not provide their average daily bed usage to the American Hospital Association for inclusion in the 1996 AHA Guide.

Source: American Hospital Association, AHA Guide, 1996-97 Edition (Chicago, Ill.: American Hospital Association).

Veterans' Usage of VHA Hospitals, by City of Chicago Zip Code

City of Chicago zip code	Number of veteran inpatient discharges				Number of veteran outpatient visits			
	Lakeside	West Side	Hines	Total	Lakeside	West Side	Hines	Total
60601	1	3	2	6	20	13	9	42
60602	0	3	2	5	8	9	4	21
60603	0	1	0	1	5	6	2	13
60604	1	2	0	3	3	8	4	15
60605	24	29	10	63	104	78	38	220
60606	2	3	2	7	8	10	4	22
60607	16	54	20	90	61	170	71	302
60608	12	137	30	179	48	502	95	645
60609	37	169	58	264	148	611	164	923
60610	112	32	28	172	466	156	67	689
60611	77	4	6	87	254	32	27	313
60612	22	222	48	292	77	878	137	1,092
60613	55	15	21	91	234	100	63	397
60614	60	23	16	99	246	103	65	414
60615	90	90	34	214	357	374	97	828
60616	60	75	35	170	236	283	98	617
60617	108	123	65	296	496	601	207	1,304
60618	70	43	37	150	319	198	125	642
60619	193	260	94	547	804	1,118	263	2,185
60620	132	322	120	574	501	1,391	298	2,190
60621	68	192	96	356	242	765	214	1,221
60622	49	66	33	148	211	276	85	572
60623	14	210	75	299	61	728	209	998
60624	26	193	104	323	87	756	229	1,072
60625	53	19	31	103	239	127	97	463
60626	65	41	23	129	290	144	65	499
60627	15	25	20	60	79	141	50	270
60628	120	297	112	529	495	1,199	294	1,988
60629	20	78	100	198	117	409	291	817
60630	31	12	31	74	128	76	151	355
60631	7	6	22	35	37	25	102	164
60632	18	63	63	144	76	266	276	618
60633	10	7	7	24	55	28	24	107
60634	28	9	106	143	90	80	441	611
60635	7	7	70	84	30	39	312	381

(continued)

City of Chicago zip code	Number of veteran inpatient discharges				Number of veteran outpatient visits			
	Lakeside	West Side	Hines	Total	Lakeside	West Side	Hines	Total
60636	59	247	60	366	189	917	159	1,265
60637	126	135	72	333	463	599	193	1,255
60638	10	43	145	198	30	188	497	715
60639	39	48	69	156	140	239	257	636
60640	135	65	40	240	511	235	157	903
60641	45	24	75	144	208	124	255	587
60642	5	3	17	25	17	38	44	99
60643	69	136	70	275	274	590	176	1,040
60644	25	188	132	345	96	690	374	1,160
60645	28	12	10	50	136	69	43	248
60646	12	6	18	36	61	41	62	164
60647	53	80	37	170	218	294	129	641
60649	125	118	74	317	497	560	163	1,220
60650	3	19	135	157	17	76	532	625
60651	30	134	75	239	174	552	248	974
60652	4	25	32	61	29	112	130	271
60653	72	132	54	258	306	512	136	954
60654	0	0	3	3	1	2	4	7
60655	4	6	42	52	20	53	108	181
60656	9	5	60	74	43	33	270	346
60657	56	9	18	83	244	84	47	375
60658	4	4	16	24	10	29	70	109
60659	11	4	3	18	73	40	26	139
60660	56	16	25	97	261	121	66	448
60661	1	1	0	2	8	4	4	16
60664	0	0	1	1	4	3	3	10
60666	0	2	0	2	2	3	2	7
60680	8	45	3	56	26	70	21	117
60681	1	0	0	1	2	2	0	4
60690	9	8	2	19	20	26	7	53
60714	6	3	16	25	29	23	91	143
Total	**2,608**	**4,353**	**2,825**	**9,786**	**10,741**	**18,029**	**8,952**	**37,722**

Source: Fiscal year 1996 VA inpatient and outpatient treatment files.

Comments From Northwestern University Medical School

Northwestern University Medical School

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February 20, 1998

Stephen P. Backhus
Director
Veterans' Affairs and Military
Health Care Issues
United States General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

Thank you for the draft report of the proposed General Accounting Office (GAO) Veterans Health Administration (VHA) Health Care report entitled, "Closing One of Four Chicago Hospitals would Save Millions While Improving Access to Services." We are appreciative of the opportunity to review and comment on the draft report and hope that our thoughts and suggestions are useful to the GAO in its preparation of the final report.

Before I address this report, I must note that the GAO has also been commissioned to prepare a report on the integration of VHA Lakeside and VHA Westside. This report is also scheduled to be released in the near future. In our view, any analysis of VHA health care in Chicago must consider the findings of both reports, as well as a thorough analysis of VHA resources and health care nationwide. In addition, I note my own observations on the success of the Lakeside/Westside integration. Our perseverance in working through an initially difficult period of transition has been rewarded with a stronger, more efficient health care provider. We believe the integration will improve both the access to and the quality of health care for Chicago-area veterans. The success of the integration should not be overlooked in assessing utilization of VHA resources in Chicago.

With respect to this draft report, I begin by noting that the GAO was asked to assess whether serving Chicago area veterans in three hospital facilities, instead of the current four, is a viable option. Despite its conclusionary title, the draft report does not provide sufficient information or data to reach an accurate conclusion on even this basic question.

The GAO identifies three factors as critical to its assessment: the availability of VHA inpatient and outpatient capacity, veterans' health care usage, and the comparability of VHA hospitals primary service areas. This list is incomplete. Quality of care, for example, is conspicuous by its absence. Of equal concern, even for some of the items on the list, the measurement and analysis in the draft report are significantly flawed.

First, in assessing capacity, the GAO relies on inpatient beds and outpatient visits. But the capacity of a health care system to provide care depends more on the availability of caregivers than beds. One critical question on which no data is provided is the capacity of physician and other care giving staffs affiliated with any of these institutions to absorb the additional workload associated with transferring hundreds of inpatient days or thousands of outpatient visits.

In assessing the second factor, health care usage, the GAO relies on inpatient days and outpatient visits. No data is provided on the health care needs, now or in the future, of this population, or on the medical reasons for the inpatient stays or outpatient treatment. This omission is particularly surprising in light of the ready availability of clinical data in the VHA clinical data system. To accept the GAO's conclusion, one would need to believe that inpatient surgical days are interchangeable among these institutions. Are all four facilities and their medical staffs equally adept at open-heart surgery? Liver transplantation? Substance abuse treatment? If not, then detailed analysis of the data is necessary before reaching the conclusion that one facility can be closed without impairing the quality of care veterans receive.

As a third critical factor in its assessment, the report examines the comparability of the primary service areas of VHA Lakeside and VHA Westside, and concludes that because they share these areas, closure of one of these two hospitals will not affect veterans. This examination fails to consider additional factors such as access to public transportation and highways and, as discussed above, qualitative differences in services offered at the various hospitals.

Finally, the report underestimates the difficulties and costs inherent in closing one facility without losing the benefits of current affiliations. Over 50 years ago, Northwestern University and the University of Illinois were the nation's first medical schools to formally affiliate with VHA, and each of these long-standing affiliations is a special relationship, providing substantial benefits to both parties. At Northwestern, medical students and residents have unparalleled clinical learning opportunities at VHA Lakeside. In return, veterans receive the same care - consistently judged to be the best in Chicago - from the same physicians, as other patients of Northwestern-affiliated hospitals. In addition, veterans

2

benefit from the proximity of top quality services at these private hospitals. For example, the cardiac surgery backup at Northwestern Memorial Hospital for the cardiac catheterization lab in the VHA Lakeside facility means that, if necessary, prompt, effective medical care can be provided immediately to veterans being served at VHA Lakeside. This is just one of a host of similar backup and response capabilities, that can be replicated only at significant expense, if at all, if one facility closes.
In addition, the VHA benefits from a unique longstanding arrangement where Northwestern physicians provide care to veterans without any compensation from the VHA. Presently, 263 Northwestern Medical School faculty physicians provide such uncompensated care. The loss of these types of benefits due to a facility closure must be strongly considered in reviewing veterans' health care resources in Chicago.

The VHA has made significant strides in improving the efficiency of its delivery system without sacrificing quality. One of the strengths of this system is the quality of care it provides, bolstered by mutually beneficial relations between VHA and medical schools. It is appropriate to continue to challenge the VHA and academic medicine to strive to improve access, quality, and cost of care. This report, however, states a conclusion not supported by its analysis.

In conclusion, any discussion of closure of facilities within VISN 12 must address quality of care for veterans and not lose sight of the threefold mission of the VHA to provide outstanding care, education of future physicians, and advancement through research of the nation's knowledge about disease and disability. Again, thank you for the opportunity to comment upon the GAO report. Northwestern has always been committed to cost effectiveness within the VHA and we pledge to work with the VA and Members of Congress to ensure that resources within VISN 12 are utilized wisely.

Sincerely,

Harvey R. Colten, M. D.
Dean
Vice President Medical Affairs

HRC/JCM:adr

3

Comments From the University of Illinois at Chicago

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February 19, 1998

Stephen P. Backhus, Director
Veterans' Affairs and Military Health
Care Issues
United States General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

Thank you for providing me with a draft copy of the proposed report entitled VA Health Care: Closing One of Four Chicago Hospitals Would Save Millions While Improving Access to Services. I am pleased to offer the following comments and, by way of background, some observations.

As you know, we have been quite concerned about proposed changes in the VHA system here in Chicago. With the assistance of our Congressional delegation and officials from the Department of Veterans Affairs, a process was instituted about eighteen months ago to guide the integration and consolidation of clinical and administrative services for the newly-created VA Chicago Health Care System (Chicago VA), which includes Westside Hospital and Lakeside VA Medical Center. The Integration Coordinating Committee served as the principal forum for making recommendations to VHA for Chicago VA; in October 1997 VHA accepted the recommendations of the ICC. This resulted in the integration of 32 services in clinical and administrative areas and produced real cost savings.

Furthermore, I am presently working closely with my colleague, Dr. Harvey Colten, Dean of the Northwestern University School of Medicine, through the newly-established joint Deans Committee, which is made up of members from both medical schools and both divisions of Chicago VA. We believe that this committee will assist Chicago VA to realize further operational efficiency, preserve the high quality care that our veterans deserve and to maintain the superb educational and research environment afforded by the VHA system. I also want to note that the University of Illinois and Northwestern University were the first two universities to establish a direct and formal relationship with the VA health care systems more than a half-century ago. In that context, I must call your attention to the fact that although it is true (as your report notes) both UIC and NWU have other affiliated hospitals, none is so integral to the educational programs of either institution as their respective VA hospitals. Assuming that losses of educational processes in either VA could be quickly replaced by other opportunities at different hospitals is erroneous. Such substitutions, while possible, would be qualitatively different from the experience currently afforded at Lakeside and Westside.

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It is important to note that establishing these constructive collaborative mechanisms and processes was not easy. There were many false starts, but I believe that essential stakeholders in the Chicago VA system are being well served by the present system. Additionally, several members of our Congressional delegation have requested a GAO study with respect to the integration and consolidation efforts in Chicago.

This study is pending, but it is my understanding it should be made available soon. Therefore, I believe policymakers should not view the Closure report in isolation, but within the context of the Illinois Member-requested GAO report as well. Furthermore, the recently established joint Deans' Committee should be given sufficient time to work and its performance evaluated before further changes are implemented.

While this clearly is a work in progress, there may be lessons in the Chicago experience that will be useful in other areas of the country as the VA strives to consolidate or close facilities to reduce duplication and overlapping efforts. During a recent House VA Subcommittee hearing in Chicago I recommended that a rational process for VHA consolidations should involve the following steps:

1. The Secretary or VISN director would identify those areas in which duplication of effort seemed likely and where geography might permit service consolidation.

2. The stakeholders in existing facilities would be convened and a clear articulation of the problem would be presented.

3. A mutually agreeable process would be constructed with appropriate representation from all affected parties.

4. All the data necessary to make a fair, balanced, and equitable decision with high face validity would be assembled.

5. Adequate time for these deliberations would be provided.

6. Appropriate opportunities for public explanation and input is essential.

7. Appropriate consultation from a neutral third party, preferably expert in health system consolidations or mergers, would be sought. A durable oversight mechanism to ensure that all parties are treated fairly would be put in place. No merger of complex institutions can be accomplished in a short period of time and be expected to function exactly as its architects intended. Mid-course corrections will be inevitable.

I would respectfully recommend that policymakers consider these criteria carefully, which may well serve to guide VA mergers, consolidations, hospital closures and other key decisions, not only for Chicago but across the United States as well.

Once again, thank you for providing me with a draft copy of the GAO report and for the opportunity to comment.

Sincerely,

Gerald S. Moss, M.D.
Dean

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cc: David Broski, Ph.D.
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In addition to those named above, the following individuals made important contributions to this report: Walter Gembacz collected and analyzed facility operating and maintenance costs data and acted as an adviser throughout this assignment; John Borrelli assessed the impact on VHA's health care missions related to medical education and research; Lesia Mandzia conducted a survey to determine the impact on veterans of closing a hospital; John Kirstein helped collect and analyze facility operating and maintenance costs data; Jonathan Ratner provided guidance in analyzing and reporting the costs of closing a facility; and Joan Vogel and Ann McDermott provided technical support.

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