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September 23, 1998

The Honorable Jerry Lewis
Chairman
The Honorable Louis Stokes
Ranking Minority Member
Subcommittee on VA, HUD,
and Independent Agencies
Committee on Appropriations
House of Representatives

Subject: VA Health Care: VA's Plan for the Integration of Medical Services in Central Alabama

This correspondence responds to your request that we review VA's plan to integrate services at the medical facilities located in Tuskegee and Montgomery, Alabama. Officials of the two facilities prepared a plan, which was approved by VA's Atlanta Network and headquarters. On June 11, 1998, VA submitted this plan as required by the Committee on Appropriations in House Report 105-175.[1]

In a July 1997 congressional hearing in Montgomery, we testified that some stakeholders found it difficult, if not impossible, to assess the reasonableness of VA's decisions and to ultimately "buy in" to them.[2] We attributed this situation to the lack of a comprehensive plan that addressed such basic questions as (1) why selected alternatives are the best ones available, (2) how services would be integrated, and (3) how potential changes would affect veterans and employees. In an earlier hearing in

[1]Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Bill, 1998, H. Rept. 105-175, 105th Cong., 1st sess., July 11, 1997.

[2]VA Health Care: Opportunities to Enhance Montgomery and Tuskegee Service Integration (GAO/T-HEHS-97-191, July 28, 1997).

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Washington, D.C., we testified that VA needed to establish a more structured process for integrating facilities that included information on alternatives and the potential effect of the changes on veterans.[3]

In House Report 105-175, the Committee expressed concern that detailed information necessary for stakeholders to understand VA's proposed changes in Montgomery and Tuskegee was unavailable. To address these concerns, the Committee required that VA provide the Congress with a detailed integration plan before proceeding. In addition, the House report mandated that we review and report on the plan. As agreed with your offices, we assessed whether VA's plan provides the information that stakeholders need to understand the proposed integration of services at these two facilities. We also assessed stakeholder understanding of, and support for, the plan.

To assess the information provided, we (1) reviewed VA's June 11, 1998, plan entitled Central Alabama Veterans Health Care System (CAVHCS) Strategic Plan and Integration Implementation Plan as well as other planning documents; (2) conducted on-site reviews of the Montgomery and Tuskegee medical facilities; and (3) interviewed VA management officials, including the CAVHCS director, operations manager, and clinical service managers. To assess stakeholder understanding and support of VA's plan, we conducted interviews and a mail survey. First, we interviewed the Chairman of the Board of Directors and the Executive Director of the Alabama State Department of Veterans Affairs, and representatives of veterans service organizations and employee unions. Second, we mailed surveys to 96 veterans representing 23 veterans service organizations. VA sent copies of its plan to these veterans for their review and comment in April 1998.[4] We performed our work in accordance with generally accepted government auditing standards.

In summary, we believe VA's plan contains the necessary information to understand the proposed integration of services at the Montgomery and

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

[4]Of the 96 surveyed, 60 (63 percent) responded. Of the 60, 34 provided us with specific information about their views of VA's plan, while the rest (26) informed us they could not complete the survey primarily because they had not read the plan. The remaining 36 did not return the survey, and our efforts to contact them by telephone were unsuccessful.

Tuskegee facilities. For example, the plan explains why VA's decisions to unify management, consolidate some clinical or administrative functions, and realign most service delivery processes are preferable alternatives to consolidating all services, contracting for services, or continuing to operate without any changes. Moreover, it explains how proposed changes should occur, such as consolidating most acute medical services at Montgomery and all long-term care at Tuskegee while maintaining outpatient care at both facilities. VA's plan also contains the necessary information to understand how such changes could benefit veterans and employees, including how VA intends to reinvest savings of $6 million. For example, the plan describes how changes such as new community clinics or new services at existing facilities may improve veterans' access to care as well as the quality of care. It also explains how VA will reduce the workforce by 157 full-time-equivalent employees through attrition or buyouts, while ensuring that employees will not be transferred involuntarily from one facility to another. In addition, VA's plan discusses changes intended to minimize adverse effects on veterans' access to care and employees' commutes, such as enhancements to a VA-operated transportation system.

Most of the veterans responding to our survey believed VA's plan contains the necessary information to understand the proposed integration of the Montgomery and Tuskegee facilities. Some stakeholders, however, indicated that the plan could have included more details about the transportation system and resource reinvestment. Most veterans supported VA's plan because they believe that integrating the two facilities will increase VA's capacity to provide health care, in part by enhancing veterans' access to care and the quality of the care they receive.

We believe VA's plan is essentially sound. The plan seems to position VA's two Central Alabama facilities to meet veterans' health care needs in a more effective and efficient manner. While more detailed information could be included, such information is not, in our view, critical to obtaining an overall understanding of VA's plan, because the plan contains the information necessary to understand the proposed integration.

BACKGROUND

VA operates over 400 medical facilities that serve about 2.9 million veterans a year at a cost of $17 billion. The Montgomery and Tuskegee facilities serve about 21,000 veterans annually at a cost of about $116 million. The two facilities employ about 1,600.

In 1995, VA organized its facilities into 22 service delivery networks. Montgomery and Tuskegee are in the Atlanta Network, which includes 19 facilities located in Alabama, Georgia, and South Carolina. VA encouraged its networks to realign services to increase efficiency, including integrating services of nearby facilities. Networks were given wide discretion in how to integrate facilities once VA headquarters had approved an initial proposal.

To date, VA has approved 23 integrations involving 48 facilities. In September 1996, VA approved the Atlanta Network's proposal to create a Central Alabama Veterans Health Care System by integrating the medical services of the Montgomery and Tuskegee facilities. After performing a wide range of planning activities, VA's Atlanta Network announced in April 1997 that it soon would begin implementing changes. A congressional hearing was held in Montgomery in July 1997 to address stakeholders' concerns about the proposed integration. VA agreed to develop a written plan and share it with stakeholders before implementing changes.

Over the next 8 months, VA developed a plan explaining how medical services at the Montgomery and Tuskegee facilities would be integrated. Veteran and employee stakeholders participated in the development of the plan through involvement in various work groups. Moreover, VA officials held eight "town hall" meetings at various locations in Tuskegee and Montgomery and made copies of the draft plan available to those attending. In addition, VA sent the draft plan for comment to 96 stakeholders representing 23 veterans service organizations.

VA'S PLAN PROVIDES NECESSARY INFORMATION ON ALTERNATIVES

VA's plan describes four alternatives, including (1) continuing to operate without any service changes; (2) contracting for services; (3) consolidating all services at one facility; and (4) unifying management, consolidating selected services, and reengineering most service delivery processes. In its plan VA explains why the latter alternative is considered to be superior to others. In essence, VA found that it reduces managerial duplication, facilitates adoption of best practices from each facility, standardizes policies and procedures, and introduces efficiencies through economies of scale by redistributing workload.

VA considered continuing operations without changes, but found this option undesirable because it would maintain duplicate services at each facility, especially administrative structures. While this option had the immediate

benefit of limiting the impact on staff, the long-run costs associated with maintaining duplicate functions at each facility would result in a competitive disadvantage in VA's resource allocation process, likely necessitating staffing reductions later on. In addition, VA concluded that implementing this option would hamper the development of a seamless continuum of care, precluding efficiencies from the consolidation of supervisory responsibility and economies of scale, which are necessary to free up resources to be reinvested in patient care.

VA considered consolidating individual services by relocating them to one facility or another, but found this undesirable because most services are needed at each facility. VA did, however, include an aspect of this option in its plan, such as the total relocation of selected clinical services, specifically inpatient surgery and intensive care at the Montgomery facility and intermediate medicine at the Tuskegee facility.

Finally, VA's plan considers contracting for services to be an alternative that might become more desirable in the future. For example, VA's plan sets as a goal treating veterans in their home communities by contracting for services such as oncology, cardiovascular surgery, gastroenterology, and nephrology rather than sending veterans to VA facilities located farther away in Atlanta or Birmingham. VA officials told us that the low workload of about 4,000 visits a year associated with these services makes contracting in the local community a viable option.

Most of the veterans responding to our survey (73 percent) said they understand what alternatives are available and why VA considers its plan to be the best alternative. One veteran said he understood that "if both hospitals are going to stay open, they didn't have much choice. They need to make sure that MD's and staff have enough practice so that they can be sure they're good at their jobs."

VA'S PLAN PROVIDES NECESSARY INFORMATION ON HOW SERVICES WILL BE INTEGRATED

VA's plan provides the information necessary to understand how services will be integrated. More specifically, it describes how (1) management will be unified for clinical and administrative services; (2) selected inpatient clinical services, such as surgery, intensive care, and intermediate medicine, will be relocated to a single facility; and (3) patient care and clinical support functions are to be reengineered.

First, VA's plan describes how managers are to assume responsibility for a prescribed line of clinical or support services. It describes which management positions are affected and how they will relate to each other in the future. For example, each facility historically managed its own food service. By integrating management functions, one chief assumes responsibility for this service at both facilities, thereby eliminating a chief's position.

Second, VA's plan describes how selected inpatient services will be relocated, moving all employees and patients to one facility rather than continuing to provide the service at both. It also describes how ambulatory care services will be expanded at both. In essence, veterans will continue to obtain primary care, mental health services, and outpatient surgical care at the same facility they used in the past. VA's plan calls for inpatient services such as intensive care and inpatient surgical services to be located at the Montgomery facility and services such as inpatient mental health and intermediate care to be located at the Tuskegee facility.

Third, VA's plan describes ways in which service delivery will be reengineered, including designing more efficient and effective ways of providing services to veterans and standardizing policies and procedures. By reengineering how services are delivered, VA expects to increase the cost-effectiveness of operations and optimize utilization of resources, including personnel and equipment, as the following examples show:

- Historically, all patients requiring nonurgent medical care were seen in the primary care clinics. Primary care clinics made a few scheduled appointments available each day, but kept large blocks of time open to accommodate patients who might come in without an appointment. This resulted in long waiting times for veterans who were trying to be scheduled for appointments. In addition, clinical staff could not make efficient use of their time because of the unpredictable workload associated with treating patients who arrived without an appointment. By shifting the workload created by patients without an appointment to an evaluation clinic and seeing only patients with an appointment in the primary care clinic, staff were able to make more appointments available and improve the efficiency of the clinics.

- Clinical support functions, such as purchasing and contracting, storage and distribution, and supply processing and distribution, are organized under one management team to increase operating

efficiency. By standardizing the type of supplies available and implementing a bar-coding and delivery system, inventory control and supply management should also improve. In addition, cross-training staff to perform various functions is expected to result in increased efficiency, since one person can then perform multiple functions during a single round through a facility.

VA's plan also identifies areas where managers may need to make important decisions concerning the size of individual services once the results of reengineering efforts are known. For example, the plan describes, in general, the number of beds, by service, to be operated at each facility, but it cautions that clinical managers will be expected to adjust the number of beds required for each level of care once reengineering efforts such as community reentry initiatives and shifts of treatment to the ambulatory care setting have been completed.

In general, most of the veterans responding to our survey (61 percent) believed that the plan provided clear information about how services would be integrated. One veteran summarized, "I do not think anyone could write up a plan on anything and explain to where everyone would understand every detail. I received enough information. I understood all of it."

Some veterans (39 percent), however, believed that VA's plan did not adequately explain the changes being made. In general, these respondents believed the information could have been presented in a clearer manner, as illustrated by the following comments:

"Very plain English is needed by some people."

"The current plan fails to recognize the lack of sophistication and institutional awareness of the average veteran applying for care at the VA hospital."

"The CAVHCS Strategic Plan and the Integration Implementation plan reflect a lot of work on the part of a lot of people. These documents are of great interest to those directly related internally to organization and operation . . . For an ordinary ex-GI, such as myself, it is a case of too many words in 5 point type."

VA'S PLAN PROVIDES NECESSARY INFORMATION ON HOW CHANGES AFFECT VETERANS

VA's plan provides information necessary to understand how the integration of services at the Montgomery and Tuskegee facilities affects veterans. It describes how changes will benefit veterans by (1) increasing their access to care and (2) improving the quality of care delivered. It also discusses potential inconveniences veterans may experience because travel distances will sometimes be longer as well as describes VA's efforts to minimize such inconveniences.

VA's plan highlights how access to care will be improved by expanding the services at existing facilities and by establishing new community clinics. For example, VA plans to expand by closing inpatient beds and shifting staff and treatment programs to an outpatient setting, which will increase the number of patients who can be treated. Also, VA plans to provide subspecialty services, such as oncology, cardiovascular surgery, and gastroenterology, locally through contractors rather than sending veterans to other VA facilities in Atlanta or Birmingham, which should increase the availability of appointments and reduce treatment delays. In addition, VA plans to increase veterans' access with the recently opened community-based outpatient clinic in Dothan, Alabama. VA estimates that approximately 1,500 veterans will receive primary care services in this clinic this year, with a goal of increasing the number treated to approximately 2,500.

VA expects the quality of care veterans receive to improve as a result of the plan's integration activities. For example, consolidating services in one location will provide the opportunity to improve patient outcomes and service delivery. VA's decision to consolidate inpatient surgical services in Montgomery was made, in part, because the quality of surgical services is dependent upon the technical skills of the surgical team responsible for delivering them to the patient. An important determinant of surgical proficiency is the volume of surgical activity. The total number of surgical procedures had been at marginal levels for both facilities, making it difficult to sustain the proficiency of the surgical teams in each facility. Locating all surgical services at one facility will provide a workload that better supports a viable surgical program.

VA's plan recognizes that because the Montgomery and Tuskegee facilities are located 35 miles apart, some changes intended to provide higher quality of care will inconvenience veterans. For example, veterans who need

specialized inpatient services such as intensive care or inpatient surgical services may have to travel farther to the Montgomery facility, while veterans who need inpatient mental health treatment, intermediate medicine, or long-term care may have to travel farther to the Tuskegee facility.

VA's plan describes two ways in which it intends to minimize these inconveniences. First, a patient transportation system has been developed to minimize the inconvenience to patients who must move between facilities. Shuttle buses are to run every hour between the Montgomery facility and the Tuskegee facility to reduce the amount of time veterans must wait for transportation. Veterans can drive to the most convenient facility and ride the shuttle to their appointment. In addition, family members of hospitalized veterans can use the transportation system to facilitate their visits. Second, because outpatient services continue to be available at both facilities, patients who are discharged from the Montgomery facility after having inpatient surgery, for example, can make a follow-up appointment at the facility most convenient for them. Similarly, veterans who need follow-up outpatient services after an inpatient psychiatric hospitalization may visit either facility.

While most survey respondents (82 percent) said that VA's plan contains enough information to understand the impact of the planned changes on services at Montgomery and Tuskegee, many expressed concern that implementing these changes would result in increased travel distances, longer travel times, and inconvenience for veterans in Central Alabama. Veterans commented, for instance, that more detailed information could have been included in the plan about how inconveniences would be minimized. For example, two veterans said that transportation priorities were unclear and more information on transportation arrangements would have made the plan clearer. One provided the following questions:

> "Will the veterans go to one campus and then be sent to the other one? For example, a bus goes from Columbus, GA to the Tuskegee VA each morning and comes back each evening. How will veterans be affected if they are not seen on East Campus but must go to West Campus? Who must provide that transportation, the VA or the veteran?"

In addition, some respondents expressed skepticism about how well VA's plan would minimize such inconveniences, as the following comments show:

> "On paper the plan looks good, but in reality its going to be inconvenient for the patients who have long distances to travel."
>
> "Vets are afraid that the extra travel will deter some vets from seeking treatment."
>
> "Veterans need to know they will get treatment and see a doctor when they arrive at a hospital - not be transported elsewhere after several hours wait."
>
> "Tuskegee is out of the way and hard to get to. Shuttle buses are available but sick veterans don't need 2-3 hours more traveling.

Also, veterans responded that more detailed information about how resources saved, including excess space, as a result of the integration were to be used could have been included in the plan, as the following comments show:

> "[W]ards [that have] been renovated are closed and remain idle. This space could be used for vets."
>
> "[E]xplain reinvestment of savings better. Except for the money they spent to open Dothan, how was the rest of the money spent?"

VA'S PLAN PROVIDES NECESSARY INFORMATION ON HOW CHANGES AFFECT EMPLOYEES

VA's plan provides the information necessary to understand how integrating services at the Montgomery and Tuskegee facilities will affect employees. In essence, it describes how employment opportunities are to be (1) eliminated, (2) shifted from one facility to another, and (3) reengineered into interdisciplinary teams.

First, VA's plan explains how 157 full-time-equivalent employees will be eliminated by not filling vacancies created by attrition, voluntary

retirements, and buyouts. This effectively minimizes the impact on current employees.

Second, VA's plan explains how employees will move between facilities. In general, it states that only employees who request a transfer or those who apply for and receive a promotion to a new position will be moved. The plan also discusses how internal redistribution of positions could occur over time as managers gain experience in the newly reengineered delivery processes and adjustments are made to the size of various services. VA's plan explains that as future vacancies occur, managers are to reevaluate staff mix and workload. The number of full-time-equivalent employees approved for individual services and their distribution between facilities will be closely tied to workload.

Finally, VA's plan describes how staff will be reorganized into interdisciplinary teams that report to a single manager responsible for the entire service. For employees, this could mean a shift from reporting to a same-discipline supervisor to one who has a different discipline. For example, historically, the chief of psychiatry was responsible for operating a Mental Health Clinic, but staff were supervised by their discipline-specific service chief. For example, the chief of social work supervised clinical social workers, while the chief nurse supervised clinical nurses. By realigning into an interdisciplinary team, the manager responsible for that service will supervise physicians, nurses, social workers, and clerks assigned to that clinic.

VETERANS AND EMPLOYEES SUPPORT VA'S PLAN

Most veterans responding to our survey (73 percent) supported VA's plan. Representatives of Montgomery's and Tuskegee's employee unions also told us that members generally supported VA's plan. In general, the 25 veterans who supported the plan did so because they believe it will strengthen VA's overall ability to meet their health care needs, and, more specifically, their access to care and the quality of care they receive will improve (see table 1).

Table 1: Distribution of 25 Veterans' Reasons for Supporting VA's Plan

Number of veterans holding view

Impact	Veterans' access to VA care	Quality of VA care	VA's overall ability to meet veterans' needs
Will improve	18	19	16
Will not change	3	5	6
Will decline	4	1	3
Total	25	25	25

Some veterans who support VA's plan identified ways that veterans benefit from service changes. For example, they cited improved access to care resulting from opening a clinic in Dothan and from establishing transportation services designed to help veterans get to their appointments. Some veterans expressed their support as follows:

> "I see many benefits of the integration. Increased access and quality make up for a little bit of inconvenience [that is, driving a little farther]."
>
> "Changes must occur due to [VA's] decreasing budget. Therefore VA is to be commended for addressing a difficult issue in favorable ways to improve care and resources."
>
> "My support for this plan is so strong I might decide to use the VA [for my health care]."

Veterans who support the plan, however, also expressed some reservations about the integration of services of the Montgomery and Tuskegee facilities, as the following comments show:

> "I'm not sure that the plan will or will not work, only time can tell and time will be the expense of the veterans."

> "If they did what they said they would do, it'll be O.K. but they're not doing that."

In contrast, the 9 veterans who withheld support for VA's plan generally believe that integrating the services of the Montgomery and Tuskegee facilities will weaken VA's ability to meet the health care needs of veterans by hindering veterans' access to care or weakening the quality of the care they receive (see table 2).[5]

Table 2: Distribution of Nine Veterans' Reasons for Withholding Support for VA's Plan

Number of veterans holding view

Impact	Veterans' access to VA care	Quality of VA care	VA's overall ability to meet veterans' needs
Will improve	1	1	1
Will not change	2	5	0
Will decline	6	3	8
Total	9	9	9

These veterans expressed their concerns as follows:

> "There were some changes made that [were] not in the best interest of the veterans or VA."

> "How can veterans receive improved care with an increase in veteran access and a reduced staff and funding?"

> "Health care has already dropped drastically. The time needed to get an appointment has gone from 3-4 weeks to 3-6 months."

[5]Of the 9 withholding support for VA's plan, 4 opposed the plan and the remaining 5 neither supported nor opposed the plan.

> "There appears to be a real ignorance in the plan about how to treat a mentally ill vet at the onset of the crisis stage of their illness. Most mental health professionals know that ease of access to a program, i.e. location of access, lack of barriers and lack of bureaucracy and paper work at the time of admission is critical to the success of a mental health program. Most admissions will be at night, or on weekends, when stress on the veteran is greatest. Our systems tell them to come back Monday to the VA in Montgomery and wait for a bus to Tuskegee or have a family member take them to Tuskegee. This plan fails to recognize most advances that have taken place over the last 25 years in dealing with the mentally ill."

As with veterans, employees in general support VA's plan to integrate the medical services at the Montgomery and Tuskegee facilities. Representatives of each facility's employees unions told us that employees understand VA's plan because they have had input into its development, essentially by participating in work groups. Moreover, the representatives told us that, like veterans, many of the employees' current concerns are related to the implementation of the plan rather than the changes proposed.

In this regard, VA's plan includes service-specific performance measures that will be used during implementation to determine the success of key patient care or service delivery outcomes. This evaluation process should provide VA officials with a mechanism for systematically identifying unintended adverse outcomes that may require corrective actions as implementation proceeds.

AGENCY COMMENTS

We met with VA officials responsible for coordinating the plan in VA's headquarters and Atlanta office on September 17, 1998, to discuss their comments on a draft of this correspondence. The officials said they believe we present an objective and accurate analysis of the Montgomery-Tuskegee integration plan. In addition, they told us that in April 1998, VA published and distributed nationally a comprehensive Guidebook for Medical Facility Integration, which will provide a framework for the planning processes of future integration efforts.

As agreed with your offices, unless you publicly announce its contents earlier, we will make no further distribution of this correspondence until 15 days after its issue date. At that time, we will make copies available to interested parties on request.

Major contributors to this correspondence were Paul Reynolds and Kathleen Kendrick. Please call me at (202) 512-7101 if you have any questions or need additional assistance.

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

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