VA CONSOLIDATION OF MEDICAL FACILITY MANAGEMENT AND SERVICES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

JULY 24, 1997

Printed for the use of the Committee on Veterans' Affairs

Serial No. 105–19

U.S. GOVERNMENT PRINTING OFFICE

45–716 CC WASHINGTON : 1998

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-056268-6

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMITTEE ON VETERANS' AFFAIRS

BOB STUMP, Arizona, *Chairman*

CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
FLOYD SPENCE, South Carolina
TERRY EVERETT, Alabama
STEVE BUYER, Indiana
JACK QUINN, New York
SPENCER BACHUS, Alabama
CLIFF STEARNS, Florida
DAN SCHAEFER, Colorado
JERRY MORAN, Kansas
JOHN COOKSEY, Louisiana
ASA HUTCHINSON, Arkansas
J.D. HAYWORTH, Arizona
HELEN CHENOWETH, Idaho
RAY LAHOOD, Illinois
BILL REDMOND, New Mexico

LANE EVANS, Illinois
JOSEPH P. KENNEDY II, Massachusetts
BOB FILNER, California
LUIS V. GUTIERREZ, Illinois
JAMES E. CLYBURN, South Carolina
CORRINE BROWN, Florida
MICHAEL F. DOYLE, Pennsylvania
FRANK MASCARA, Pennsylvania
COLLIN C. PETERSON, Minnesota
JULIA CARSON, Indiana
SILVESTRE REYES, Texas
VIC SNYDER, Arkansas
CIRO D. RODRIGUEZ, Texas

CARL D. COMMENATOR, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON HEALTH

CLIFF STEARNS, Florida, *Chairman*

CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
SPENCER BACHUS, Alabama
JERRY MORAN, Kansas
JOHN COOKSEY, Louisiana
ASA HUTCHINSON, Arkansas
HELEN CHENOWETH, Idaho

LUIS V. GUTIERREZ, Illinois
JOSEPH P. KENNEDY II, Massachusetts
CORRINE BROWN, Florida
MICHAEL F. DOYLE, Pennsylvania
COLLIN C. PETERSON, Minnesota
JULIA CARSON, Indiana

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

TERRY EVERETT, Alabama, *Chairman*

BOB STUMP, Arizona
FLOYD SPENCE, South Carolina
STEVE BUYER, Indiana

JAMES E. CLYBURN, South Carolina
VIC SNYDER, Arkansas
FRANK MASCARA, Pennsylvania

CONTENTS

Page

OPENING STATEMENTS

Hon. Cliff Stearns, Chairman, Subcommittee on Health 1
Prepared statement of Chairman Stearns 45
Hon. Terry Everett, Chairman, Subcomittee on Oversight and Investigations . 2
Hon. Luis V. Gutierrez 3
Prepared statement of Congressman Gutierrez 52
Hon. James E. Clyburn 4
Prepared statement of Congressman Clyburn 47
Hon. Lane Evans 49
Hon. Helen Chenoweth 56

WITNESSES

Backhus, Stephen, Director, Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division, U.S. General Accounting Office; accompanied by Paul Reynolds, Assistant Director, Health Care Delivery and Quality Issues, Health, Education, and Human Services Division, U.S. General Accounting Office 27
Prepared statement of Mr. Backhus 99
Cohen, Dr. Jordan J., President, Association of American Medical Colleges 37
Prepared statement of Dr. Cohen 122
Cummings, Joan, M.D., Director, Veterans Integrated Service Network (VISN) 12, Department of Veterans Affairs 9
Prepared statement of Dr. Cummings 68
Goff, Jim, Director, Palo Alto Division, VA Palo Alto Health Care System, Department of Veterans Affairs 13
Prepared statement of Mr. Goff 83
Kizer, Kenneth W., M.D., M.P.H., Under Secretary for Health, Department of Veterans Affairs 5
Prepared statement of Dr. Kizer 61
Smith, Dennis, Director, Baltimore Division, VA Maryland Health Care System, Department of Veterans Affairs 15
Prepared statement of Mr. Smith 91
Starr, James E., Senior Associate, McManis Associates, Inc., accompanied by Linda Wendt, Principal Associate McManis Associates, Inc. 31
Prepared statement of Mr. Starr, with attachment 115
Terrence, Christopher, M.D., Chairman, Integration Coordinating Committee, VA Chicago Health Care System, Department of Veterans Affairs 11
Prepared statement of Dr. Terrence 80
Vitikacs, John, Assistant Director, National Legislative Commission, The American Legion 39
Prepared statement of Mr. Vitikacs 126
Widerlite, Paula, Senior Director for System Strategy, Adventist HealthCare . 28
Prepared statement of Ms. Widerlite, with attachment 107

MATERIAL SUBMITTED FOR THE RECORD

Statement:
Hon. Danny K. Davis, a Representative in Congress from the State of Illinois 57
Tables:
Approved VA Integrated Facilities 67
McManis Associates' Veterans Affairs Contracts, Fiscal Year 1995 to Present 119

Page

Written committee questions and their responses:
Congressman Evans to Dr. Kenneth Kizer, Department of Veterans Affairs 129
Congressman Evans to Dr. Joan Cummings, Department of Veterans Affairs 132
Congressman Evans to U.S. General Accounting Office 135
Congressman Evans to Paula S. Widerlite, Adventist HealthCare 139
Congressman Evans to James E. Starr, McManis Associates, Inc. 140
Congressman Evans to Association of American Medical Colleges 144

VA CONSOLIDATION OF MEDICAL FACILITY MANAGEMENT AND SERVICES

THURSDAY, JULY 24, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH, JOINT WITH
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittees met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Everett, Moran, Cooksey, Hutchinson, Gutierrez, Clyburn, Kennedy, Doyle, Peterson, Carson, and Snyder.

Also Present: Representative Lane Evans.

OPENING STATEMENT OF HON. CLIFF STEARNS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. STEARNS. On behalf of my colleague and friend, Terry Everett, Chairman of the Oversight and Investigations Subcommittee, I welcome all of you to this important joint hearing today.

All of us involved with health care policy are acutely aware of the dynamic nature of the health care marketplace. In the private sector, market forces have been powerful levers for change. In the face of market challenges, hospitals have increasingly turned to mergers and alliances.

The VA has been a bit slow to transform itself. Long after the private sector had embraced primary cares as a core business, VA has remained entrenched as a hospital-based system. Until 1995, VA had not consolidated a facility in some 15 years. Since then, however, VA has initiated 19 consolidations involving 40 VA medical facilities. With such steps as approving VA's proposed reorganization and adopting a sweeping eligibility reform measure in the 104th Congress, this committee has given Dr. Kizer critically needed tools to transform the VA health care system.

In my view, VA should continue to consolidate facilities where that process will improve patient care and achieve greater efficiency. Several witnesses this morning cite the complexity and difficulty of integrating two or more hospitals, even when they have the same corporate identity. The private sector has certainly seen such efforts fail altogether. The process through which VA integrates facilities is vital, however.

In holding this hearing this morning, we want to review the record of the VA's past efforts and the promise of the future. We

seek to understand better the process by which VA facility integration is initiated, analyzed, planned, and carried out. And most importantly, my colleagues, we seek to explore whether there are opportunities for significantly improving these efforts.

We are fortunate this morning to have an outstanding group of witnesses who bring wide-ranging expertise to the table. Several of our panelists, representing both private sector and public, have participated in the development of integrated health care systems as consultants, strategic planners, system architects, and administrators. We will also have the benefit of hearing from important stakeholders.

I want to thank our witnesses in advance for their testimony, and look forward to their insightful discussion.

I particularly want to thank my friend Terry Everett for co-chairing this joint hearing, and invite his opening statement at this point.

[The prepared statement of Chairman Stearns appears on p. 45.]

OPENING STATEMENT OF HON. TERRY EVERETT, CHAIRMAN, SUBCOMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. EVERETT. Thank you, Chairman Stearns. I want to thank you in welcoming those attending our joint hearing today, and I also want to thank you for calling this hearing and making it joint with the Subcommittee on Oversight and Investigations which I chair.

I associate myself with the Chairman's remarks. Consolidation and the integration of VA medical centers is occurring around the country, and is a matter of major interest to stakeholders involved in each one. First and foremost, veterans and their organizations, and also local communities, including VA employees and the elected representatives in Congress. Other stakeholders may be present in some scenarios as well.

Under the best of circumstances, these processes have the opportunity to get "stuck in the mud" in complex planning tasks, in implementing the integration of management, administration and clinical functions, and in communication with stakeholders.

While it is hopeful, it isn't "mission impossible". It may look that way sometimes, and achieving success in facility integration does present real challenges to the VA Administrators and managers responsible for them.

Mr. Evans, Ranking Democrat Member of the full Committee, and I will be in Montgomery, Alabama to follow up this hearing with a field hearing on the planning and formation of central Alabama Veterans' Health Care System. It will consist of Montgomery and Tuskegee Medical Centers. We will examine the same issues as the apply to central Alabama that we are examining here today, planning and implementation, cost-benefit analysis, communication with stockholders, and reinvestment of savings from improved facilities and efficiencies for the benefit of veterans and better use of tax dollars.

What we are really trying to do, though, through these hearings, as Chairman Stearns has stated, is find out if there are ways that these consolidations and integrations can be significantly improved.

I look forward to hearing from our witnesses today on this important issue, and I thank you again, Mr. Chairman.

Mr. STEARNS. I thank my colleague. The Ranking Member of the Health Subcommittee, Mr. Gutierrez, opening statement?

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you very much, Chairman Stearns and Chairman Everett, and my Ranking Member, Mr. Clyburn, for convening this very timely hearing to discuss one of the most important issues confronting the Department of Veterans Affairs Health Care System.

Facility integration and consolidation will affect veterans throughout America. Currently, it is affecting veterans in my community. This process, these reforms and transformations will greatly affect the manner in which veterans receive their care, where veterans access their care, and how these medical services that millions of veterans depend on are provided.

In this era of fiscal constraint, the VA has been compelled to develop a more efficient and cost-effective health care structure, while maintaining an adequate level of services. This is by no means an easy task, and has been accomplished with varying degrees of success.

The era of restructuring will most likely continue for the better part of the next decade in many regions of our nation. A decentralized VA system based around 22 service networks has been charged with implementing these visions of change.

As we know, the experiences of these regional systems has been varied, and we are only now beginning to learn from these episodes. I have learned first-hand about this process and what it means for our veterans.

In my hometown of Chicago, the integration of one of our nation's largest veterans health care networks is presently underway. The Chicago experience may offer some lessons for other regions and teach us all about how we can make integration process work better in the future in Chicago and elsewhere.

Unfortunately, I don't believe that at this time the Chicago model provides us a clear alternative to duplicate. I have followed this issue closely, and have yet to see a strategy for assuring that the Chicago area veterans will continue to receive the services, benefits, and care that they have earned and deserve.

We still don't know what the Chicago VA will look like in 2 years, 5 years, or further into the future. Rumors and speculation have been widespread, but a clear plan for the future has been absent.

When I first became involved in this process, I was concerned that the VA was moving unilaterally to implement an unjustified consolidation of Lakeside and West Side Hospitals. My main concern was that nuances had been provided to the veterans community about the needs and potential effects of this dramatic reform. The VA simply has not been able to answer our questions about the proposed consolidation. The VA has not been able to financially justify all of the actions that it is taking. The VA has not justified why an incorporation of this nation was warranted to enhance services to veterans.

The effects on adjacent communities, affiliated medical and VA employees remain similarly undeterminate. What I want to see is a sensible, inclusive, forward-looking process that answers these vital questions before consolidation occurs; a process that establishes goals and feasible options to achieve and a timetable in which to achieve them; a process that systematically responds to the concerns of veterans, stakeholders, community leaders, and elected officials.

To date, I do not believe that a comprehensive process has been developed. The VA has made some progress on achieving these goals, however. Stakeholders and veterans communities in Chicago have been afforded an increasing ability to voice their concerns and ensure that their needs are considered as integration proceeds. However, I feel that fundamentally the process in Chicago still needs to be strengthened.

I still have not seen a vision of the future of veterans service and care in Chicago. I have yet to see a clear plan of how service and access to veterans in my community will improve and expand. This is the only goal that matters.

I realize that this is a difficult process, but our veterans deserve a vision, a blueprint that guides our action. A vision of a better VA where our veterans are the first and foremost constituency, and their interests determine the bottom line.

This hearing is important not only for how it affects Chicago and any single network. This is also about health care of our veterans, that they've earned and deserve in VA facilities in Florida, Boston, Los Angeles, and anywhere the process of change has begun. We owe our veterans answers to the questions.

I am hopeful, Mr. Chairman, that today will be one more step in achieving that important goal in getting us those answers. I look forward to working with the VA in order to accomplish these goals. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague, and now we'll hear from the Ranking Member on Oversight, the gentleman from South Carolina, Mr. Clyburn.

OPENING STATEMENT OF HON. JAMES E. CLYBURN

Mr. CLYBURN. Thank you very much, Chairman Stearns, Chairman Everett. I wish to commend both of you—and Ranking Member Gutierrez, for calling this important hearing. I will try to keep my remarks brief since we have a number of witnesses before us today.

In my view, this morning's hearing will help provide some much-needed background into how the VA plans for the consolidation and integration of hospitals and medical services. Although some people in this room may not want to believe it, the changing nature of the health care industry may soon dictate some form of integration or consolidation is necessary to ensure that we are serving the needs of our veterans in the best and most efficient ways.

The broader concern, and a concern that the GAO has made quite clear in the written testimony it provided to our subcommittees in advance of this hearing, is that the VA needs to have a well developed plan in place before any of these consolidations or integrations take place. VA should be careful not to undertake such ac-

tivities unless it has crafted a clear and comprehensive plan, and unless the health care benefits to our veterans are clear.

I look forward to this morning's testimony, and I wish to thank all three of you for calling this hearing.

[The prepared statement of Congressman Clyburn appears on p. 47.]

Mr. STEARNS. I thank the gentleman. I would like to also recognize now for an opening statement, if he'd like, Mr. Lane Evans, the Ranking Member on the full Committee. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I appreciate the opportunity to speak, and I congratulate both Chairmen and the Ranking Members for holding this important hearing. I associate myself with most of the remarks made so far, and have a lengthy opening statement I'd like to place in the record.

Mr. STEARNS. So ordered.

[The prepared statement of Congressman Evans appears on p. 49.]

Mr. STEARNS. Is there any one of my other colleagues who would like to have an opening statement?

[No response.]

Without further ado, we will have the first panelists come forward.

Dr. Kenneth Kizer, Under Secretary of Health, Department of Veterans Affairs; Dr. Joan Cummings, Director of Veterans Integrated Service Network, Department of Veterans Affairs. And for the benefit of my Members, Dr. Cummings is in the 12th Region. There are 22 Regions, and that Region, I believe, includes much of Wisconsin and Illinois. Dr. Christopher Terrence, Chairman, Integration Coordinating Committee, VA Chicago Health Care System, Department of Veterans Affairs; Jim Goff, Director of Palo Alto Division, VA Palo Alto Health Care System, Department of Veterans Affairs; and Dennis Smith, Director, Baltimore Division, VA Maryland Health Care System, Department of Veterans Affairs.

I want to welcome all of you, and I thank you very much for your time, knowing how busy you are. At this point, we will proceed with Dr. Kizer.

STATEMENTS OF KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; DR. JOAN CUMMINGS, M.D., DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK (VISN) 12, DEPARTMENT OF VETERANS AFFAIRS; DR. CHRISTOPHER TERRENCE, M.D., CHAIRMAN, INTEGRATION COORDINATING COMMITTEE, VA CHICAGO HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS; JIM GOFF, DIRECTOR, PALO ALTO DIVISION, VA PALO ALTO HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS; AND DENNIS SMITH, DIRECTOR, BALTIMORE DIVISION, VA MARYLAND HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF DR. KIZER

Dr. KIZER. Good morning, Mr. Chairman. I welcome this opportunity to discuss with the subcommittees this particular strategy that the VA has been utilizing to better serve its patients.

In my brief opening comments, I want to do two things. First, I would like to provide some context for these integration efforts and for some of the more facility specific comments that will be made by other witnesses on this panel. And, second, I would like to quickly overview the generic process being utilized to implement this strategy.

I think you and others have already commented on the really revolutionary nature of change that's going on in health care today, and the different models of service delivery that are being pursued. The model that is being pursued, probably most widely, is the integrated service network or integrated delivery system, which VA is pursuing as well. However, and certainly in the private sector, these integrated service networks are taking a myriad number of forms and are developing in quite a number of different ways in response to all the various antecedent conditions that prompt their genesis.

In the VA health care system, hospital and other facility integrations, as well as the clinical and support service integrations, are part of the larger Veterans Integrated Service Network (VISN) integration strategy aimed at providing more accessible, more reliable and more consistently high quality health care for as many patients as we can provide for with the resources that we have available.

Having said that, there are five specific generic purposes that we are trying to achieve with each of these facility integrations; these purposes apply to the 40 facilities that have already and/or are currently in the process of integration. These purposes are: (1) to increase access to care; (2) to increase the predictability and consistency of high quality care being provided; (3) to optimize the utilization of physical plant and other assets, including personnel resources—i.e., to capitalize on the strengths of each of the facilities that are involved; (4) to modernize VA health care. (Comments made this morning already indicate that the VA is playing some catch-up as far as modernizing its health care system and, as we try to modernize VA health care, we need to look at our administrative practices and our clinical and care management strategies, as well as the physical assets supporting care delivery.)

And, finally, (5) the fifth generic goal or purpose of our integration efforts is to reduce unnecessary costs, to increase efficiency and, in particular, to free-up dollars that historically have been spent on administration and redirect those dollars into direct patient care.

I think having noted these five generic purposes that our integration strategy involves, it's important to also note a few contextual things to provide some background for these efforts.

The first thing I would note in this regard, as I already mentioned, is that facility integrations are really part of a larger network-based integration strategy. As we have discussed previously at many hearings, the basic operating structure of the organization is now the VISNS. Although care is delivered at specific sites and at facilities, facility integrations should not be viewed as an end product. These integrations are merely part of a larger process aimed at providing the continuum of care that people so often talk about, but which is, in fact, so rarely actually achieved.

Also, as the VISNs develop integrated service networks, it is important to realize that what a facility may do at a point in time may change because of larger network efforts. For example, two facilities may be considering consolidation of their laboratory services or their radiology services and how consolidation or integration may improve those services, while there may be a VISN-wide review of a delivery strategy of new technology that may affect these same services. For example, in some networks where integrations are going on, there's also efforts underway to implement teleradiology. While the radiology service may integrate or consolidate at those two facilities in a matter of months or a year down the road all for good reasons teleradiology initiative progresses, and that integration may be superseded by a larger effort to integrate radiology over the entire network as opposed to just at those two facilities.

Similar situations exist for numerous other services that range from food service or laundry to all the other things that go into supporting a health care activity like a hospital.

A second point of context that's important to note, is that despite literally hundreds of these mergers, consolidations, integrations having occurred in the private sector, there has not yet been a single process, or template, that has been devised that addresses all of the issues that are associated with the circumstances that prompt those integrations.

Indeed, if we look at the 40 facilities involved in the 19 integrations that have occurred or are occurring in the VA from the perspective of whether they are rural, urban or suburban facilities; whether they are tertiary care or non-tertiary care; whether they are academically affiliated or non-academically affiliated; whether they provide general acute care, psychiatric care or extended care; or whether they are small or medium or large in size we find that by looking at just these five variables, there are no two integrations that are the same. Each of the 19 that we have pursued so far involve a different set of circumstances and different conditions at the involved facilities. So, it has been difficult in our experience, as well as in the private sector, to define a process that fits all of the varying circumstances involved with integrated facilities.

I also would note that these integrations have to be viewed within the context of all the change that is occurring outside of those facilities and in their regions that make this a living, evolving process that can't be viewed from just a single point in time. And while I know that there is a desire to look 5 years, or even 10 years, into the future, nobody in health care today that I know of views 5-year planning, and certainly not 10-year planning, as at all realistic. The nature of health care is changing so rapidly today that most people look in terms of 1 or 2 or 3 years down the road. There are just so many things that are changing so rapidly that it's impossible to make viable plans for 5, 6, 7 years into the future.

Another contextual point I would note—and I see that the red light is on, so let me try to wrap this up quickly—but another contextual point that I think is important to put on the table is that we are committed to having a high degree of stakeholder involvement and participation in the decisionmaking process. Quite simply, if we are going to honor this commitment, it's pretty hard to

have predetermined outcomes. If we are going to actually have an open and participatory process, it is hard to have predetermined outcomes where the stakeholders actually have a significant role in shaping what those outcomes are going to be.

Mr. EVERETT. Mr. Chairman, I ask unanimous consent that the Doctor be given an additional 5 minutes.

Mr. STEARNS. Any objection to giving Dr. Kizer an additional 5 minutes?

[No response.]

Without objection, so ordered.

Dr. KIZER. Thank you, sir. I will actually try to wrap this up in less than that and not usurp any more time.

Let me just shift gears a little bit. We think that, to date, the results of the integrations have been substantial. VISNs report well over $50 million worth of savings, and that they have been able to make quite a number of significant enhancements and expansions to care, and add clinicians as opposed to administrators and supervisors.

Recognizing where the science of this process is, if you will, and the lack of a single process or template that is followed elsewhere, we have tried to provide guidance to our facilities and we have tried to inform ourselves as we go forward in this process. After the first half-dozen integrations were pursued, we compiled a notebook, a guidebook if you will, and we disseminated that. Now, after another year of experience, we are currently compiling the data and providing additional guidance to the field.

It has been my intent, however, to not put in place any sort of process that is unnecessarily prescriptive. Recognizing all the variables that go into play, a rigid bureaucratic process that could stifle the creativity and innovation that are so important for these efforts to work.

I have in my prepared comments indicated what the general five-phase process is that we are utilizing, and what a few of the steps are underneath that. This process will be part of the guidebook being developed for field use, which will provide additional detail regarding the steps and the planning efforts that need to go into future integrations of entire facilities.

I would also note that in recognizing the absence or the dearth of literature that exists in this regard, I have requested our HSR&D activities to engage in a systematic assessment and evaluation of these efforts, they are currently in the process of investigating the integrations that took place between January 1995 and September 1996.

Let me close by just saying that, so far, integrating our treatment facilities has produced very tangible benefits for expanding care. These integrations have allowed us to increase services and functions, and we believe they are a very valuable tool to be used in pursuit of a network integration strategy.

These changes, not surprisingly, have produced anxiety and some concern, indeed, in some cases, resistance by some of our stakeholders. The one concern that I hear most often expressed is the erroneous perception that the integration is a precursor to closure of one of the involved facilities when, in fact, the integration is being pursued to improve the viability of the facilities and hope-

fully obviate the need for closure at some point in the future—i.e., so that we can continue to provide services at these facilities with the resources that we have.

I recognize that the process is not perfect. Certainly, experience in the private sector has been variable. We are trying to improve our process, as I have noted very briefly here and we certainly welcome suggestions from the GAO, from private consultants, from the Committees or from others, on how we can improve our process even more as we go forward, since we see this strategy as something that we will continue to employ for quite some time to come. Thank you.

[The prepared statement of Dr. Kizer appears on p. 61.]

Mr. STEARNS. Our next panelist is Dr. Joan Cummings. Welcome.

STATEMENT OF JOAN E. CUMMINGS, M.D.

Dr. CUMMINGS. Thank you, Chairman Stearns and Chairman Everett and members of the subcommittees. I'd like to thank you for the opportunity to discuss the integration of the Chicago Health Care System, the Lakeside/North Side Divisions.

I'd like to again state, as Dr. Kizer said, that the integration is just one element of a larger network strategy really aimed at accomplishing five principal goals, and I'll relate these. Two specifically network, one is increasing the access over the next 5 years. We would like to increase access to veterans in Chicago so that we are able to see 28,000 more veterans than we currently do. To do this, we need to establish care sites that are easier to access than the present hospitals we have. For example, we would like to see veterans in the West Side Austin area, very low access now, by establishing a community-based clinic there. To do that, we're going to have to shift resources from established places to the new community-based outpatient clinics.

Second, we'd like to modernize the VA healthcare system, as has been mentioned. We have major needs in our VISN for investing in fiber-optic infrastructure and computers. Again, these kinds of savings that link us and increase our efficiency are only found by developing savings and efficiencies in other areas so that we can redirect the resources into allowing us to practice the current state-of-the-art, both medical practice and technology, which really means that today health care has really become primarily an ambulatory activity and in settings far more than just in our hospitals.

Our third goal is optimizing utilization of our capital assets. We need to maximize the cost-effectiveness of our services. We must eliminate unnecessary duplication or redundancy of services and technology, consolidate low-volume specialty services, coordinate resource decisions better, increase telemedicine usage, and achieve better economies of scale and productivity wherever feasible. For example, one of our Chicago inpatient surgical services has an occupancy rate of about 30 percent. A generally accepted standard in health care is that this should be about 85 percent.

We need to reduce costs. The cost of VA health care in Chicago has been substantially higher than in most of the rest of the nation. We must use our resources as effectively and efficiently as possible. Even in the absence of any budget imperatives, our VISN

needs to realign clinical and administrative programs to reduce their resource consumption. The goal here is simply to bring VISN 12 into better alignment with VA costs elsewhere. A significant part of the problem in this regard is the over-utilization of VA inpatient care in the Chicago area. I want to stress that costs are being reduced by making our programs more efficient, not by diminishing the quality or amount of care we provide Chicago area veterans. We have in this VISN decreased our length of stay—bed days of care—by such a degree that we have closed 1,688 acute care beds across our VISN which are no longer needed. These recovered resources will be utilized to provide better, more accessible care to larger numbers of veterans particularly in the outpatient setting.

The fifth goal is to ensure consistently high quality care. We are trying to ensure that VA provides consistently high quality care throughout the Network as well as throughout the system. This will require more standardization of our services and better utilization of resources, including the elimination of certain low-volume services, and we need to do this more effectively than in the past.

I would also like to take this opportunity to reaffirm my believe that both the Lakeside and West Side Divisions are essential. If we are going to achieve the five goals I just mentioned, we need to change how we provide these services, what the facilities provide, and how they are linked and coordinated.

I have serious concerns about suggestions that the integration process should be delayed until a complete master plan is available, and I'd just like to touch on that briefly, if I may.

Since the decision to administratively integrate the two facilities occurred, we set up an Integration Coordinating Committee, which you'll hear more of later, that had not only representatives from those directly involved in the two divisions, but from all the medical schools in northern Illinois and from VA staff outside of the two divisions, as well as a Stakeholder Council of all of our major stakeholders to get input and receive input to that Integration Coordinating Committee.

And I'd like to give a couple of examples of some of the things that have happened in this integration that I believe are reasons to be pleased with its current success and look forward to better successes.

Part of the plan that this Integration Coordinating Committee did was to re-evaluate what's going on. As you all know, there are long-time construction plans. We have resubmitted all of those to the Integration Coordinating Committee and work groups to evaluate whether in the changing VA they are still necessary.

As an example, there were two angiography suites that were actually in progress at the time this committee met to replace angiography equipment at both divisions. We developed a plan to look at these with data for the workload, the procedures done. The Integration Coordinating Committee and the work group decided there was no justification for two, and also decided that there should be one for the Chicago area and it would serve the needs of the veterans—and this is at a cost avoidance of $1.25 million, which was the cost of the equipment and the cost of the contract.

In addition, it allowed us to delay any default on the contract or unreasonable delay in implementation.

There are other similar issues facing us, including ordering a replacement cardiac cath equipment, where the Integration Coordinating Committee and its work groups are making significant recommendations as we go forward in how to handle this.

The two divisions have eliminated 108 positions during our hiring freeze. Many of these were eliminated either through the buyout or attrition in the expectation of the work groups recommending a smaller number of employees and less supervisors.

Normal turnover has generated some vacancies which have been left unfilled in anticipation of the same outcomes. If we are not allowed to integrate and the work groups are not allowed to make their recommendations, we are ending up with longer-term vacancies that are more difficult to provide adequate service with.

We are facing and in the middle of a reduction-in-force and a staffing adjustment in our VISN. Because of the integration, we have been able to avoid some separations. If we have to stop and we do these as separate integrations, the reduction-in-force may go far deeper into both divisions and affect far more employees.

Eleven out of the 33 groups are finished and have had their recommendations in. One of them is a recommendation from Nutrition and Food Service for consolidation of food services at one place and eliminating the other kitchen. That recommendation is in the process of planning to implement. Again, if we were delayed, we would end up still functioning with two kitchens and lose the savings that would accrue to us from that.

And, finally, all of our minor construction and NRM projects are being sent to the ICC for their review, to review that in view of the overall mission that's been developed for this new VA Chicago Health Care. Going back to those original plans and doing those projects without this review I think also would cost us additional funds and would make our budget challenge more difficult to accept.

We plan to proceed with the Coordinating Committee and the stakeholders and keep them informed as much as possible, and I thank you very much for the opportunity to present this overview.

[The prepared statement of Dr. Cummings appears on p. 68.]

Mr. STEARNS. Thank you. Dr. Terrence.

STATEMENT OF DR. CHRISTOPHER F. TERRENCE

Dr. TERRENCE. Good morning, and thank you for this opportunity to discuss the Integration Coordinating Committee of the VA Chicago Health System. At its first meeting, the Integration Coordinating committee decided that we would proceed in forming chartered work groups with the approval of the Medical Center Director. These groups were service specific and were charted with developing a proposal for integrating specific services. The goal of the group was to produce a health system that would maintain the quality or enhance the overall service to the veterans while minimizing the costs inherent in operating two hospitals with similar missions in close proximity.

The Committee decided to start with services that were relatively noncontroversial in order to prove that the process was valid and

could be accomplished in the context of the VA Chicago Health System.

When a group completed its proposal, the proposal was submitted to the Integration Coordinating Committee for its review and subsequent recommendation to the Medical Center Director. The proposal was also reviewed at the Stakeholders Advisory Group by the chairmen of the various chartered work groups. The recommendations from the Stakeholders Advisory Group were brought forward to the Integration Coordinating Committee in order to provide maximal input into the deliberations of the Integration Coordinating Committee.

In order to keep the staff at the two divisions up-to-date on the process of the Committee, we have used a number of formats to achieve this goal. The Chair of the Integration Coordinating Committee has had four town hall style meetings at the Lakeside and West Side division. These meetings had two goals; first, to present the activities of the Integration Coordinating Committee and, second, to seek information from the staff at the two divisions concerning the future process of the Integration Coordinating Committee.

These meetings were extremely well attended and had a of information brought forward. There also have been regular updates of the progress of the Integration Coordinating Committee in the VA Chicago Health Newsletter. Also, the committee's minutes are put on the hospital computer system available for all those who have access, and they are also placed in the libraries at the two divisions.

By July of 1997, over half the work groups will have presented their recommendations to the ICC. Up until now, most of the recommendations have been forwarded to the Medical Center Director with little changes. A few have been referred back to the service work groups for more information. As one can see, the process is very time consuming, but the Committee believes that it is very worthwhile in that it involves the maximum number of people in the proposing process. Until the inception of the Integration Coordinating Committee, there was very little active participation by the two divisions in coming up with joint plans as to consolidation.

As of this date, the ICC has approved the goals and mission statement for the VA Chicago Health Care System. The ICC recommended the consolidation of audiology and speech pathology, chaplain, dental, environmental management, hospital based primary care, information resources management, neurology, nuclear medicine, nutrition and food services, pharmacy, police, and many others. In addition, the Committee has also recommended the replacement of angiography equipment at the West Side division, and the replacement of the cardiac catheterization equipment at the Lakeside division. The Committee also approved the integration of pathology and laboratory medicine services.

In the next few months, we will complete the large service work groups. This will include such services as medicine, surgery, psychiatry and nursing service. Although these are the largest services to be dealt with to date, I think the Committee has built up a track record of accomplishment that will allow us to deal with the thorny issues of affiliation interests and placement of bed service facilities.

In order to facilitate the process among the bed service working groups, the Medical Center Director and I have been meeting with the Chairs of the bed service chartered work groups such as medicine, surgery, psychiatry, and nursing on a monthly basis to facilitate interservice planning that will be necessary for a coherent proposal.

In order to review what we have done in the Committee, there will be a proposal brought forward in the July meeting to develop measures of the integration process. We expect either in the Committee or in the various work groups to propose to the medical center management the types of measures that should be done in the future to ensure that the integration has achieved its stated goal of maintaining the quality and enhancing the access of care for veterans in a cost-effective manner. I expect these measures will include the usual quality management activities, but I expect the work groups to also recommend very service specific measures.

In summary, I believe the Integration Coordinating Committee of the VA Chicago Health System has worked very diligently in setting up a process and framework for the integration of two tertiary care hospitals. This Committee would have never been successful without the support of the four medical school Deans, the union representatives who have contributed greatly, the Chair and members of the stakeholders group and other veteran service organization representatives.

Thank you, Mr. Chairman, for the opportunity to present this brief overview of the Integration Coordinating Committee of the VA Chicago Health System.

[The prepared statement of Dr. Terrence appears on p. 80.]

Mr. STEARNS. Thank you. Mr. Goff.

STATEMENT OF JAMES A. GOFF

Mr. GOFF. Thank you, Mr. Chairman and members of the subcommittees. It's a pleasure to have the opportunity to tell you about the positive experience of consolidating and integrating the Palo Alto and Livermore VA Medical Centers.

As has been stated earlier, there are really two reasons to do this. The driving one, as far as I'm concerned, is always to improve the quality and quantity of patient care. Obviously, you want also try to save some resources or redirect them to help with the first effort.

In Palo Alto and Livermore, there was a history that went back to about 1989 when Livermore was affiliated with Stanford. Palo Alto had been affiliated before then. Since then there has been discussion, although no action, and no one really believed it was going to happen, about consolidating these two facilities.

When I came to Palo Alto, I was given three charges by the Regional Director. One was to get our hospital built, which is of some interest to you, and another was to fully integrate the Menlo Park and Palo Alto campuses which, although operated as a single facility, really functioned as two separate ones. And the third was to consolidate the Livermore and Palo Alto VAs.

Those three things have all been accomplished. Essentially, we did the latter when the Director left at Livermore and the Regional

Director was able to put in a Director who understood going in that his charge was to integrate those facilities.

We were proceeding along about a 2-year plan to do that when he (the new Director) took the buyout and I was made Acting Director there. That sped things up, which was both good and bad. It was good because we were able to make it happen faster. It was bad because the system really wasn't ready to respond to an integration proposal. And being the first one doing anything is always a little difficult.

Among the things we did to make this happen that were of particular importance, we involved the unions early on. Even as the Director were meeting, we got the unions together with management and had them involved from the beginning.

We also involved the other stakeholders from a very early point in time, and I think these two things were key to us not having major problems.

Following are some of the actions that I think are important to a successful consolidation, I think we have to develop a single management and do that early in the process, and we did that. You have to have a lot of communication, and that's not just from the staff but from the Director. We had town hall meetings, retreats, one-on-one meetings with people, lots of interaction, and that has to be ongoing.

And in that process, you have to tell people things they don't want to hear sometimes, but I think it's important that you do that.

We, as I mentioned, developed a labor-management partnership which has actually been recognized as one of the better ones in the country, and we did that even before the consolidation. With the unions at both places, we got together and had a common partnership agreement.

We also, at the time, promised that we wouldn't conduct a RIF in conjunction with the consolidation. We did stick by that, but later on budget concerns did force us to conduct a RIF. It was not because of the consolidation, and the unions understood that because they had been involved from the beginning.

One of the things, as I said earlier, you want to demonstrate is improvement in patient care. As I was preparing for this, I got a letter just the day before yesterday from a veteran that probably explains it better than anything else. It says, "I am writing to tell you how pleased I am with all the new improvements at the Livermore VA. There is so much less waiting, the appointments are on time and are much improved. I am really impressed by the telephone care program. It makes things much easier now to make a trip to the hospital. I have been using the VA health service for about 10 years, and this is the best it has ever been. I am not much for writing letters, but this is one time that I thought I'd better write". I thought that probably said better than I could say what the results have been and what you want to get out of a consolidation.

There are some important things that have to be done that aren't easy to do. You have to integrate your databases, your computers, your fiscal systems, your telephone equipment. You have to worry about mundane things like name changes and station numbers and

organizational charts and informing people that you now have one organization where there used to be two, that there's going to be one report instead of two, and congressional correspondence has to be directed properly—lots of things that don't come to mind immediately when you begin this process.

And it's particularly important you be sensitive to the employees, especially the mid-level managers because they are the ones who can subvert this thing, but they are also the ones usually most impacted by the consolidations.

In summary, while each integration is unique, I believe that the things I mentioned are probably common to all. And we had some things going for us like advanced planning and a common affiliation. We also had radically different cultures, long-standing rivalry between the two places, the administrative delays because we were the first and the large versus small facility issue. Some of the results were that we saved immediately 78 FTE and about $5 million including significant contract hospital savings, more veterans were served, waiting times reduced, access to care was improved, and quality was improved. We have now a seamless referral process and efficiency is better. We've done more care with reduced budgets. We are actually treating more veterans now than we did before with the two separate facilities.

Livermore has a new lease on life. The issue has been raised about people worrying about one of the facilities being closed. That could have happened to Livermore had the consolidation not taken place.

Palo Alto has the advantage of having an expanded primary care base. And remember that all this has taken place while lots of other changes are going on in the VA system that have already been mentioned here, and it's very hard to sort out what is cause and effect. I'm asked often with the consolidation—exactly how much did you save, exactly what did the changes cost in the way of morale and other stuff. You cannot sort that out from the other things that are happening in the system.

In summary, I'd just say that consolidation is not an end in itself, it's a means to the greater end of improved service to veterans, and I think if we keep that in mind as we do these consolidations, we will be successful. Thank you.

[The prepared statement of Mr. Goff appears on p. 83.]

Mr. STEARNS. I thank the gentleman.

Mr. Smith.

STATEMENT OF DENNIS H. SMITH

Mr. SMITH. Good morning, Mr. Chairman, members of the subcommittee. It is my pleasure today to share with you the Department of Veterans Affairs' experience with integrating the VA Medical Centers in Maryland. There are five of these facilities. The Baltimore VA Medical Center, which is a tertiary care facility that has 163 acute operating beds, and is affiliated with the University of Maryland Medical School. The Fort Howard Medical Center is a subacute and rehabilitation facility that has 154 hospital operating beds. It operated a 47-bed nursing home until 1996 when we closed it and opened the new Baltimore Nursing Home located at Loch Raven Boulevard. The third facility is the Perry Point VA Medical

Center, which is a psychiatric long-term care facility with 305 hospital beds, an 80-bed nursing home, and a 25-bed domiciliary. The Cambridge Outpatient Clinic is located on the Eastern Shore of Maryland and approximately 92 miles from the Baltimore facility. We accommodate approximately 17,000 outpatient visits there a year. And, finally, the Baltimore Rehabilitation and Extended Care Center, which is a free-standing 120-bed nursing home that we opened in August of 1996.

The Maryland integration process was approved March 17, 1995. Our integration was one of two that involved three medical centers. In July of 1995, the senior management of the Baltimore and Fort Howard Medical Centers merged, and in November of 1995 the Perry Point facility joined the integration. That was really the beginning of the integration.

I came to the integration process about 4 months into its start, and I identified five things that we needed to do in our process to get the integration moving forward.

The first thing was to improve the stakeholders involvement in what we called our Executive Council, which was the main body that was overseeing the integration.

Second, we needed to develop a written communication plan, as was mentioned by Mr. Goff, a very important part of the integration process.

Third, I did not feel that our current organizational structure would be sufficient to manage the integration process. We redesigned our organization to include service lines.

Fourth, we needed to develop a strategic plan, which we did, that identified areas where we could improve our medical care to our veterans, reducing beds and consolidating services.

And, fifth, I thought we needed to take a business planning approach to all of the above. When we decided that we wanted to look at an area to consolidate, we developed a business plan before moving ahead.

Major accomplishments. The primary goal of the integration, as was said, is to improve patient satisfaction, improve access, increase efficiency, and enhance quality. These goals were the driving force behind designing and implementing a new integration organization, and every accomplishment through the process can be directly associated with one of these goals. Although we had many accomplishments, our major accomplishments were in the areas of program consolidations, cost savings and reinvestment, staff reductions, organizational redesign, and stakeholder involvement.

Some of these accomplishments include reducing our FTEE by 297, closing 232 inpatient beds, redirecting our emphasis from inpatient to outpatient, opening a 120-bed nursing home, opening 32 substance abuse transitional beds, and opening 25 domiciliary beds. We did all this while receiving the highest scores at all three medical centers for our Joint Commission Accreditation. Our average score was 95. We also did it while meeting all the target performance measures set out by Dr. Kizer and exceeding four of the six incentive measures. We avoided any major opposition from employees, veterans groups, unions, affiliates, and congressional delegates.

We believe our intense efforts dedicated to communicating with our stakeholders during this process was instrumental in the success of our integration. Many mediums and techniques were used for this communication. For example, newsletters 800 toll-free hotline numbers, electronic mail, work groups, open forums, and individual meetings with constituents such as congressional members and unions.

In addition to the financial benefits associated with the accomplishments mentioned above, the VA Maryland Health Care System has transformed itself into a modern business entity capable of delivering quality services that meet community standards and address business trends.

The savings generated through the integration process has enabled us to manage budget constraints without the need to implement reductions-in-force. More importantly, health care services available to our veterans have been enhanced tremendously due to the creation of a seamless continuum of care managed by one executive team.

In conclusion, we have accomplished a minimum cost-savings of approximately $15 million, reduced full-time equivalent employees by 297 while simultaneously expanding and improving patient care services to our veterans.

We have enhanced the continuum of care to veterans, reduced duplication of services, enhanced quality, shifted program emphasis from inpatient to outpatient. We believe our efforts have met the intent of the integration in a means that is mutually beneficial to our stakeholders. Thank you, Mr. Chairman.

[The prepared statement of Mr. Smith appears on p. 91.]

Mr. STEARNS. Thank you. I'll start with my first question for Dr. Kizer.

The GAO appears to take the view that the VA would benefit from developing discussing with the stakeholders—for the Members, the stakeholders, I understand, are the associated interest groups with the hospital, veterans union, teaching hospital-associated and, I might add, that includes the Members of Congress. Their position is a very detailed integration plan should be presented to the stakeholders. That's what the GAO is saying.

I guess the question is, do you agree?

Dr. KIZER. Let me respond to that in a couple of ways because we actually have some experience now pursuing that approach as well. First, we have made a judgment that there was a necessity to move forward and implement many of these changes which, frankly, for lack of a better term, were no-brainers. There were a lot of changes that needed to occur that would enhance care and improve efficiency, so the judgment was made to move forward with these (recognizing that there was no agreed upon process anywhere at the outset) and refine the process as we moved forward. We have divided the potentially integrating facilities into three tiers. First, would be those that we thought would be relatively easy to accomplish and which were expected to be straightforward and which would quickly produce benefits and give us experience. A second tier, which we are now working with, which would be those facilities perceived to be more difficult to integrate for a variety of reasons. And then, finally, there is a third tier that is felt

to be even more difficult and which we will hopefully approach at sometime in the future.

Having said that, I also would go back to a philosophical position. We felt that the stakeholders should be involved in the decisionmaking process and in the development of the plans. That is the tact that we have taken. We have tried to involve all of the stakeholders, whether they are academic affiliates or the veteran service organizations or others, in the development of these plans. That is, not surprisingly, sometimes a messy process because of the variable needs and desires of different people for information, the various positions that they come with, the vested interests that they represent, and all the other things. Again, we philosophically felt they should be involved in from the beginning, as opposed to delivering them a detached plan that would appear as a fait accompli with stakeholders not being involved in its development.

The third point I would make is that we have looked at the suggested approach in the case of Boston. A decision has not yet been made as to whether or not we are going to pursue integration, although everyone agrees that it should be done. We utilized an outside consultant to actually do a lot of work and develop a detailed plan, and they developed a recommendation. At this point, I now have two stacks of letters from advocates for the Jamaica Plains facility in Boston, and the Brockton/West Rocksbury facility, and the stacks of letters are about equally high, one recommending that we go with the consultant's plan, and the other stock from those who say that the consultant's detailed plan doesn't make sense. And so we will have to work through that process.

So, I'm not sure, frankly, that developing a plan without the stakeholders' involvement actually speeds up the process or makes it any more expedient than involving the stakeholders from the beginning.

Mr. STEARNS. VA could probably develop a theoretical plan that represents what the VA thinks the outcome should be, and then discuss it with stakeholders, and say this, in our opinion, is the best way to do this. You seem to say that you would not want to present that theoretical plan to the stakeholders and say to them, okay, here's what we think in detail, what do you think, even knowing they were resistant. I mean, you seem inclined not to want to develop and present a theoretical plan to them.

Dr. KIZER. I think it really goes to the level of detail. In all of the integrations that we have pursued, we have started with some generic goals, some of which I discussed, and then amplified them in the specific situation with some of the specific goals that we felt would be achievable. However, we wanted other people's involvement and participation in that process to see if our thinking made sense before we actually got down to the implementation details.

One of the things that we have found, and I think members of the subcommittees can probably comment on this as well, is that when we do go out and say we think this is what may make sense, the next thing I receive is a letter from a member saying that the VA has decided to do this (whatever "this" is) without the benefit of any stakeholder involvement and you question how can VA come to this conclusion without involving people in the process?

Even though it may be simply a musing, or maybe a little bit more than a musing, and it would appear that the proposal combine these services would make sense, people tend to translate that into a decision or determination that that is what is going to be done, even when it is presented as just a consideration or something that we want to work through in detail. I know that you can appreciate the sensitivity in dealing with the various interests that are involved in the process and how they may take even very tentative bits of information and come to conclusions that may not be sound, or at least not at all what you intended.

Mr. STEARNS. I understand. I can appreciate the delicate balance that you have.

Mr. Goff, is there anything you would want to add just briefly to this? I understand from staff that since you've been very successful in the consolidation process in your experience, you might just add a few comments.

Mr. GOFF. Our experience was, as I said earlier, the first one and, in our case, a decision was made up front that we were going to consolidate. Once that decision is made, then the involvement of the stakeholders is extremely important in deciding how you're going to do it.

If you're going to involve them in making the decision in the first place, as Dr. Kizer was just discussing, that was not our experience, so I can't comment on that part of it.

Mr. STEARNS. I thank you.

Dr. KIZER. Let me just add one thing because there's a nuance here that may be useful to put on the table. There is really two aspects of the integration that have to be viewed. One is what is often called in the private sector the "functional" integration, which is the management integration, which is the decision that we have generally, in the case of Palo Alto and others, made when it made sense to merge or integrate the management of the facilities. And then there is the much more difficult process, the one that people have much more interest in, concerning how the care is actually going to be provided, how the various clinical services will be apportioned, and how that will sort out.

So, there is an administrative or management phase, and then a clinical or clinical service phase, which is the one that typically, in the private sector and in our experience, takes about 12 to 24 months to sort through all of the details.

Mr. STEARNS. My time has expired. Mr. Gutierrez.

Mr. GUTIERREZ. Thank you very much. Welcome, Dr. Kizer and Dr. Cummings, and to the rest of the panel, very interesting testimony this morning.

I guess the coordination of all of the different groups is probably one of the most critical and essential components and, as we began this process, particularly in VISN 12, I remember being at meetings both here in Washington and in Chicago, where preliminary questions were being asked—basic kinds of questions were being asked—and very few, if any, answers were being given to those questions, so that it wasn't a question of even what is the whole plan that the VA has, but what is the plan. And the plan usually centered around, well, we're going to integrate Lakeside and West Side, and where it makes sense to integrate things and where

there is cost-savings, we're going to do that. And someone would say, well, can you give us five specific examples of areas that you're going to look at and, really, there weren't a lot of answers coming back as that process began.

And much has been said about the stakeholders and the involvement of the stakeholders. And I don't remember, and I'm sure you'll refresh my memory, that there was a lot of involvement of those stakeholders because those stakeholders were kind of running around the city of Chicago from congressional office to congressional office, and from Senator to Senator, and from place to place, saying will you help us, we'd like to get some answers. And so we asked for the GAO report that will hopefully come out by the fall of this year to let us know what's going on in Chicago because it's a very serious process.

As a Member of Congress, people ask me, when I present legislation, "Well, Congressman, what is the impact of your legislation on this population in three years, in five years, in ten years", "Congressman, you have to be very specific when you introduce this legislation in terms of what its ramifications for everything else are". And as Members of Congress, we kind of say, "Here's our legislation". Here it is for the public. The newspapers get it. All the different groups get it. Everybody gets to take it apart, criticize it in open and in public, and then we have hearings and we move forward, and I guess that's my basic point, both Dr. Cummings and Dr. Kizer, that when we say, well, we'd like to see a little more and we'd like to know a little more, I guess it is in part based on our own experience about how we go about telling people what we're going to do. I know that complicates matters.

Let me say that I think that the process of communication has greatly improved and is greatly enhanced, at least in my experience in the city of Chicago. And, you know, I know that Dr. Cummings specifically—not you, Dr. Kizer, so much because you get it here in Washington, DC, so you get to meet with the fine, distinguished congressmen from the Illinois Delegation, including myself—Dr. Cummings gets it a little rawer over there back in Chicago with everybody coming together from the community, and so she has quite a different experience.

So, let me just ask, as we look back at how we did it—you know, where we're at in this process—is there anything we could have done better? What are those areas that we could do better, and what have we done to correct them in this very immediate phase because I know you can't tell me where we're going to be next year. Dr. Cummings, if you would.

Dr. CUMMINGS. Thank you. Actually, I'm very pleased with that question because I think that there are some things that we've learned from this, and I think Dr. Kizer's comment about the management structure, when we made the decision to work towards the integration of management, what I would have done is to have both the Integration Coordinating Committee and especially the Stakeholders Council, start earlier.

I think one of the key success pieces for the integration in West Side and Lakeside that I think is going reasonably well, has been the Stakeholders Council. It's chaired by a national representative member of one of the service organizations, it includes congres-

sional folk, staffers, it includes service organizations, community people, and that contribution to the openness of the so-called "functional" thing when you begin to decide where do you put an angiography suite, how do you consolidate labs, I think has given us a view that has given the whole process credibility.

So the biggest thing I would have done is at the time we were looking at the decision to administratively integrate West Side and Lakeside under the same management, I would have put together that Stakeholders Council up front, even when we had not maybe had as much of a decision because I think the question, in Chicago certainly, when we began as the VISN started to identify areas that needed addressing through data, when we began to look at our occupancy rates and our utilization of inpatient services, we did not get very far into that process before a lot of stakeholders got very, very interested in it.

So we really had had no ability to collect the data before the stakeholders got it, and my concern, I think what I would do is, one, to enhance that and start it earlier.

Mr. GUTIERREZ. So, before we start the process, we get everybody involved and we tell them we're going to start the process, and we're going to figure this thing out together, because I think, Dr. Cummings, maybe you've hit it on the nail. If you start something and then everybody who is affected—or a lot of people, not everyone—but a lot of people that are affected find out about it and then they come and they say, well, what are you going to do, and you say, well, we're just starting to try to figure that out ourselves, I can see how people—you know, it can get very confusing for everybody and very tense for everybody, so I think that's good.

Mr. Chairman, I'm going to ask unanimous consent that the Members' statements and follow-up questions and answers be made part of the hearing record because I have some questions that I'm going to submit to the panelists.

Mr. STEARNS. Without objection, so ordered.

Mr. GUTIERREZ. And, secondly, Mr. Chairman, I just want to end by saying thank you once again, and I'd like for all of us to go to Chicago. With all deference to our fine, distinguished guests here from other States, I'd like to go to Chicago to see where this process is working, and have the Members of the committee here from the veterans community and all the stakeholders about how this process is working out there, so that we can get some more exchange out in the field before the report comes out, so we're not prejudiced by the GAO report. We've got something of our own out in the city of Chicago, and I welcome you all there. Lunch is on me, anyway, for all the Members.

Mr. STEARNS. Thank you, appreciate the invitation.

The committee is going to adjourn and reconvene after the vote which is on the House Floor, and I appreciate your indulgence.

[Recess.]

Mr. STEARNS. We'll reconvene the joint hearing of the Health and the Oversight and Investigations Subcommittees.

Mr. Peterson, would you like to have your questions?

Mr. PETERSON. Thank you, Mr. Chairman. I appreciate all the witnesses' testimony.

Dr. Kizer, as you probably are aware, we are in the process of starting to look at an integration in Minnesota, including a hospital in my District of Minneapolis, which a lot of my folks view as the enemy, so you've got problems to start with with that whole deal. And I've been briefed by your folks out there, and the process has been kind winding up here a little bit.

But to be real blunt about it, you've got big problems out there because the entire veterans community, so far, is pretty much united against this idea. The veterans service officers are extremely concerned about it. I think almost everybody now has taken an official position against it. And I'm not sure that's the right reaction, but there's a lot of different things involved in this.

My concern is that if this process—I've been told by your people out there that as we work through this, that you're going to bring all of these people onboard before we move ahead with this, and I think, frankly, if we don't bring these people onboard it isn't going to work. So is that, in fact, how this process is going to work? Are we going to work through this and get everybody comfortable with it before we move ahead with it? Can I get that assurance from you as well as from your people out there?

Dr. KIZER. As you know, the decision has not been made. Indeed, even a recommendation from the network director has not been made. They are in the exploratory phase of determining whether this is something that programmatically, managerially, politically and otherwise makes sense and is feasible to do.

I was out there for a field hearing in Minneapolis a couple of months ago, and had the opportunity to discuss the issue with some people, and I know that there are significant feelings and emotions on the subject, not unlike a number of other places. And I think, as other witnesses would testify, that's generally the first reaction in all cases. What the process has to do is work through some of these issues, including involving the stakeholders in the process.

But they have to, first, view it as something that's going to be fair and open, and that integration is not a precursor to closure of one of the facilities, and then they have to gain some comfort that there really is an opportunity to expand services, and to address some of the problems and deficiencies that may exist with the current array of services. Notwithstanding the good job they may already be doing, they can do better, and that's something that the VISN Director and stakeholders have to work through. At the point where the positive benefits for the veterans of both communities can be demonstrated I think you actually can move forward in more of a planning mode. But at this point in your district VA staff are still out working with stakeholders and exploring the possibilities.

Mr. PETERSON. Well, I think I appreciate that. I think your folks have an idea where this is going, and they've relayed that to me.

One of my other concerns is that if this thing proceeds, as I understand they've envisioned it, at least at the administrative level, they would be opening up some kind of outpatient facility in St. Cloud and then the hospital would be in Minneapolis. That's all well and good, you know, and it may make some sense, but my concern, and I think the concerns of the people that live further out,

is how can we be assured that that is going to be maintained, and that someplace down the road that outpatient is going to be eliminated and we're going to end up being a nursing home and a psychiatric hospital, and then people have to travel to Minneapolis. That is a big problem because we have such a huge State.

So, say that this thing goes through, what assurance do we have that this is going to be the situation for the long-term, if that's something you can answer.

Dr. KIZER. Well, there are a couple of things. First, these are questions that have to be addressed during the process of developing the plans, and second, not knowing whether they are even going to recommend consolidation, I am somewhat in a compromised position as far as what I can say about the long-term plan.

Mr. PETERSON. Well, you've been through this with some other facilities and, when they are completed—I mean, what assurance do we have that that's going to then hold, or that you're not going to come in in another 5 years, because of budget pressure or whatever, and then decide that you've got to do some more. What assurance do we have that this is going to last for 20 years?

Dr. KIZER. Well, I think we have probably the same assurance that we are going to have an adequate budget, same assurance that you are going to give me that you're going to keep our funding at a level that we can provide all those services.

Mr. PETERSON. I don't know if they'll let me do it.

Dr. KIZER. Well, if you can speak for the Congress, and I can take that to the bank, then okay. I am not sure that I can do that. I mean, that's basically the dynamic that we have to deal with. We don't generate our own funds, even though we're trying to actually diversify our funding base.

Mr. PETERSON. I understand what you're saying, but that's also the concern of the people out there. I mean, we go through this, and then if the budget cuts come—politically, we can't sustain against Minneapolis. They've got four Representatives and we have one. That's part of the problem that we've got to deal with here. I know we've got some difficult issues to work through.

One other thing before my time runs out, in your testimony you talked about there being four facilities where there were problems, out of the 40. What were the problems? Were they problems like this——

Dr. KIZER. There are four facilities or two integrations that have been most visible, Lakeside and West Side in Chicago, and then the two in Mr. Everett's District in Alabama, Montgomery and Tuskegee, which we are currently in the process of working through. I guess I referenced those figures to indicate that if, overall, we are looking at 40 facilities, and four of them have been difficult or more difficult than others, the flip side of that is about 90 percent of them have gone pretty well. Overall the process, as Mr. Smith and Mr. Goff had discussed, has worked quite well. There are interests and issues that have to be worked through, but, by and large, the end result has been very positive. Back to the question you asked before, perhaps the assurances that your constituents need to hear are some of the lessons and some of the advantages that have accrued from places where the process has gone to

completion and they can actually see how services have been expanded and increased and how access and timeliness have been improved. I think that's part of the dialogue that needs to occur over time.

I think your comment also goes to another point that was raised by Mr. Gutierrez earlier about when you start saying things and putting a plan out, how that immediately engenders a response by the affected parties, and that is a very fine line to walk as to how much information, and when do you provide the information so as not to polarize people before you even have a chance to present your case.

Mr. PETERSON. Thank you. Thank you, Mr. Chairman.

Mr. STEARNS. Thank you. Mr. Everett.

Mr. EVERETT. Thank you, Mr. Chairman. Welcome, Doctor, you and your staff. Let me just comment briefly on something that's already been said, and that is that I'm not sure we can compare the mergers and integrations in the private sector to those of VA. As a substantive matter, I guess you could do that, but I would like to point out that it has been pointed out that the sensitivities involved are not necessarily the same, and I recognize that you recognize that also.

How would you define a successful integration outcome?

Dr. KIZER. I think a successful integration outcome would be defined as to whether those five generic goals are met. Have we actually increased accessibility to care? Can we show that the consistency and the predictability of the care is better than it was before? Have we improved the timeliness of care? Are we better utilizing by demonstrable data that the facilities have more productivity and they are achieving better results, and other things that are listed as far as those five generic criteria.

Mr. EVERETT. I know this is a little bit elementary, but I know you have devices for measuring that, and would you describe some of those measuring performance devices, or devices for measuring performance that you just described?

Dr. KIZER. Sure. The measures range the gamut, depending on what specific variable you are looking at. If you are looking at access, for example, you can look at the timeliness—i.e., how long do people have to wait to get a scheduled appointment. How long do they have to wait to see a caregiver when they arrive at a facility, and other sorts of timeliness issues which are all part of accessibility.

When you look at the quality of care, there are a whole host of things. For example, you can look at surgical outcomes and the expected-to-observed complication rates, whether they be post-operative bleeding, post-operative infection, et cetera, are better or worse than they were before. Again, you can go down a whole host of specific measures that look at the quality of care.

We also look at customer satisfaction. As you know, 2 years ago we put in place customer service standards and now we are routinely measuring and monitoring those things. We can track whether our patients, our users, are more satisfied with the care by how they rate the service that they receive. There are basic measures and monitors that are used in the industry, and what we've tried to do is make ours the same as in the private sector

so that you can actually do the comparisons to see whether the care that is received in the Veterans Health Care system is on par with what is received in the private sector, if not better.

For example, customer service standards. We use the Picker Institute's instrument that's used throughout the private sector; many of the other measures that we use are the same as are used elsewhere in the industry.

Mr. EVERETT. Dr. Cummings, would you have anything to add to that?

Dr. CUMMINGS. I think the other piece is, certainly from our VISN perspective specifically is, how do you handle the budget that you're living with because I think another measure is not just are you performing the services to the satisfaction of the veteran, but are you using your resources in a way that reach and access those individuals that you've not reached in the past.

We, through some of the earlier savings and some of the things that have been done with the integration, are going to be able to fund and open a clinic in Chicago Heights which will be run by the VA Chicago Health Care System. Without some of the savings such as avoidance of the angiography suites and the lab consolidation, it's very unlikely that we would be able to put these community-based outpatient clinics in the undeserved areas in Chicago.

So, I think you can measure where your resources are redirected to, to see if you are increasing the customers and reaching the different customers.

Dr. KIZER. In that regard—I forget whether Mr. Goff or others have shown—I know in Texas they were able to show where savings from administrative positions were redirected and could detail exactly how many new physicians, how many new RNs were added, direct caregivers as opposed to administrators, as a result of the savings that were achieved. These are another index along the lines of what Dr. Cummings was saying that how you can assess the success of the effort.

Mr. EVERETT. Mr. Chairman, that's all I have. Thank you.

Mr. STEARNS. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Dr. Kizer, anything I've learned on this topic I've learned in the last 18 hours, so it's new material for me.

Would you help me, please, what factor does geography play in all this? Do you have a certain distance where you say we don't even need to think about integrating these two facilities because they are more than 30 miles apart, 80 miles apart, or can you just give me a little background?

Dr. KIZER. It's not a hard and fast rule and, indeed, some of the easier ones have been further apart. At the one end of the spectrum you would have, say, a Denver and a Salt Lake, and there isn't really anything in between. It's obvious—or at least it's obvious to me—that it doesn't make sense to try to integrate those two facilities at this point in time, even though they are part of the same network.

In the case of Chicago, one of the more difficult integrations, the facilities are 6 miles apart. Some of the ones that have been easier have been 100 miles apart. So, exactly what is the range is not clear. We have set some targets that, say, generally, we would hope

people would not have to travel more than an hour's time to get to a care site. That, of course, is not met in most parts of the country, and historically was not even close, although we're making improvements in that regard. But our target is that people would be able to access a clinic within an hour of their home. In the case of Minnesota and some of the parts of the north central U.S. that are relatively sparsely populated, people travel many hours to get to VA health care right now, and we'd like to be able to establish community-based clinics or other presences in these communities so they our patients didn't have to travel those distances.

Dr. SNYDER. Tell me about the 100-mile-apart facilities. I assume you had two fairly typical free-standing VA Hospitals, clinics. What did integration mean for that? What is the efficiency? Did each hospital start specializing in certain areas so you didn't duplicate services? Tell me what happened in that?

Dr. KIZER. In some cases, what has happened, for example, in some of the facilities that were in the 50–100 mile range, they have had complementary missions. For example, one might have been a long-term care psychiatric facility with limited acute-care and the other was an acute care facility with limited extended care or psychiatric care. By merging them under common management, they will complement the services that they provide to each other. The net effect will be that by pooling the resources, they were able to expand the scope of services that were available to each of the service areas. Before integration they were focusing only on the resources that they individually provided and, as a result, had gaps in those services because they were primarily focused on doing one particular line of service and had a very small presence in the other.

Dr. SNYDER. So Hospital B may have become a little satellite to help Hospital A provide whatever specialty services they had in that geographic area, is that the way it went?

Dr. KIZER. I'm not sure I'd characterize it as a satellite, but they merged their resources. One that worked—I forget what the exact distance is, 30 or 40 miles as I recall—in New Jersey. For example, when they pooled their resources the facility that historically was not able to offer neurology and orthopedics and some other consultation clinics, could now provide those services to the population that previously did not have access to those services. By integrating services, veterans are now able to receive services in that community as opposed to having to travel some distance—maybe not a large distance but in New Jersey, where it's fairly congested, even though the miles may not be that great, the time can often be great because of traffic congestion and other things.

Dr. SNYDER. Thank you. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague. We thank the panel for testifying, and I think we're completed, and if we have any further questions, of course, as Mr. Gutierrez said, we'll send them to you. Appreciate it, have a nice day.

Mr. STEARNS. Our next panel is Stephen Backhus, Director, Veterans' Affairs and Military Health Care Issues, General Accounting Office accompanied by Paul Reynolds, Assistant Director, Health Care Delivery; Paula Widerlite, Senior Director for System Strategy, Adventist HealthCare; James Starr, Senior Associate,

McManis Associates; accompanied by Linda Wendt. And I welcome the members of the second panel, and we'll start off with Mr. Backhus.

STATEMENTS OF STEPHEN BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY PAUL REYNOLDS, ASSISTANT DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; PAULA WIDERLITE, SENIOR DIRECTOR FOR SYSTEM STRATEGY, ADVENTIST HEALTHCARE; AND JAMES E. STARR, SENIOR ASSOCIATE, MCMANIS ASSOCIATES, INC., ACCOMPANIED BY LINDA WENDT, PRINCIPAL ASSOCIATE MCMANIS ASSOCIATES, INC.

STATEMENT OF STEPHEN BACKHUS

Mr. BACKHUS. Thank you, Mr. Chairman, Mr. Everett, other members of the subcommittees. With me today is Paul Reynolds of GAO. He has been working on VA health issues for many years, and has seen many changes not only in health care but in the VA. He has led this particular assignment.

We are pleased to be here today to discuss our ongoing evaluation of VA's integration of medical facilities. As you requested, I will address the role of facility integrations in reshaping VA's health care delivery systems, and lessons learned from these integrations.

Our observations are based primarily on our work at four medical facilities being integrated in Alabama and Chicago. We have, however, discussed with VA officials their other integrations, and we've discussed integration issues with several private health care providers and consulting firms, including Paula and representatives from McManis.

Facility integrations are a critical piece of VA's overall strategy to enhance the efficiency and effectiveness of health services provided to veterans, and is similar to how the private sector is evolving. Integrations take several forms. It includes unifying management by creating a single team to manage all facilities instead of using separate management teams at each facility; consolidating the service by moving all employees and patients to one facility rather than continuing to provide the service at multiple locations; centralizing unit service by moving some but not all of the employees associated with it to one of the facilities; contracting out some services that VA employees have historically provided; and re-engineering service delivery by designing more efficient and effective ways to meet veterans' needs.

VA's integrations have generated over $83 million in savings. Veterans benefit from these actions when savings are used to open new clinics, offer new services at existing facilities, or extend operating hours.

There are, however, inherent difficulties in planning and implementing these integrations. The difficulties stem from the potential adverse impacts on multiple stakeholders such as employees, facil-

ity and medical school personnel, and local communities. For example, integrations will likely result in fewer and less convenient employment opportunities for VA and medical school employees, or training opportunities for medical school residents and students. Obviously, with so much at stake, it is imperative that VA carefully plan all aspects of these integrations.

VA's integration planning approach has many positive features. For example, local facility employees are involved in the planning activities. This appears to be very beneficial in that it expedites the process, includes those most familiar with the operations at each facility, provides stakeholder involvement in the outcomes. But our work indicates four areas where improvements in the process could be made that might yield even better results.

First, adopting a more comprehensive or strategic planning approach. Essentially, this means assessing the resources needed to meet the expected workload over several years in an entire geographic service area.

Second, completing planning on a facility-wide basis before implementing the changes, and being able to answer in detail questions such as how the services will be integrated, how potential changes will affect veterans and employees, why selected alternatives are the best ones available, how much the potential changes will cost to implement and save overall, how VA will reinvest the savings to the benefit of veterans.

Third, improving the timeliness and the effectiveness of communications with stakeholders at key decision points.

And, fourth, finding the best mix of planners, balancing those with vested interests with those of independent interests, that will produce the most appropriate decision.

Mr. Chairman, I know VA is considering ways to improve its planning process that should increase the availability of information at important decision points and result in even better integration decision.

Towards this end, we encourage VA to follow through with these improvements because the greatest benefits are yet to be realized. Every dollar saved by integrating can be reinvested to better meet veterans' medical needs or serve veterans who might otherwise not be served.

This concludes my prepared statement. I'll be glad to answer any questions you or Members of either subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 99.]

Mr. STEARNS. Thank you. Ms. Widerlite.

STATEMENT OF PAULA WIDERLITE

Ms. WIDERLITE. Good morning. I'm Paula Widerlite. I'm the Senior Director for System Strategy for Adventist HealthCare, and we are an integrated delivery network based here in Montgomery County. Our organization has annual revenues of about $400 million, with about 5,000 employees, and it makes us the second largest private employer in Montgomery County.

In 1993, the need to develop a vertically and horizontally integrated and coordinated system of care for the residents of Montgomery and Prince George's Counties in Maryland, was recognized by the leaders of our organization. At that time, there were several

governing boards responsible for the two acute care facilities, four nursing homes, a home health agency, and other affiliated health care services. Through a strategic planning process during 1993, it was agreed that those operating units would be integrated and operate under the governance of one board of directors, one president and CEO, and one management team.

Since that time, the level of integration among those operating units has primarily focused on integrating management support functions, such as finance, information systems, human resources, strategic planning and marketing. However, the objective was to produce a seamless continuum of care of which a major component would be clinical integration. The strategic plan that called for the integration of these operating units was implemented during the period of 1994 and 1995. At the end of 1995, the strategic planning process was initiated again with a planning horizon of another 24-month period. In just that short span of time new critical success factors and goals were identified and a changed course of direction was charted different than that which was set out in 1993.

The revised strategic plan that was approved by the board of directors in October of 1996 was revised 60 days later in December of 1996 because an important market condition had changed for us and an opportunity had presented itself to our President/CEO who went back to the Board of Directors and asked them to accept a modification to the plan that had just been approved 60 days prior.

Those sorts of actions, those sorts of market condition dynamics exist almost on a daily basis for the health care industry, particularly in this region. Maryland and the DC marketplace has one of the highest penetrations in the country for managed care, which is the single most important marketplace condition that drives an organization such as ours to develop strategic initiatives to enable it to continue to provide the level of service and standard of care that the community has come to expect.

Some of the lessons that we have learned through this journey over the past 4 years have been that there is no one prescriptive method for integration that a health care organization can adopt. We received lots of advice, did lots of research on our integration efforts back in 1993, and over several months quickly found that we needed a much more customized, flexible and responsive approach to restructuring our organization. We have some unique features, being based in the State of Maryland; namely, operating in a rate-regulated all-payor system. So, when we get advice from experts and consultants and read the literature about integration efforts across the country, it becomes painfully obvious to us that those methods may not be effective or ones that meet our objectives.

In some areas of the country, managed care may be the driving force, in other areas preserving access to high quality, cost-effective services; in others there may be a need to reduce excess capacity, to rationalize services and thereby avoid duplication. Some may even need access to capital to fund improvements. And perhaps others may be facing a combination of all of these factors. The most difficult steps of rationalizing scarce resources and refraining from duplication are seldom, if ever, accomplished in the private sector, and we are proud to have been among the few to achieve that goal.

Another lesson that we've learned is that the process of integration is just that, that it's a process. It should not be an objective in and of itself. It tends to proceed along evolutionary lines, first beginning with the integration of governance, then management support, then ultimately clinical and physician integration.

Those first areas of governance and management support functions tend to be, and this could be obvious to some, significantly less complex than the issues of clinical integration. The importance of the process of integration is the participation, input and commitment from all stakeholders in this process. Ultimately, our objective, which is consistent with our mission as a faith-based organization, is to enhance the patient's experience.

Also, it may appear to some that as hospitals, nursing homes and hoe health agencies owned and operated by a common organization—that is, the Seventh-Day Adventist Church—integrating should be a relatively simple process. However, on the contrary, coming together to meet the different demands was difficult for us, if not more difficult.

It was a relatively smooth transition to develop a common mission and vision for our organizations, however, some of our organizations had 100 years of experience of operating independently and, as free-standing institutions, developed independent cultures. The changes that would be required to blend these disparate cultures were challenging for us and, in some regards, continue to be a challenge.

We've seen some cycles of change concerning integration. First, there was buy-in from the operating units in support of centralization and integration. Subsequently, a wave of a different culture began to emerge where separate identities was valued over a system-wide approach. Communities, physicians, and patients tend to identify with hospitals and not systems of care.

We remain firmly committed to the notion that an integrated delivery system which enhances a patient's experience is ultimately the most effective care delivery model. To that end, we believe that the network that we've developed meets our needs given the current conditions. We also fully expect that the model will be modified from time to time as necessary, and we're thinking we might need to redefine what it means to be an integrated delivery network.

Our strategic planning horizons seemingly continue to be shortened from 5 years to 2 years, sometimes down to almost 6 months; however, we will continue the course of aspiring to develop a rational integrated system of care for our community. Thank you.

[The prepared statement of Ms. Widerlite, with attachment, appears on p. 107.]

Mr. STEARNS. Thank you, Ms. Widerlite. It's interesting that you say that, particularly in light of the GAO's comment on the time frame.

Mr. Starr.

STATEMENT OF JAMES E. STARR

Mr. STARR. Thank you. Mr. Chairman, members of the subcommittees, thank you for the opportunity to share my experiences and those of McManis Associates regarding the integration and

consolidation efforts of Veterans Affairs medical centers. We appreciate the chance to discuss this important topic with Members of Congress, VHA representatives, Veterans Service Organizations and other stakeholders.

McManis Associates is a management and research consulting company that specializes in the field of health care. We have assisted hundreds of health care institutions evaluate and implement mergers and affiliations across the country. This testimony is based on McManis' experience in working with the private sector and VA health care institutions.

This country's health care delivery system is undergoing rapid and dramatic changes in both the way it delivers and finances health care in the private and pubic sectors. Today's health care consumers and payers are demanding higher quality and better access for lower costs. In addition, other factors such as the aging population and federal budget constraints have magnified these challenges. Health care providers in both the private and public sectors are seeking innovative solutions to these problems.

Many of the veterans integrated service networks have explored and implemented integrations or consolidations of their medical centers. These mergers have achieved varying levels of success. McManis has found that there is no one standard approach to integrating medical centers in the VA. Several factors need to be considered—the population served by the medical centers, the proximity of the facilities to each other, the overlap of services, community resources, referral patterns, organizational cultures, and the viewpoints of concerned stakeholders. These considerations dictate how best to proceed in examining the potential integration of facilities.

While there is no one right way to conduct an integration, McManis Associates has developed a general process to ensure that these critical success factors are addressed. Our approach to the integration of VA medical centers includes three major phases: an assessment, creation of a VISN and high level plan, and service specific cost-benefit analyses with ongoing implementation.

The first phase involves conducting an assessment of the overall health care market and organizational performance of the medical centers. This includes determining the current and projected populations served by the medical centers and their corresponding workload, examining referral patterns between the facilities, identifying duplicate and complementary services of the medical centers, and assessing performance data such as cost and quality.

A critical component of this phase is the involvement of stakeholders such as veterans, employees, affiliates, congressional offices and other key constituents. The goal of the assessment is to determine if integration is feasible and, if so, to what extent. The compelling reasons for integration must be clarified and clearly communicated to all concerned stakeholders to gain their acceptance of the reasons for integration.

Once a decision has been made to integrate and at what level, a greater degree of detail needs to be outlined. This is the focus of the second phase of integration, creating a VISN for the integrated facilities.

This involves identifying the specific areas for further study, developing the leadership and governance structure for the integrated

facilities, and outlining a high level implementation plan that identifies the scope and timing of integration. Stakeholder buy-in at this stage is vital to moving to the next phase of integration.

The last phase of integration is the most difficult and requires the greatest level of effort and time. During this phase, specific work groups are established at the direction of the new leadership structure to examine the areas identified in phase two.

It is during this stage that specific cost-benefit analyses are conducted that examine the opportunities to improve service and quality, to improve access and reduce costs or redirect savings. As recommendations are made, the leadership structure should move ahead with implementation in a timely manner. This is a key success factor for several reasons: resistance to change increases with time, changes are occurring at such a rapid pace that opportunities may be issued, and we've found that success typically breeds success.

Through our experience, we've identified several critical lessons. (1) Communicate with and involve stakeholders and employees during all phases of integration. (2) Use an objective third party, either a VA employee that is outside of the network of the facilities being looked at or an outside consultant. (3) Demonstrate progress and results continuously. (4) Have an overall plan to guide specific efforts so that the leaders of the integrated facilities can see the systemic impact of decisions and recommendations being made regarding integration of specific services. And (5) don't expect significant results overnight. We're talking about major changes taking place for employees, for veterans, and for leaders, and it takes time for people to get used to new processes.

This concludes my prepared statement. Thank you for the opportunity.

[The prepared statement of Mr. Starr, with attachment, appears on p. 115.]

Mr. STEARNS. Thank you, Mr. Starr.

When I look at this, I'm trying to generalize, and let me ask Mr. Backhus, from what you've heard and seen, do you think the VA is on target here in the schedule of the integration? Based upon your recommendations, do you think they should be further along? I'd like you to be objective here and say do we have a problem in terms of the time frame, do we have a problem in terms of results.

Mr. BACKHUS. I think they've made substantial progress. There are obviously successes that have occurred. I think what we have seen is that there's an opportunity for greater success. What is unclear at this point is whether at this pace the process will achieve the results that VA ultimately needs, and that the veterans need; that is, to expand services to veterans within the confines of the budget situation.

Mr. STEARNS. If you had to say, which is more important, the detailed integration plan, the development thereof, or extensive interface with the stakeholders participating in formulating the plan, which would it be? And I'm going to ask this to the folks in the private sector, too.

Mr. BACKHUS. They go hand-in-hand. The way to engage the stakeholders and to get the buy-in of the stakeholders is to include them in the process. That means to develop and present to stake-

holders proposals that can be meaningfully discussed; where there can be a clear understanding of where the proposed integration is headed, and where a debate can occur, if necessary, over the sufficiency of that proposal. And based on that feedback, that input, revisions are made.

We aren't suggesting here that once a plan is developed it never changes. Clearly, that's not the case. What we're suggesting here is that there are key points along the way, key decision points where the stakeholders need to come together and weigh-in and have input to that process, and it gets progressively more detailed.

Mr. STEARNS. Ms. Widerlite, in your testimony, you characterized elimination of duplication as one of the most difficult steps in integration, and one that few ever accomplish. Would you elaborate on that observation?

Ms. WIDERLITE. Well, in the private sector I know there's a lot of integration and consolidation, and I think those two terms are very different. Sometimes we use them interchangeably, but usually what we hear about are hospitals coming together and forming horizontally integrated systems, or vertically integrated systems, and seldom are any services ever taken out, or beds closed or shut down. As a matter of fact, you might find just the opposite, where there is some duplication.

Mr. STEARNS. Mr. Starr, are you familiar with the GAO recommendations?

Mr. STARR. Yes, I am.

Mr. STEARNS. I'd like you to comment on their overall plan. Do you agree with the recommendations? Maybe you would like to elaborate where you disagree.

Mr. STARR. Okay. I think that I just want to restate, there are several approaches to conducting integrations of medical centers today, but our experience has shown that involvement of the stakeholders is probably one of the key critical success factors in integrating VA medical centers just based on the constituents involved, the level of political clout that they carry. And involving them from the very beginning we've found has been strongly linked to the success or failure in the future.

Our approach is to involve the stakeholders right from the beginning, from the very first phase, which is determining if even an integration is feasible. We think it's critical that the stakeholders have an understanding of what the compelling reasons are why this topic was even brought up, is being addressed, and that they be a part of some of those discussions, through interviews, through focus groups, and through other mechanisms to gain their input.

We also suggest that they become part of the process in terms of developing an overall VISN of what the integration should look like, and what areas should be focused on with more detail, and looking at certain things like surgical services and medical services between the facilities. So, I think that's probably where we differ from the GAO's approach in that respect.

Mr. STEARNS. Okay. I think we're going to adjourn the joint Subcommittee and reconvene after this vote, and thank you for your patience.

[Recess.]

Mr. STEARNS. The joint Subcommittees hearing will reconvene, and we'll now move to the Chairman of the Oversight Committee, Mr. Everett.

Mr. EVERETT. Thank you, Mr. Chairman. Welcome, everybody. Mr. Backhus, can you elaborate on what you mean when you say VA may be more successful if a comprehensive planning approach is used?

Mr. BACKHUS. Yes, I will. We are of the opinion that in order for the VA to maximize the benefits out of an integration, there is a need to look at all of the services provided in an entire geographic area—if it's Chicago, it's all the hospitals that serve the Chicago area, not just a couple of the facilities—and to be able to identify and project out into future years the resources that they think are necessary to serve that population as it's going to be several years down the road.

VA is a little unlike, I believe, the private sector in that they know who their beneficiary population is. It's predictable what it's going to be. The demographics of the population are well known and understood. They have an infrastructure in place that is going to be there for some time. There are a lot of factors that make longer-term planning possible here in VA.

I think that kind of a strategic view, and a more comprehensive planning approach will yield better results in the long-run because everything is being considered and everything is on the table. That is not to say that they can't get where they are with an incremental approach. I mean, it's possible that they will, but it's also possible, in our view, more unlikely that they will unless they consider all things in the beginning that's going to affect them years out.

Mr. EVERETT. I come from way back when we used to have courses called MBO, management by objectives, and I think it's a pretty good idea. You had literally a roadmap on where you wanted to go. And one of the things that has served me—and last year I was the Subcommittee Chairman on Pensions and Compensations—and when we took up the computer modernization plan and the year 2000 problem, is that VBA had no roadmap of that sort. They had a description of what they wanted to achieve, but they didn't have a roadmap. MBO, you put down how you want to get where you want to, but you have an action and interaction every step of the way on what may happen.

Do you see that kind of detailed planning by the VA in this integration process, notwithstanding the suggestion that one is impossible to come up with?

Mr. BACKHUS. Well, it seems to occur simultaneously I think with implementation, not necessarily in the detail we believe it should be in advance of implementation. And I can think of again our experience in Chicago and in Alabama, where some of the very key questions that I would view, and based on our discussions with several people in the private sector would view, need to be answered prior to implementing integration. Some of the key answered questions are what services specifically need to be integrated, how services will need to be integrated, what are the costs and the benefits of it, what are the specific impacts on employees and veterans.

The Chicago situation, to me, is this: Implementation is underway, however, it hasn't been determined yet how medicine, how surgery, how psychiatry, and how long-term care are going to be integrated. That's the bulk of the operation, and I would expect to see the details of how those are going to be integrated prior to beginning implementation.

The answer to your question is, no, the detailed planning isn't done, in my view, prior to implementing, but it's not to say it won't be done before it's all complete.

Mr. EVERETT. Well, I see my time is running out. The only problem and what worries me is not having that sort of planning done. And in looking at some of these cases, if we move ahead and we do X before it should be done, and then we find out that we've spent $1 million, or $2 million, or $7 million redoing buildings or whatever, and then we find out that X should not have been done, then it seems to me we have wasted a lot of dollars that could be better used for veterans health care. And that also doesn't touch on the fact that we may have perhaps hurt veterans health care in the process of doing that.

Thank you, Mr. Chairman.

Mr. STEARNS. Thank you. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Mr. Backhus, in your statement or your report on page 2, you say—talking about integration decisions being made incremental on a service-by-service basis instead of waiting until I guess you could do it at one time, I'm not sure I understand that.

It would seem to me that one advantage of doing it service-by-service, I assume you mean, for example, if somebody decided, hey, we could have a joint laundry facility between two facilities. What's the point of waiting around to try to work out the details of some elaborate health care part of it—I'm over-simplifying it, I think—but also doesn't it make some sense in terms of a gradual kind of change to have—if you're ready to move ahead on one section—not everything is a critical path, I guess is what I'm saying.

Mr. BACKHUS. Not everything is on the critical path, but most services do affect others. Making decisions and implementing recommendations on a specific services more than likely will limit alternatives that other services have.

Dr. SNYDER. By your analysis here, doesn't that mean that improvement in the VA health care system, as the years go by, will be one big change after another, that you'll have to wait until they were prepared to move ahead. Here's this big change for this decade, but we need to do other stuff on this service, but we can't do it service-by-service, and wait for the next big change?

Mr. BACKHUS. I think in most of these—at least the ones I'm most familiar with among the integrations—most of the planning among the different services that are being evaluated can be completed within maybe 6 months of each other. In other words, the critical path is essentially that difference.

In Chicago, I think I heard today and based on our visits out there, the rest of the planning is going to be finished soon. The recommendations are going to be made from the remainder of the services sometime in the September time frame, a couple of months from now. And while that requires some waiting—July, August and

September—it seems that that's not an unreasonable amount of time to be able to mesh all of these together and have the big picture and then proceed.

Dr. SNYDER. Ms. Widerlite, I was struck by what you talked about, that you see this as a process of integration, that somehow it has this big climactic end and then it's over, which seems to me to be a little bit in conflict with what Mr. Backhus was just talking about. Maybe that's being in the private sector that you always have to be prepared to adapt to change. Do you have any comments on that?

Ms. WIDERLITE. Absolutely. Some of the cyclic changes that I referred to in my statement is what we're seeing now that maybe integration isn't meeting the objectives that we thought it was going to meet. Some systems came together, or former systems, to gain market leverage in the marketplace, and to secure contracts with managed care payers, and I would bet that managed care was very happy with the disorganized, fragmented system, and really didn't see anything to be gained by integrated delivery networks. So, if that was the objective, maybe an integrated delivery network isn't functioning the way we thought it was going to be.

So, we continue to evaluate on a quarterly process, we don't change our overall vision, but on a quarterly basis we evaluate strategies that we set out, sure.

Mr. BACKHUS. May I jump in again?

Dr. SNYDER. Sure.

Mr. BACKHUS. I'm sorry, I didn't mean to suggest that once the Chicago or Alabama integration is complete, that that's the end of it.

Dr. SNYDER. Maybe that's the way I read that. It made it sound like you can't do anything until you're ready for the one, big, complete integration change, and then that's it. And then I'm not sure, in response to Ms. Widerlite's comments, where that leaves us. It seems like this ought to be an ongoing process adapting to change. And I was talking with Donna Shalala the other day, and she says one of the problems—we all talk about a 10-year Medicare plan—the problem with a 20-year Medicare plan is we don't know what American health care is going to look like in 20 years. And you all are part of the medical system—well, anyway. Thank you, Mr. Chairman.

Mr. STEARNS. Thank you, Dr. Snyder.

Mr. Everett, do you have a follow-up?

Mr. EVERETT. Thank you, Mr. Chairman.

McManis, in your statement on the second page, you talked about the three major phases of integration. The third is service-specific cost-benefit analysis with ongoing implementation. How should a cost-benefit analysis be done, and what should it consist of?

Mr. STARR. A cost-benefit analysis examines looking at basically what it's costing the medical centers to provide specific services—for example, surgical services—what are the costs of providing those services, what are the outcomes that are being achieved by those services at each of the medical centers, and then what would be the benefit, if any, of combining that particular service into either one medical center, closing surgical beds in one place and

maybe converting them to ambulatory care beds or what have you. What benefits would be derived from doing that in terms of would there be cost-savings that could be redirected to other areas? Would there be opportunities to improve the quality of care based on declining censuses and things of that factor that impact the quality of a particular medical service?

So it's really looking at specifically what are the resources required to provide particular service at a medical center, comparing the two, and then looking at what the benefit would be from combining that particular service, or integrating it in some fashion?

Mr. EVERETT. Thank you. That's all Mr. Chairman.

Mr. STEARNS. Thank you. Remind all Members and staff that they have the opportunity to submit questions. And we want to thank the members of the panel for taking their time and participation.

Mr. STEARNS. Now we will have panel number three, Dr. Jordan Cohen, President of the Association of American Medical Colleges, John Vitikacs, Assistant Director, National Legislative Commission, the American Legion. Welcome to you folks, and Dr. Cohen, I'll let you start.

STATEMENTS OF DR. JORDAN J. COHEN, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; JOHN VITIKACS, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

STATEMENT OF DR. JORDAN J. COHEN

Dr. COHEN. Thank you very much, Mr. Chairman, ladies and gentlemen, good morning, or good afternoon now, I'm sorry to say. I am Jordan J. Cohen, President of the Association of American Medical College, and obviously appreciate the opportunity to testify today about a very important issue, the integration of medical facilities within the Department of Veterans Affairs health care system.

Currently, as I'm sure you know, 139 VA medical facilities are affiliated with 103 of the 125 medical schools in this country. Affiliations, academic affiliations are symbiotic arrangements that benefit not only the VA, but its partner medical schools. While affiliations between the VA medical centers and medical schools greatly enhance the patient care environment at VA medical centers, they also enhance the education and research programs of medical schools. The fact that education requires access to a diverse mix of patients who come to an academic medical center with the expectation that they will receive the highest quality, comprehensive and compassionate medical care; AAMC embraces the VA's primary purpose of providing quality health care to eligible veterans. We embrace it both because it's good for veterans and because it's good for students.

One of the main reasons for the success of the VA's unique programs for patients with special needs is the infrastructure provided by comprehensive VA medical centers. This common support system is a necessary foundation upon which the VA builds expertise in such specialized areas as cardiac care, long-term care, substance abuse treatment.

The new organizational structure of the VA can best achieve its full promise, in our view, by building on the foundation established by the joint medical school-VA partnership. A partnership, as you know, that's been strengthened by more than 50 years of close collaboration.

The VA intersects our nation's entire health care system at two crucial points, both of which deeply involve the VA's academic affiliations. First, the VA plays a critical role in the education and training of health care professionals who are destined to serve the entire nation, not just the VA system.

Second, the VA contributes in a major way to advances in medicine through a research program that has an impressive history of success and innovation.

The future of the VA as a comprehensive, high quality health care system currently faces serious challenges quite similar, as we've heard this morning, to the ones that medical schools and teaching hospitals are encountering as well as the entire system.

The continued success and vibrancy of both VA medicine and academic medicine in the evolving health care delivery environment depends greatly upon our responses to these challenges over the next few years.

In response to the imperatives for change, both academic medicine and the VA are moving away from the traditional hospital-based model of health care delivery to one that emphasizes the delivery of care in ambulatory and out-of-hospital sites. Moreover, academic and VA medical centers are establishing new partnerships with other health care providers to increase efficiency, to rationalize resource distribution, and to manage effectively in the emerging health care marketplace.

Among the many attractive features of the new VISN structure is its emphasis on performance-based evaluation. VISN directors and other key leaders in the new system are informed prospectively about the goals they are expected to achieve and are systematically evaluated at an appropriate time to assess whether or not those goals were achieved.

Academic medical centers, I have to confess, have a great deal to learn from this forward-looking management technique. Affiliated medical schools are quickly adapting to the new VISN structure and are exploring new collaborative arrangements with all of the VA facilities and sometimes with other medical schools within their respective VISN. The AAMC is eager to continue to work with VA officials in Washington on national policies that affect the health of veterans and that foster the affiliations between the VA and medical schools. The Association recognizes, however, that decisions regarding the local administration of VA resources are best made locally. Although the task of altering long-standing relationships and forging new collaborations is never an easy one, maintaining a sharp focus on the primary purpose of academic affiliations—to provide health care of unsurpassable quality for our deserving veterans—remains our best guide to continued success.

I firmly believe the VA's academic partners can play a vital role in securing a strong future for the VA health system. In capitalizing on this potential, I would mention three facts that are especially worth noting: (1) the rapidity and the magnitude of the

changes required to implement the VISN structure successfully, (2) the number of new individuals recently recruited to the leadership positions from outside the VA, and (3) the VA's traditional and reconfirmed commitment to maintaining robust education and research programs.

Given this collection of facts, it seems clear that some special care must be taken to ensure that the inevitable stresses on the long-standing and successful partnership with its medical school affiliates do not hamper achievement of the VA's missions.

To minimize this possibility, let me conclude by emphasizing two suggestions we'd like to make: (1) Incorporate within each VISN director's annual performance contract specific goals that foster the education and research missions of the VISN, and (2) in keeping with much of what you've already heard this morning, we think we need to establish an explicit and workable mechanism for ensuring routine consultation with the VISN leadership and the academic leadership—that is, the medical school dean and the university hospital CEO, for example—of the medical school affiliates.

And the reason for doing that, at a minimum is, first of all, to guarantee timely communication by all parties of information relevant to the strategic and program planning of the VISN and the various affiliates, (2) to ensure optimal deployment of education and research resources, (3) to assess the impact on academic programs of consolidation and restructuring of the VISN's clinical services, and finally, to identify opportunities for cost-effective strengthening of the VISN's clinical services by contractual relationships with one or more of the academic affiliates.

I appreciate the opportunity to appear this morning and will be happy to answer any questions.

[The prepared statement of Dr. Cohen appears on p. 122.]

Mr. STEARNS. Thank you. John Vitikacs.

STATEMENT OF JOHN VITIKACS

Mr. VITIKACS. Good afternoon, Mr. Chairman and members of the subcommittees and staff. First of all, Mr. Chairman, thank you for holding today's important hearing on this subject.

The American Legion supports the effort to streamline and consolidate the health care services of the Veterans Health Administration when it is in the best interest of veterans. Without a doubt, the present series of VHA mergers and integrations raise issues and concerns that demand accurate answers.

The American Legion does not oppose VHA's advocacy for streamlining its health care operations and becoming more responsive to veterans and to the American taxpayer. We do, however, have serious concerns about the rapidity with which the present merger and integration process is proceeding.

The burden of proof, Mr. Chairman, is on the VA to demonstrate the efficiency and potential enhancement of health care services to veterans through the merger/integration process.

Some of the proposed mergers and integrations present less concern than others. There is no one model to be applied throughout VHA. Each proposed integration must be tailored to its own uniqueness.

The American Legion believes that lean medical care budgets require VHA to move precipitously ahead of a preferred merger/integration schedule. And on that note, I would like to say that we heard this morning that VA has saved approximately $85 million through the integration process to date and, of that amount, it's a relatively small percentage of that amount that has been reinvested back into the system. The majority of those savings have simply evaporated due to inflationary and other monetary shortages.

The merger/integration process, Mr. Chairman, assumes a spirit of cooperation among facilities that have never historically existed. The infrastructure of many medical centers does not support a rapid merger/integration time frame. In many instances, critical information management systems are incompatible, and videoconferencing and telemedicine capabilities do not meet necessary standards.

Mr. Chairman, how can medical centers plan and achieve a successful integration when they only have a short period to accomplish the task? Many medical centers are struggling to complete a targeted integration by the end of fiscal year 1997.

When VA's 20–30–10 plan has a 5-year target, why attempt to accomplish the majority of budget savings in the first fiscal year? No wonder there is so much doubt, frustration and confusion among VA employees, veterans, and other significant stakeholders.

Mr. Chairman, the merger/integration process requires detailed planning. Managers should be able to articulate the process in a comprehensive manner to all affected stakeholders.

Today, the decision to merge facility programs and operations is made prior to the development of an integral blueprint on whether the goals of the integration are realistic.

How this process will specifically improve conditions for veterans remains mostly unanswered. VHA says it will eliminate needless duplication in clinical services and management, improve the quality of care, reduce costs, and ensure that the VA health care system is overall more efficient.

As veterans advocates, the American Legion thinks these goals are ambitious, ambiguous, and hasty. The American Legion recommends that VISN directors more closely involve the management assistant councils in the merger/integration process—also known as the "MACc".

The Management Assistant Council representatives include veterans service organizations, the area congressional delegation, VA employee unions, and university affiliates. The representation of qualified stakeholder groups is critical to the success of planned VHA mergers and integrations.

As long as VHA can demonstrate that the quality of care and access to care are improved as a result of a facility integration and not just focus on cost savings, the stakeholder groups will be better informed and more open to the process.

I would like to lastly close and mention that we are pleased to see that Dr. Kizer is going to take action, as he states in his testimony today, on updating and reissuing specific five-phase guidance to the field. And I think that looking at his approach here in his testimony and what the other witnesses have said today, in par-

ticular GAO and the McManis group and the VA Employees Union, that there is a lot of good ideas in all of these statements that really need to be integrated into one comprehensive blueprint. Thank you.

[The prepared statement of Mr. Vitikacs appears on p. 126.]

Mr. STEARNS. Thank you. Dr. Cohen, of the approximately 17 integrations that have progressed substantially or have been implemented so far, have academic affiliations in general suffered or benefited as a result thereof?

Dr. COHEN. I don't know if I can give you a judgement about that, Mr. Chairman. I think there's been a lot of still-in-process activities, so some of the impacts are not really well known as yet. I think, in general, there is a lot of optimism among the academic affiliates that, with proper consultation, with proper involvement in the ongoing process, that there will be a net benefit. Certainly, there is enormous opportunity. I think everybody appreciates that in the midst of all this change and all this reformation, that there is not only a great deal of concern and anxiety, but the recognition that there is real opportunity for improving the quality of the services, the access to services, and the ability to continue to recognize the importance of the academic missions, the education and research missions in all this, really does open up some real opportunities.

Just to give you one example, one of the real struggles that almost every medical school in the country is currently engaged in is finding enough ambulatory sites for its education. Most of the education has been riveted in major tertiary hospitals. And there's a recognition, has been for a long time, that a lot of medicine now is occurring in an ambulatory setting, and developing the proper kinds of educational programs in that new and much more complicated and fragmented environment is a real challenge.

The VA's commitment to try to get into a more ambulatory mode and to involve its services in more accessible ways to its beneficiaries is an opportunity for the medical school affiliates to also involve those kinds of movements in an educational domain. So, that's one example.

I think, as I say, there's a good deal of optimism, a lot of opportunity, and I think it's too early really to answer your question effectively.

Mr. STEARNS. Mr. Vitikacs, you mentioned the word "hasty" in your opening statement. Did the American Legion recommend in any instance that a specific proposed integration not go forward? If so, what were the circumstances?

Mr. VITIKACS. To date, we have not made any specific recommendation on moving forward. We have urged caution. The decisions on the list for already approved VA facilities for integration does not include several that are currently in discussion stages, and that's the Brockton and West Rocksbury facilities and the Minneapolis and St. Paul facilities.

We basically respond to our stakeholders, the veterans that we represent in these various departments and areas. They have concerns that these integrations are moving forward at too great a speed, and I am only echoing today what we are hearing from our constituents.

Mr. STEARNS. Well, your constituents are my constituents, and so what you echo is something that I want to fully understand and help you because I think, obviously, the American Legion is very important to Members of Congress.

That's all the questions I have. Mr. Everett.

Mr. EVERETT. Thank you, Mr. Chairman.

Mr. Vitikacs, in your testimony highlights the successful mergers and integrations should include detailed planning and careful implementation. I've seen some of that planning and implementation, and I am not satisfied with it.

Would you characterize VA's integration efforts that way, that they've done detailed planning?

Mr. VITIKACS. Just the opposite. I think that there are some integrations that have already occurred that have been done in a detailed way. There are some that I can't make the same claim.

I think the integrations that have already occurred—and let me give you some examples—San Antonio in Kerrville, Texas, and Temple, Waco, and Marlin, Texas occurred over a longer period of time. They had more detailed analysis completed before they went forward with the implementation phase. So, those, in our judgment, were based on a sound model. And from what I'm aware, thus far in the State of Alabama is that Phase I might be designed and implemented before they really understand what Phase II will be and how Phase I will affect Phase II or Phase II will affect Phase III. I think those are unsound practices. And from our point of view, we—we heard today that there are certain guiding principles for these mergers and integrations in a VHA document, but how well these principles are being applied and followed through varies from VISN-to-VISN, and I think that's the area that really needs to be focused on, is—I hate to use the word "micromanagement"—but I think there needs to be an oversight mechanism to ensure that these integrations are being accomplished in a sound manner.

Mr. EVERETT. I certainly can identify with those remarks. When I suggested that we slow down the process, the response was, you caused us to do that and you're going to cause us to lose money that could be directed toward veterans health care.

If you've had that same response, how did you respond back to the VA?

Mr. VITIKACS. I think that the services that the VA is able to provide to the veterans has to take paramount importance here. We see too many veterans falling out of the system when these mergers are progressing too rapidly. Through our National Field Service and our visits to hospitals in the field, in particular we see mental health services really dropping, the number of patient visits. A good majority of the substance programs and PTSD programs and mental health programs are being integrated, being eliminated, moved from one State to another within a VISN. I don't think that's in the best interest of veterans. And specifically your question about the rapidity with which they need to conserve resources, the VA is in a shortage situation as it is. Its budget isn't adequate as it is and, as I said, these $85 million of savings, only a small percentage of that has been reinvested back into the system. So, they are losing money anyway, but I think what we have to do is

protect the level of services and programs that are available for veterans. That has to be a paramount concern.

Mr. EVERETT. I think you for your testimony. I think we all recognize that there's got to be some changes within the VA. I think it's prudent that we do that in a methodical planned way. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my co-chair for his participation, and I thank the panel. We've completed what I think is a very necessary and educational hearing this morning. I want to thank the staff on both sides of the aisle for their support and participation. The subcommittees are adjourned.

[Whereupon, at 12:35 p.m., the subcommittees were adjourned.]

APPENDIX

Opening Statement
Representative Cliff Stearns
Chairman, Subcommittee on Health

Good morning. On behalf of my colleague and friend, Terry Everett, Chairman of the Oversight and Investigations Subcommittee, I welcome all to this important joint hearing.

All of us involved with health care policy are acutely aware of the dynamic nature of the health care marketplace. In the private sector, market forces have been powerful levers for change. And in the face of market challenges, hospitals have increasingly turned to mergers and alliances.

The VA has been slower to transform itself. Long after the private sector had embraced primary care as a core business, VA remained entrenched as a hospital-based system. Until 1995, VA had not consolidated a facility in some fifteen years. Since then, however, VA has initiated 19 consolidations involving 40 VA medical facilities. With such steps as approving VA's proposed reorganization and adopting a sweeping eligibility reform measure in the 104th Congress, this Committee has given Dr. Kizer

critically needed tools to transform the VA health care system.

In my view, VA should continue to consolidate facilities where that process will improve patient care and achieve greater efficiency. Several witnesses this morning cite the complexity and difficulty of integrating two or more hospitals, even when they have the same corporate identity. The private sector has certainly seen such efforts fail altogether. The process through which VA integrates facilities is vital, however. In holding this hearing, we want to review the record of VA's past efforts, and the promise of the future. We seek to understand better the process by which VA facility integration is initiated, analyzed, planned, and carried out. And most importantly, we seek to explore whether there are opportunities for significantly improving these efforts.

We are fortunate this morning to have an outstanding group of witnesses who bring wide-ranging expertise to the table. Several of our panelists, representing both private sector and public, have participated in the development of integrated health care systems as consultants, strategic planners, system architects and administrators. We will also have the benefit of hearing from important stakeholders. I thank our witnesses in advance for their testimony, and look forward to an insightful discussion.

I particularly thank my friend Terry Everett for co-chairing this joint hearing, and invite his opening statement.

STATEMENT BY THE HON. JAMES E. CLYBURN
RANKING DEMOCRAT
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JOINT HEARING WITH THE SUBCOMMITTEE ON HEALTH
REGARDING INTEGRATION OF
VA MEDICAL FACILITY AND SERVICES

JULY 24, 1997

Chairman Stearns and Chairman Everett, I commend both of you along with Ranking Democrat Gutierrez for calling for this important hearing. I will try to keep my remarks brief since we have a number of witnesses before us today.

In my view, this morning's hearing will help provide some much-needed background into how the VA plans for the consolidation and integration of hospitals and medical services. Although some people in this room may not want to believe it, the changing nature of the health care industry may

soon dictate some form of integration or consolidation is necessary to ensure that we are serving the needs of our veterans in the best and most efficient ways.

The broader concern -- and a concern that the GAO has made quite clear in the written testimony it provided to our subcommittees in advance of this hearing – is that the VA needs to have a well developed plan in place before any of these consolidations or integrations take place. VA should be careful not to undertake such activities unless it has crafted a clear and comprehensive plan, and unless the health care benefits to our veterans are clear.

I look forward to this morning's testimony. Thank you.

OPENING STATEMENT OF LANE EVANS

SUBCOMMITTEES ON HEALTH AND OVERSIGHT AND

INVESTIGATIONS OF

THE COMMITTEE ON VETERANS AFFAIRS

HEARING ON VA INTEGRATIONS

Good morning, Mr. Chairman. I want to thank you for holding this timely hearing today. As a member of the Illinois delegation, I am obviously concerned about the changes occurring in the Chicago area as a result of the integration at West Side and Lakeside. As the ranking Democratic member of this Committee, I have more general concerns about how we can avoid some of the miscues and disconnects which resulted in confusion over the integration activities in Chicago and Central Alabama. This is particularly important as we see integrations proliferating around the system.

The witnesses have been asked to discuss the *process* by which VA undertakes its consolidations. It is my hope that we can take away from this hearing some "lessons learned" from the consolidations that have occurred thus far and establish some better foundation for those consolidations either underway or being considered for the future. I want to better understand the VHA Headquarters role in orchestrating change in the field. If the Headquarters role really is to steer rather than row, where are policies and guidance provided by the Veterans Health Adminstration's policymakers taking the system?

There are clearly some benefits to be gained by integrating some VHA activities and facilities, and in our current funding environment, I believe we cannot overlook these opportunities for achieving cost savings while maintaining, if not improving services to veterans. Some facilities have saved millions of dollars and retrenched this funding into increasing access to primary care and other care veterans need. This result obviously accrues to both veterans and taxpayers. Where the goals and advantages to integrating services are less apparent, conflict seems, inevitably, to follow. I believe this is the case in Chicago where specific goals and benefits to various stakeholders have not been explicitly identified and the perceived losses to all parties are great.

Congress has now had the opportunity to review several strategic plans from the "new" Veterans Health Administration. Most of the networks, in turn, have strategic plans that respond to achieving system-wide goals at the local level. I think I speak for most of the members on the Committee when I state that we generally believe the system is moving in the right direction. I think it is equally fair to say that neither the strategic plans for the system, nor those for the networks, give clear direction on how integrations are to occur or what they are to achieve.

Nowhere is the role of veterans and other interested parties more important than in undertaking facility consolidations and integrations. Networks have responded to the need for stakeholder involvement in different ways with varying degrees of success. Some VA managers have found out the hard

way that any efforts to downsize will be met with resistance from interested parties who do not feel their concerns are being given a fair hearing. To avoid this problem, I believe VA managers must offer basic guidance in the goals, directions, and reasons for change, then assure that veterans and other "stakeholders" enter the process. The involvement of veterans, academic affiliates, employee unions and other partners is critical in planning and managing these changes. VHA managers must provide leadership, be able to articulate tangible benefits to all parties before implementation begins and be held accountable for the results of their plans.

These are some of my initial observations. I am eager to learn from our witnesses to see if they share these views. I hope that they can shed some light on how to undertake this difficult process and avoid some of the problems we have observed to date.

Thank you, Mr. Chairman. This concludes my statement.

Statement by Rep. Luis V. Gutierrez
Subcommittees on Health and Oversight and Investigations
Committee on Veterans Affairs
July 24, 1997

Thank you Chairman Stearns, Chairman Everett and Ranking Member Clyburn for convening this very timely hearing to discuss one of the most important issues confronting the Department of Veterans Affairs health care system.

Facility integration and consolidation will affect veterans throughout America. Currently, it is affecting veterans in my community.

This process, these reforms and transformations will greatly affect the manner in which veterans receive their care, where veterans access this care and how these medical services that millions of veterans depend on are provided.

In this era of fiscal constraint the VA has been compelled to develop a more efficient and cost-effective health care structure while maintaining an adequate level of services.

This is no easy task and has been accomplished with varying levels of success. The era of restructuring will most likely continue for the better part of the next decade in many regions of our nation.

A de-centralized VA system based around twenty-two service networks has been charged with implementing these visions of change.

As we know, the experiences of these regional systems has varied and we are only now beginning to learn from these episodes.

I have learned first-hand about this process and what it means for our veterans.

In my hometown of Chicago, the integration of one of our nation's largest veterans health care networks is presently underway.

The Chicago experience may offer some lessons for other regions and teach us all about how we can make the integration process work better in the future, in Chicago and elsewhere.

Unfortunately, I do not believe at this time however that Chicago provides a model for others to duplicate.

I have followed this issue closely and have yet to see a strategy for assuring that Chicago-area veterans will continue to receive the services, benefits and care they have earned and deserve. We still don't know what the Chicago VA will look like in two years, in five years, or further into the future.

Rumors and speculation have been widespread. But a clear plan and sensible vision for the future have been absent.

When I first became involved in this process I was concerned that the VA was moving unilaterally to implement an unjustified consolidation of the Lakeside and Westside hospitals.

My main concern was that few answers had been provided to the veterans' community about the needs and potential effects of this dramatic reform.

The VA simply has not been able to answer simple questions about this proposed consolidation.

The VA has not been able to financially justify why consolidating the medical/surgery unit at either the Lakeside or Westside hospitals was the most feasible and cost-effective option to end duplication and save precious resources.

The VA has not justified why an incorporation of this nature was warranted to enhance services to veterans?

The affects on adjacent communities, affilitated medical schools and VA employees remain similarly undetermined.

What I want to see is a sensible, inclusive, forward-looking process that answers these vital questions before consolidation occurs.

A process that establishes goals and feasible options to achieve them.

A process that systematically responds to the concerns of veterans, stakeholders, community leaders and elected officials.

To date, I do not believe that a comprehensive process has been developed.

The VA has made some progress on achieving these goals.

Stakeholders and the veterans community in Chicago have been afforded an increasing ability to voice their concerns and ensure that their needs are considered as integration proceeds.

However, I feel that fundamentally the process in Chicago remains flawed.

I still have not seen a vision of the future of veterans' service and care in Chicago. I have yet to see a clear plan of how service and access to veterans in my community will be improved and expanded. This is the only goal that matters.

I realize that this is a difficult process.

But our veterans deserve a vision, a blueprint that guides our actions.

A vision of a better VA, where our veterans are the first and foremost constituency and their interests determine the bottom line.

This hearing is important not only for how it affects Chicago or any single service network.

This is also about the health care our veterans have earned and deserve in VA facilities in Florida or Boston or Los Angeles or anywhere the process of change has begun.

We owe our veterans answers to their questions.

I am hopeful that today's hearing will help us achieve this goal.

Mr. Chairman, I thank you again for calling this timely hearing to address this important matter.

I look forward to the testimony of our witnesses and thank them all for joining us this morning.

Statement of Reprentative Helen Chenoweth

7/24/97

Opening Statement for Hearing on VA Health Facility Consolidation

As I've watched the process of health system consolidation proceed in the private sector, I have observed developments that are both positive and disturbing. On the one hand, we see new efficiencies, greater access, and lower costs. On the other hand, we all too often see quality suffer, access restricted, or at the very least, inconveniences imposed on patients. It is because of the potential *and* the drawbacks that can result from facility integration that today's inquiry is so important. And I would like to thank each of the witnesses for participating.

We cannot gamble where veterans health is concerned. I look forward to applying what we learn here today to plan the best possible strategies for facility integration, so that we can maximize the efficiency benefits without sacrificing quality or access.

Statement of Congressman Danny K. Davis
Before the House Committee on Veteran's Affairs'
Subcommittee on Health Care
July 24, 1997

Chicago's Veterans Integrated Service Network

I want to thank Dr. Cummings for her appearance her today. The 7th Congressional District, which I have the honor to represent, is home to three of our nation's VA hospitals and has a special responsibility in the care of our nation's veterans.

I believe that it was Voltaire who said that "God is in the details." There is nothing so revealing in politics or government than the moment when general policy must be converted into specific action. That's when the high sounding rhetoric goes out the window, or becomes a pathetic apology or an attempt to cover up.

These moments become or should become markers, measurements of our real intent and commitment to meeting the needs of the people we serve. We have such a moment here and now in the 7th Congressional District. It will become a test case for the entire nation, a measure of our commitment to honoring the promises we made to our veterans; an indisputable signal of our priorities for public spending; an example of how government and the private sector can work together for the public good or how a lack of understanding, inability to be flexible and unwillingness to cooperate cans conspire to twist public policy thereby causing activities and services to become more costly, or at worst unavailable.

As a part of a commendable effort to improve the efficiency of the Veterans Administration's ability to deliver health care, VISN 12 has been charged with helping to lead the way nationally in an "integration" to create the most efficient and manageable service possible while expanding service to veterans, including quality and timeliness of care, accessibility of care - of particular importance for Chicago's large homeless veteran population - , and patient satisfaction. Goals were also set for concern for employees and concern for other stakeholders. A stakeholders Advisory Group was established to provide input and feedback to help ensure the achievements of these goals.

It was estimated by the Secretary of Veterans Affairs, the Honorable Jesse Brown, that VISN 12 needed to reduce annual expenditures by $57 million over fiscal years 1997 - 1999 in order to bring expenditures into better alignment with VA costs elsewhere. The Secretary pledged that in the process of reducing costs that VISN 12 would improve the quality of care, increase the number of veterans served by 20% - nearly 28,000- by the year 2002. The Secretary outlined a plan for integration addressing all of the specific Congressional mandates and indicating that both the Lakeside and Westside facilities are essential and that there was no plan or intent to close either campus.

Certainly there was no end of stories of inefficiency and waste in the VA system. Stories of vets who had been admitted to the hospital in order to be issued crutches due to outdated standards of practice. Stories of running two laboratories conducting the same test, both of them operating with less than optimum loads. Stories of waste and inefficiency in purchasing and food service and data processing. VISN 12 has made significant strides in integration and in achieving cost savings, cost avoidance, improved management and a higher standard of care. Certainly more work remains to be done.

But the overall picture is a positive one. The VA Chicago Health Care System with over 40,000 veterans served is the largest health care provider in VISN 12 and delivers services in a highly cost effective manner. Over a three year period the number of veterans served exceeded 70,000 with 15,000 inpatients admissions and 500,000 outpatient visits annually.

VISN studies and working groups concluded that VA Chicago benefitted from, and needed to insure the continued existence of both its campuses: Lakeside and Westside. VA Chicago is unique among integrated VHA health care systems with two major academic affiliates: McGaw Medical Center of Northwestern University with Lakeside and the University of Illinois at Chicago with West Side.

Mr. Joseph L. Moore, Director of VA Chicago Health System wrote: "my promise is this: we at VA Chicago will continue to meet the challenge and stay the course. Neither of our facilities will close. We ask only that you keep the faith as we set our sights high and aspire to serve, as never before, you who yourselves have served."

Yet somehow the specter of closure continues to haunt VA Chicago, and particularly the Westside facility, fanned by ax wielding budget cutters, short-

sighted planner/managers and a host of other modern day activities. These proposals are a deep and fundamental disservice to our veteran community, the medical community and all other people of the region. The mechanisms to close one of the facilities only serve to diminish the ability of the University of Illinois and Northwestern University to serve the health needs of veterans and to train physicians and other health professionals. Both these institutions are outstanding and highly rated. In fact, the University of Illinois is responsible for the graduation of more African-American medical doctors than any other institution.

The proposals for closure of facilities are made with the simplistic logic which has become so fashionable today. There is no consideration of human cost cutting. There is no consideration of societal costs of closing. There is no consideration of the effective use and preservation of resources. There is no consideration of the long term costs and impacts. There is no consideration of the disproportionate costs which may be borne by one or another segment of the population which is more often than not the minority community. Short term, superficial gain is offered as the rationale. Did Aesop teach us nothing with his fable of the goose who laid the golden egg ?

How often is the public to evaluate these debates ? How can those who have not had a chance to read the working group reports on VA integration make sense of all this ? Let me suggest some rules for the general public in evaluating the arguments in this debate.

- If or when an elected official tells you that we cannot afford to fulfill our promises to those who served their country and that we must close hospitals in order to provide quality health care then it is time to offer that elected official a reality check.

- If or when an official in the veterans administration tells you that we have to cut back on services to vets in order to save the system then it is time for that individual to go back for basic re-indoctrination on the mission of the VA.

- If or when the infighting for control of resources reaches the point where the needs of our vets are endangered then its time to expose those intrigues for the real dangers that they are and to exclude those who seek bureaucratic control from decision-making roles.

Now is the time to get our priorities straight. Yes, we are for efficiency- we are

stewards of our precious, hard earned tax dollars, especially as more and more of those dollars come from our constituents who can least afford them. Yes, we must look at new ways of doing things- it is part of our responsibility to constantly seek new, innovative, better ways of addressing the needs of our people.

But the constant hysteria which denigrates all public programs, which blindly calls for cutting, closing and terminating for the sake of arguments which comfortably fit into sound bites is dangerous, and now it is endangering the health and well being of our vets. Complex problems cannot be addressed by simplistic solutions.

There ought to be a way to reorganize health care for our veterans without diminishing the quality, timeliness, humaneness or accessibility of that care. There ought to be a way to reorganize health care for our veterans which preserves treasures such as our twin affiliations to our outstanding medical teaching institutions. There ought to be a way for our VA health services to play their rightful role in advancing the state of medical knowledge. There ought to be a way we can include the interests of all of our dedicated employees, many of whom have devoted their entire careers to the service of our veterans.

There is such a way. It has been outlined by Secretary Brown and Director Moore in writings and in discussions with myself and other members of the Illinois delegation. It is a plan which seeks out and uses every available resource, including both Westside and Lakeside to fulfill the mission of VA Chicago. The veterans of the Chicago area, and certainly of the 7th Congressional District will accept nothing less.

America has no "surplus" people; every veteran, every employee, every health care provider and student is precious and invaluable. We urge VISN 12 to continue to reaffirm their commitments to the stakeholders, to continue their reorganization and continue their commitment to an open process.

STATEMENT OF
KENNETH W. KIZER, M.D. , M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
ON VA'S TREATMENT FACILITY INTEGRATION STRATEGY
BEFORE
THE
SUBCOMMITTEE ON HEALTH AND SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

JULY 24, 1997
**

I am pleased to be here today to discuss with the Subcommittees one particular strategy that VHA is utilizing to better serve its patients. This is our treatment facility integrations strategy.

In these opening comments I would like to briefly do two things. First, I would like to provide some context for these integration efforts and for some of the more facility specific comments that will be made by other witnesses on this panel. Second, I would like to quickly overview the generic process being utilized to implement this strategy.

As you know, revolutionary forces are buffeting the entire American healthcare system. These forces are causing profound changes in private sector healthcare, as well as in government programs, and they necessitate the creation of new types of delivery organizations. The delivery model being pursued most widely, for a number of reasons, is the integrated service network (ISN) – also known as an integrated delivery system (IDS) – in which organizational entities like hospitals and clinics, partner with physicians and other caregivers, as well as healthcare support functions, in creative ways to pool their resources and align them to better serve patient needs. These ISNs are taking many forms and are developing in different ways in response to the myriad antecedent conditions and specific circumstances driving their creation.

In the veterans healthcare system, hospital and other facility integrations, as well as clinical and support service integrations, are part of the larger network integration strategy aimed at providing more accessible, reliable and consistently high quality care for as many patients as possible with the resources available.

More specifically, the five generic purposes of this strategy that apply to the 40 facilities that have, so far, been approved for integration are:

1. To increase access to care;
2. To increase the predictability and consistency of high quality care being provided;
3. To optimize the utilization of physical plant and capital assets, personnel and other resources (i.e., to better capitalize on the strengths of each facility);
4. To modernize VA healthcare - its administrative practices, clinical and care management strategies, and physical assets; and
5. To reduce unnecessary costs and increase the efficiency of operations (and especially to free up dollars spent on administration for direct patient care).

In considering these generic purposes it is important to also consider several other contextual points. For example, as noted above, facility integrations are part of a larger network integration strategy. Facility integrations do not necessarily produce a lasting end product, but instead are part of an ongoing integrative process that may involve circumstances and changes beyond the specific facilities involved. For example, the merger of the radiology services at two integrating hospitals may be superseded by a network-wide teleradiology initiative. Similarly, the consolidation of the food service or laundry operations at two integrating facilities may be superseded by a network-wide bulk food preparation initiative or consolidation of all network laundry activities at a yet different facility. Unfortunately, the disparate circumstances prevalent at facilities and within the networks mean that these various activities are evolving from differing starting points and at different paces.

A second point of context is that no single formula or process has yet been devised that works for these integrations because of the varying nature of the involved facilities (i.e., rural-urban-suburban location, small-larger size, general acute care-psychiatric-extended care mission, tertiary-non-tertiary care), the different specific services they provide and the particular issues being addressed by the integration, among other things. Every one of our 19 integrations so far has involved a different set of facility characteristics.

Treatment facility integrations are all different because they address different issues and circumstances. Indeed, despite the hundreds of hospital mergers and integrations that have occurred in the private sector, there is not yet an agreed upon integration process or template in the private sector. To quote from an article in the May 1997 issue of Healthcare Leadership Review, "There is no 'right' way to integrate." The article goes on to say that, "It isn't possible to develop a model that anticipates changes

in the marketplace. Integrated delivery systems (IDSs) need to explicitly acknowledge and plan for change as markets develop and participants adapt and grow." An article in the July/August 1997 issue of Healthcare Forum Journal further makes this point with its title, "One size doesn't fit all ... The right way to integrate." It is generally not possible to describe all of the long-term outcomes of facility integrations since the integrated facilities and their delivery systems are living entities that will continue to change and evolve over time as they address their unique mix of clinical, demographic, geographic, social, economic and cultural issues.

Another important contextual point to be made is that VA has committed to having a high degree of stakeholder involvement and participation in the decision-making process regarding clinical service integration. If we are going to honor this commitment, which Congress has generally supported, then we cannot have determined all the outcomes before stakeholders have a chance to work through the issues with VA. Quite simply, we cannot have an open and participatory process and have predetermined outcomes. If stakeholders are going to be meaningfully involved in decision making then VA cannot have already made the decisions prior to involving them in the process.

To date, VA Headquarters has approved integration of the management of 40 medical treatment facilities (19 integrated facilities). Of course, each integration is at a different phase of reorganizing since the approvals have occurred at different times over the last two years. So far, these facility integrations have produced efficiencies estimated at well over $50 million; we expect this amount to significantly increase in the future. Over 1,000 FTE have been reduced as a result of the integrations. While administrative FTE has been decreased, the facilities have been able to add clinical staff. Even in times of limited budgets, the facilities have increased primary and specialty care. Clinics have been opened or enhanced at facilities that historically referred patients to more distant facilities, resulting in improved access and reduced waiting times. In addition, resources generated from these efficiencies have been used to open Community Based Outpatient Clinics, replace much needed medical equipment, and make necessary facility capital improvements.

In developing plans for and in implementing facility integrations, network directors collaborate widely with leadership and stakeholders. The need to do this has been repeatedly reaffirmed. Further, VHA Headquarters has tried to provide guidance to field facilities to assist the process. For example, in the spring of 1995, authority and guidance was issued to the field granting individual medical centers the flexibility to respond to changing local and regional circumstances in the healthcare marketplace.

Organizational changes that add, eliminate, or consolidate clinical and support services at facilities are subject to review and approval by the Network Director. However, proposals to integrate entire treatment facilities under a single management structure are reviewed and approved by VA Headquarters. Information submitted for review includes, for example, a statement on the missions and geographical service areas of the facilities affected, patient referral patterns, historical background, significant milestones, stakeholder involvement, current issues, goals, and evaluation plan.

I want to emphasize the important role of our stakeholders in this change process and assure you of our intent to involve stakeholders from the beginning of the process to final evaluations. Our stakeholders include veterans service organizations, Congressional members and staff, academic affiliates, the community, labor-management partnership councils/unions, and employees. With stakeholders' help most of the integrations and consolidations have proceeded without significant difficulties or incident. Indeed, at integrations involving only 4 of the 40 facilities pursuing integration have notable problems developed.

As we all know, change is not easy, and lessons are inevitably learned with experience. As such, VHA has tried to learn from its experience and refine the integration process over time. In May 1996, VHA prepared a 'lessons learned' book to share information on successes and problems encountered on the integrations that were then underway. And now, after an additional year of experience, we are preparing a more current guidebook based on a much larger number of facility integrations. This publication will better identify and define the general phases and many steps of the integration process. I want to stress, however, that it is not my intent to be unnecessarily prescriptive or to formulate a rigid bureaucratic process that stifles creativity and innovation. However, with the experience that we now have we can more clearly define a process that should help guide VISNs and facilities through this process. Indeed, based on our experience to date, there appears to be 5 phases to the integration process. These phases are as follows:

- Phase I - Visualization, Conceptualization and Initial Exploration

  The internal exploration and discussion of the possible integration, initial communication with stakeholders about the idea, and delineation and specification of the reasons and criteria for integration.

- Phase II - Quantitative and Qualitative Analysis and Decision Making

Completing a detailed analysis of the economic, administrative and clinical impacts of integrating services, initiating active stakeholder involvement to understand their concerns and issues, and convening planning committees, as needed, if the decision is made to proceed with the integration.

- Phase III - Implementation Planning

  The specification of the tasks required to integrate the facilities, evaluation and analysis of alternative integration scenarios, and selection of the best approach.

- Phase IV - Implementation of Integration Plan

  The integration of common management and administrative functions, successive integration of clinical and clinical support services, and course corrections, as needed.

- Phase V - Evaluation

  Monitoring results of the integration, analysis of whether the integration's stated goals were achieved, identifying other results and outcomes of the integration, and further course corrections, as needed.

With respect to evaluation, I have also requested that our Health Services Research and Development Service, through its Management Decision and Research Center, to conduct a systematic assessment and evaluation of all of our medical facility integrations. The study is currently in progress and, at present, is focusing on treatment facilities approved for integration between January 1995 and September 1996, plus the Southern California System of Clinics.

Mr. Chairman, in summary, integrating medical treatment facilities, as well as individual services or functions, has proven to be a valuable tool for VISN Directors in restructuring and establishing integrated service networks. This strategy and its implementation has produced understandable anxiety and resistance from some of our stakeholders. The one concern expressed most often has been that the integration was a precursor to closure of one of the facilities when, in fact, it was being done to improve the viability of both facilities. Indeed, as a result of these integrations, the VHA has been able to treat more veterans, make VA care more accessible, reduce administrative costs, expand services, and achieve many other positive results in light of our severe fiscal constraints. We are continually trying to improve the integration

process and, thus, we welcome suggestions from GAO, the private sector, or others on how best to accomplish this strategy.

That concludes my statement. I will be happy to answer your questions.

Approved
VA Integrated Facilities

VA Black Hills Health Care System:
(L) VAMC Ft. Meade, SD
VAMC Hot Springs, SD

VA Central Alabama Veterans HC System:
VAMC Montgomery, AL
(L) VAMC Tuskegee, AL

VA Central Iowa Health Care System:
(L) VAMC Des Moines, IA
VAMC Knoxville, IA

VA Central Texas Health Care System:
VAMC Marlin, TX
(L) VAMC Temple, TX
VAMC Waco, TX

VA Chicago Health Care System:
(L) VAMC Chicago (Lakeside), IL
VAMC Chicago (West Side), IL

VA Connecticut Health Care System:
VAMC Newington, CT
(L) VAMC West Haven, CT

VA Greater Nebraska Health Care System:
VAMC Grand Island, NE
(L) VAMC Lincoln, NE

VA Hudson Valley Health Care System:
VAMC Castle Point, NY
(L) VAH Montrose, NY

VA Maryland Health Care System:
(L) VAMC Baltimore, MD
VAMC Ft. Howard, MD
VAMC Perry Point, MD

VA New Jersey Health Care System:
(L) VAMC East Orange, NJ
VAMC Lyons, NJ

VA North Texas Health Care System:
VAMC Bonham, TX
(L) VAMC Dallas, TX

VA Northern Indiana Health Care System:
(L) VAMC Ft. Wayne, IN
VAMC Marion, IN

VA Palo Alto Health Care System:
VAMC Livermore, CA
(L) VAMC Palo Alto, CA

VA Pittsburgh Health Care System:
VAMC Pittsburgh (Highland Drive), PA
(L) VAMC Pittsburgh (University Drive), PA

VA Puget Sound Health Care System:
VAMC American Lake, WA
(L) VAMC Seattle, WA

VA S. Texas Veterans Health Care System:
VAMC Kerrville, TX
(L) VAMC San Antonio, TX

VA Southern California System of Clinics:
(L) VAMC Sepulveda, CA
VAOPC Los Angeles, CA

VA Western New York Health Care System:
VAMC Batavia, NY
(L) VAMC Buffalo, NY

VA Health Care System (Name pending)
VAMC Leavenworth, KS
(L) VAMC Topeka, KS

Summary: 19 Integrations / 40 Medical Facilities
(L) -Lead Division
10NA 07/15/97

STATEMENT OF
JOAN E. CUMMINGS, M.D.
NETWORK DIRECTOR
VETERANS INTEGRATED SERVICE NETWORK 12
HINES, ILLINOIS
JULY 24, 1997

Mr. Chairman, other speakers and guests - Good morning and thank you for this opportunity to discuss the integration of the VA Chicago Health Care System (Lakeside/West Side Divisions).

I would like to state that the Lakeside/West Side VAMC integration is one element of a larger Network strategy aimed at accomplishing five principal goals. These goals are to:

1. **Increase Access:** VA has systemwide goals of increasing the accessibility of VA healthcare and of increasing the number of veterans receiving care from VA by 20 percent by 2002. For VISN 12, this goal equates to increasing the number of persons who use VA by approximately 28,000. That is, over the next 5 years, we would like to see the veterans healthcare system providing care for an additional 28,000 veterans in Chicago and other areas of VISN 12. To do this, we need to establish care sites that are much easier to access than the present hospitals. For example, we would like to see that veterans in high-need areas such as Austin on the West Side have much better access to VA by establishing a community-based clinic there. As you know, however, there is not expected to be any new Federal funding to achieve the goal, so if we are going to increase the accessibility of VA healthcare, then we simply have to do so by providing care more efficiently than we have in the past and redirecting the savings to expand access.

2. **Modernize VA Healthcare:** There is a need to modernize both the manner in which veterans healthcare is provided in Chicago, as well as to modernize our facilities. For example, in VISN 12, we need to invest more in fiber-optic infrastructure and computers. Again, given Federal funding realities, progress in this regard can only be achieved by finding savings in other areas. In this regard, I would again note that current state-of-the-art medical practice and new technology is allowing much more care to be provided in outpatient settings than in hospitals and that in recent years healthcare has become primarily an ambulatory activity.

3. **Optimize Utilization of VA Capital Assets:** We need to optimize the utilization of VA physical plan and capital assets to maximize the cost-effectiveness of our services. To do this, we must eliminate unnecessary duplication or redundancy of services and technology, consolidate low-volume specialty services, coordinate resource decisions better, increase telemedicine usage, and achieve better economies of scale and productivity wherever feasible. For example, one of our Chicago inpatient surgical services has an occupancy rate of about 30%, while the generally accepted standard in health care is that this should be about 85%. Maintaining such low utilization neither uses taxpayer dollars prudently nor promotes quality care

4. **Reduce Costs:** The cost of VA healthcare in Chicago has been substantially higher than in most of the rest of the Nation. We must use our resources as effectively and efficiently as possible. Even in the absence of any budget imperatives, this VISN needs to realign clinical and administrative programs to reduce their resource consumption. The goal here is simply

to bring VISN 12 into better alignment with VA costs elsewhere. A significant part of the problem in this regard is the over-utilization of VA inpatient care in the Chicago area. I want to stress that costs are being reduced by making our programs more efficient-not by diminishing the quality or amount of care we provide Chicago-area veterans. We have in this VISN decreased our length of stay(Bed Days of Care) by such a degree that we have closed 1688 acute care beds which are no longer needed. These recovered resources will be utilized to provide better, more accessible care to larger numbers of veterans particularly in the outpatient setting..

5. **Ensure Consistently High Quality Care:** Finally, we are trying to ensure that VA provides consistently high quality care throughout the Network (as well as throughout the system). This will require more standardization of our services and better utilization of resources, including the elimination of certain low-volume services, than has occurred in the past.

Mr. Chairman, I would also take this opportunity to reaffirm my belief that both the Lakeside and West Side Divisions are essential and that I, and the Department, have no plan to close either Division. However, if we are going to achieve the five goals: 1.Increase access; 2. Modernize VA Healthcare; 3. Optimize utilization of VA capital assets; 4. Reduce costs; and 5. Ensure consistently high quality care, then there is a need to change how these facilities provide care and what specific services they each provide. I have serious concerns about suggestions that the integration process should be delayed until a complete master plan is available. Since the decision to administratively integrate the two facilities, many work groups have been established and are planning to implement the goal of a single entity providing primary and tertiary care to the veterans of Chicago. Part of that plan has included reevaluating and assessing all equipment needs and putting them in the context of one VA. For example, there were two angiography suites planned prior to the integration at a cost of $ 2.5 million ($1.25 million per suite-construction and equipment) each. The work group analyzed the patient needs, location, space, etc., and decided to place one suite at West Side and eliminate the second suite. Not only did this save our VISN $1.25 million, because the work group recommendations were able to be implemented immediately we avoided any default on contracts or any unreasonable delay in providing the angiography exams to the patients of Chicago.

There are similar issues facing several other work groups including the ordering of replacement cardiac catheterization equipment. Lakeside has had to suspend cardiac angioplasty procedures inspite of having staff well qualified and highly trained. The work group is again evaluating and is close to a recommendation. Patients who now need cardiac angioplasty require referral to Hines where previously these procedures were done in close proximity to their primary care team and without incurring added expenses related to transportation or the need for local emergent care.

The two divisions have eliminated 108 positions during our hiring freeze. Many of these vacancies were eliminated either through the buy-out or attrition in expectation of the work groups recommending a smaller number of employees and less supervisors. In addition normal turnover has generated some vacancies which have been left unfilled in anticipation of the outcome of the work groups. If these work groups are not allowed to integrate services between the two divisions for any prolonged period of time, the short term solutions providing the replacement of the direct and support care which these vacant positions represent no longer are satisfactory and thus this becomes a serious patient care issue.

From the time the integration was administratively approved any service chief vacancy which occurred was not filled to allow for the integrated service to function without a loss of leadership. VA Chicago has eight service chief vacancies, some of these have been integrated with a single chief such as Nutrition and Food Service. To fill the others would be difficult if not impossible when applicants would know that an integration was in process. Delaying the integration of a service until all other plans are approved would be very difficult with one of the divisions having no permanent chief or supervisor. An Acting Chief can provide short term coverage but real management requires a permanent Chief.

There are plans in the VISN for another Reduction-In-Force and Staffing Adjustment of Title 38 personnel due to our continued drop in length of stay and movement to more ambulatory care. When this occurs we have been planning to use both divisions and the integrated services will allow us to move employees across the two divisions potentially avoiding some separations. If the RIF/Stafffing Adjustment were to occur separately in the two divisions, we believe the RIF will go deeper into the organization and will result in more employees actually being separated.

The Nutrition and Food Service work group has recommended one kitchen to serve both divisions. Delaying the closure of the second kitchen while awaiting the total plan would also delay the savings from the closure of that second kitchen. The anticipated savings from the integration are in our plan for the coming fiscal year. To delay any implementation until the entire plan is available for review by a body unknown, would also force us to look for alternative sources for those savings and may cause a higher number of RIF/Staffing Adjustment requests and may impact on patient care programs directly. At this point with the integration proceeding we would not expect any patient care program closure. We will proceed with following the Integration Coordinating Committee and Stakeholders Advisory Task Group findings and recommendations and thank you for the opportunity to present this overview.

Finally we have in place a review of all minor construction and NRM projects which are being measured against the progress of the Integration Coordinating Committee and are being sent to the various work groups for review. As with the Angiography, we expect that some will be cancelled and others may be modified based on the deliberations of the groups. To stop and have all scheduled projects go forward without this review may well cause significant waste of resources. In addition, our space planning would be adversely affected as viewing these as serving two divisions is actually generating available space for VA Chicago to utilize. Both the angiography and kitchen deletion projects demonstrate how space has been made available through the integration process.

Historical Background
Lakeside and West Side VA Medical Centers

COMPLEMENTARY MISSION AND SERVICES

Lakeside and West Side VA Medical Centers (VAMCs) are both predominantly acute care, highly affiliated, urban medical care facilities. Both opened in 1954 and their respective academic affiliations have been in place since then. In addition, the two medical centers serve the same patient service area. They currently share programs and affiliations in nuclear medicine, chaplain support, music therapy, and human resources management.

Lakeside VA Medical Center, located on the near north side of Chicago, offers primary and tertiary care to 460,000 veterans living in Cook County, Illinois and Lake County, Indiana. Lakeside treated 21,476 veterans in FY95 and had more than 6,600 inpatient admissions and 208,000 outpatient visits. It has 350 authorized beds, 1,200 employees, 300 volunteers and a $96 million annual budget. Lakeside's Adam Benjamin, Jr. VA Outpatient Clinic, located 55 miles southeast of Chicago in Crown Point, Indiana, provides services to veterans (46,700 visits in FY95) in northwest Indiana. Residents and medical students who train at Lakeside rotate through the outpatient clinic as well. Lakeside services Vietnam Veterans Outreach Centers in Chicago Heights, Illinois and Gary, Indiana.

Lakeside is a member of the McGaw Medical Center of Northwestern University, which also includes Children's Memorial Hospital, Evanston Hospital Corporation, Northwestern Memorial Hospital, and the Rehabilitation Institute of Chicago. Northwestern University Medical School is Lakeside's primary affiliation for the training of 102 paid medical residents and fellows. All physician staff have faculty appointments at the affiliate. There are 22 additional affiliation agreements with 16 other institutions covering eight clinical and allied health professions. Lakeside has a diversified research program consisting of 40 VA-funded and 30 non-VA-funded investigators with 175 projects and funding of approximately $5 million.

West Side VA Medical Center, located on the near west side of Chicago, is a 435-bed facility offering primary and tertiary care. West Side primarily serves the veterans of Cook County, Illinois, who number 411,000. West Side treated 24,781 veterans in FY95 and had more than 8,100 inpatient admissions and 280,000 outpatient visits. It has 1,570 employees and a $123 million annual budget. West Side has three community-based off-station programs: a Veterans Resource Center, a Drug Dependency Treatment Center and the Hyde Park outpatient clinic.

The University of Illinois at Chicago is West Side's primary affiliation for the training of 129 paid medical residents and fellows. Other training programs cover such areas as dentistry, nursing, podiatry, pharmacy and other allied health professions. West Side has a research program of approximately $1.6 million funding 20 medical investigators focusing on such areas as hematology, gastroenterology and, molecular biology.

GEOGRAPHIC AREA

Lakeside and West Side VAMCs share similar geographic and patient population areas:

- The commuting distance between Lakeside and West Side is about six miles and can be traversed by car in 10-20 minutes.
- Both facilities are accessible through a variety of public transportation networks.
- Both Lakeside and West Side draw the majority of their patients from Cook County, Illinois -- 67% for Lakeside and 90% for West Side. Another 19% of Lakeside's patients live in Lake County, Indiana, the site of the medical center's satellite outpatient clinic.

- The geographic area comprising the two medical centers and their overlapping patient populations is also the site of several Vietnam Veterans Outreach Centers and additional access points.

NATURAL PATIENT REFERRAL PATTERNS

The proximity of the two facilities has fostered a referral pattern that readily flows in both directions:

Shared patients:	3,500
Unique patients at Lakeside:	21,476
Unique patients at West Side:	24,781 (excluding fee basis)

HISTORICAL INFORMATION

- Due to their proximity (six miles and 10-20 minutes travel time), the integration of Lakeside and West Side VAMCs has been discussed for many years. In 1994, a VHA Management Improvement Task Force, one of several nationally appointed task forces, evaluated potential FTEE savings from VA medical center integrations and consolidations. The task force identified a number of potential integrations sites, including Lakeside and West Side. In March 1995, the Secretary of the Department of Veterans Affairs approved integrating sixteen (16) medical centers into seven (7). Lakeside and West Side were not included on this initial list. Since that time, the Secretary has approved three additional integrations from that list, e.g., East Orange/Lyons, Pittsburgh--Highland Drive/Pittsburgh--University Drive, and Hot Springs/Fort Meade.

- The four Chicago-area VAMCs, under the auspices of the Chicago Network Council, conducted the facility development planning (FDP) process as a single, integrated planning group. Although the plan identified the potential for integration of facilities, the Network Council took no action since the Veterans Integrated Service Network (VISN) structure was being planned nationwide and it was believed that the VISN would be the appropriate body to deal with most of these issues.

- In August 1995, the Chicago Network Council consolidated the Human Resources Management Services of Hines, Lakeside, and West Side. The consolidated Service is located at Edward Hines, Jr. Hospital. Other potential administrative service consolidations were referred to the VISN for further evaluation.

- Since the establishment of the VISN in October 1995, one of the highest priorities has been the review of the VISN tertiary care facilities for the most effective use of resources. Administrative and clinical integration and consolidation issues were discussed starting with initial visits by the VISN Director to each of the eight facilities and meetings with the Deans of the affiliated medical schools. At the employee "town hall" meetings, which were open to all employees (including union representatives), the Network Director discussed the need to review all clinical and administrative programs, identify appropriate efficiencies, including integrations and consolidations, and evaluate the potential for improvements in resource utilization and patient care. The most commonly identified programs were cardiac surgery, angioplasty, and neurosurgery. The Lakeside and West Side meetings were held in January of 1996.

- Between November 1995 and May 1996, teams to evaluate Pathology and Laboratory Medicine, Imaging, and the development of a single Business Office for the VISN were established. The Communication Team has already implemented a computer network linking all eight of the VISN Medical Centers and is making plans for telemedicine and videoconferencing to enhance services at primary care/rural sites.

- Between October 1995 and February 1996, the Network Director met with the Deans of the six medical schools affiliated with the VISN 12 VAMCs. During these meetings, the Network Director discussed the similarities and proximity of the tertiary care facilities, clinical redundancies, and the potential for cross-facility medical residency training. Edward Hines, Jr. Hospital already has multiple affiliations, specifically with Loyola University, University of Illinois at Chicago, and Chicago Medical School.

- Both medical centers are located in the State of Illinois and therefore equally subject to the impact of existing and future state healthcare legislation. (The Adam Benjamin, Jr. VA Outpatient Clinic is located in Indiana).

- Lakeside and West Side share the same U.S. Senators (Paul Simon and Carol Moseley-Braun) and Congresswoman (Cardiss Collins).

- Both facilities share the same labor market. Both are represented by GSEU, Local 73 of SEIU. In addition the nurses at West Side are represented by the Illinois Nurses Association (INA).

SIGNIFICANT MILESTONES

November 6, 1993	Joan E. Cummings, M.D. (Chairman of the Chicago Network Council and Director, Edward Hines, Jr. Hospital) testified to a subcommittee of the House Veterans Affairs Committee about the Network Facility Development Plan then being formulated by Lakeside, West Side, Hines and North Chicago VAMCs and discussed planning options, including program and facility integration among these four Chicago-area VAMCs.
June 1994	Network Facility Development Plan finalized and forwarded to VHA Headquarters (then VACO).
August 1995	Human Resources Management Services of Hines, Lakeside and West Side are consolidated.
October 15, 1995	Position of Director at Hines became vacant. There are immediate and widespread rumors that Lakeside and West Side will be integrated.
January 22, 1996	Network Director visited Edward Hines, Jr. Hospital and held town hall meeting with employees.
January 25, 1996	Network Director visited West Side VAMC and held town hall meeting with employees.

January 25, 1996	Network Director met with the Dean of the College of Medicine of the University of Illinois at Chicago.
January 30, 1996	Network Director visited Lakeside VAMC and held town hall meeting with employees, including teleconference hookup with employees of the Adam Benjamin, Jr. VA Outpatient Clinic in Crown Point, Indiana.
January 30, 1996	Network Director met with the Dean of the Northwestern University Medical School.
February 27, 1996	Network Director visited North Chicago VAMC and held town hall meeting with employees.
February 27, 1996	Network Director met with the Dean and department chairs of the Chicago Medical School.
March 28, 1996	Network Director met with the representatives of the Chicago area Veterans Service Organizations and discussed the issues surrounding duplication of services. The Network Director emphasized the VISN position that the special needs of psychiatry and rehabilitation patients preclude closure of any facility. Consolidation of medical/surgical inpatient services between the two Chicago VAMCs was identified as requiring study by the VISN.
March 29, 1996	Network Director met with a group comprising the Dean or his representative from five of the six medical schools affiliated with VISN VAMCs (the Dean from the University of Wisconsin was unable to attend). The issue of medical/surgical inpatient services in Chicago was reviewed at length, including discussion of closure of beds at either Lakeside or West Side and increased use of the beds at Hines. The group discussed the creation of a committee, whose members would have no links to Lakeside or West Side, to assess and make recommendations to the Network Director regarding the placement of the medical/surgical inpatient services.
April 1, 1996	Network Director met with the staff of the Chicago area Congressional delegation. The clinical redundancies, as discussed with the Veterans Service Organizations, were presented, including the proposed evaluation of the placement of acute medicine and surgery inpatient services.
April 7, 1996	The position of Director at West Side became vacant with the transfer of John DeNardo to the position of Director of Edward Hines, Jr. Hospital.
April 16, 1996	Network Director briefed Secretary Brown and his staff on discussions concerning the potential for an integration of Lakeside and West Side in preparation for the Secretary's meeting with Congresswoman Cardiss Collins and Dr. Gerald Moss, Dean of the College of Medicine of the University of Illinois at Chicago.

April 17, 1996	A newspaper for the faculty, staff, and students of the University of Illinois published an article opposing consideration of facility integration.
April 24, 1996	Network Director held a second meeting with Dean Moss, University of Illinois, and discussed integration issues, particularly the integration of Lakeside and West Side and the concept of multiple medical school affiliations.
May 8, 1996	An article regarding the possible integration of Lakeside and West Side appeared in the Business Section of the *Chicago Tribune*.
May 13, 1996	Network Director had a discussion with Dr. Harry N. Beaty, Dean of Northwestern regarding the potential for integration. The University is very concerned regarding the maintenance of training programs with VA and wishes to work with the VISN on the implementation of any plans for integration. Dr. Cummings stated her appreciation of the University's position and assured him that they would be full partners in the process.
May 13, 1996	Letters were sent to the Unions by the Director of Lakeside and the Acting Director of West Side informing them of the potential for integration.
May 13, 1996	Network Director sent letters to the stakeholders such as VSOs, Congressional delegation members and affiliated medical schools informing them of the planning for a possible integration of Lakeside and West Side VAMCs.
June 27, 1996	Secretary of Veterans Affairs Jesse Brown announced his decision to integrate the Lakeside and West Side VAMCs under a single management structure.
September 12, 1996	Network Director met with James A. Balcer, Director/Community Liaison, City of Chicago to provide the Mayor's Office with an overview of the integration.
September 26, 1996	Network Director met with members of the Minority Veterans Steering Committee and the Montford Point Marine Association to provide them with an update on the integration.
October 28, 1996	First meeting of the VA Chicago Health Care System Integration Coordinating Committee chaired by Dr. Christopher Terrence, Chief of Staff, VA New Jersey Health Care System. Subsequent meetings have taken place on December 1, 1996, January 29, 1997, March 5, 1997, April 23, 1997, June 4, 1997, and scheduled for July 16, 1997.
October 28, 1996	First meeting of the VA Chicago Health Care System Stakeholders Advisory Group, chaired by George Cramer, Assistant Director, Illinois Department of Veterans Affairs. Subsequent meetings have taken place

on December 4, 1996, February 20, 1997, May 7, 1997, and scheduled for July 30, 1997.

STAKEHOLDER AWARENESS

Background

Prior to the implementation of the VISNs in late 1995, the Chicago area VA facilities operated with a Network Council. A representative of the Veterans Service Organizations and the affiliate Deans as well as the VBA Regional Office Director were members of the Council. The management teams of these facilities recognized that, because of their geographic locations, planning needed to be done as a unit. The Chicago Network Council worked to develop a Veterans Health Administration (VHA) health care plan for the four VA facilities in the Chicago area: Hines, Lakeside, North Chicago, and West Side. The goal was a health system that would enhance service to veterans while minimizing the costs and inefficiencies inherent in operating four hospitals with similar missions in close proximity. To this end they adopted several assumptions which remain relevant in the current VISN. These assumptions include:

- All patients are Network patients and are not identified as patients of a specific facility, but identified by physician providers.
- All resources flow through the Network including resident allocation.
- Primary care sites are the entry points for the Network. New Network participants are possible.
- Facilities will be developed to meet the Network integration strategy.

These issues will be continually discussed with stakeholders in the months to come.

Discussions will be occurring against the backdrop of the current negotiations over balancing the Federal budget as well as the wide-ranging debate over the future of the nation's health care system and how VA would fit into a reformed health care delivery system. Although the focus of the health care debate has shifted somewhat to the states since 1994, its impact on the importance of facility and/or service integration remains high.

Status

Stakeholders will continue to be apprised of developments concerning the integration process by the Network Director. She has had several telephone conversations with staff members of the Congressional delegation and the news media and will continue to be available as needed. Network staff will continue to respond as rapidly as possible to letters of inquiry and other requests for information.

Veterans Service Officers, Commanders, and Representatives

Ongoing dialogue about service integration will continue to take place with representatives of various Veterans Service Organizations during each facility's regularly scheduled meetings. The Network Director will also continue to have frequent communication with these important stakeholders. The following organizations will be included in this dialogue:

- The American Legion
- AMVETS
- Disabled American Veterans
- Jewish War Veterans

- Military Order of the Purple Heart
- Paralyzed Veterans of America
- Veterans of Foreign Wars
- Vietnam Veterans of America
- Montford Point Marine Association
- Minority Veterans Affairs Steering Committee
- Others

Congressional Representatives

The Network Director will continue to keep all Congressional representatives involved in and apprised of the integration discussions.

Employee Relations

A key factor in any plan to integrate services is the impact on staffs at both Lakeside and West Side. Management will continue to keep employees informed of ongoing developments through staff meetings, newsletters, and other forums.

The GSEU, Local 73 of Service Employees International Union (SEIU) represents employees at both facilities. The Illinois Nursing Association (INA) also represents nursing personnel at West Side. The unions will continue to be informed about integration discussions.

Medical School Affiliates

Northwestern University Medical School and the University of Illinois at Chicago College of Medicine, continue to be involved in and apprised of discussions concerning integration. Both institutions are active on the Integration Coordinating Committee and the Stakeholders Council.

CURRENT STATUS AND ISSUES

1) Integration of

- medical inpatient services,
- surgical inpatient services,
- ambulatory care and access points,
- physical medicine and rehabilitation services,
- mental health services,
- pathology and laboratory medicine,
- dental,
- information resources management, and
- administration.

is underway.

The June 27, 1996 announcement by VHA Headquarters to integrate the Lakeside VAMC and West Side VAMC initiated the process to establish an Integration Coordinating Committee to oversee and coordinate:

- developing a single management team,
- developing a unified mission and vision,
- developing recommendations for reducing unnecessary service duplication,
- fostering maximum cost effectiveness, quality, consolidation and satisfaction,
- integrating Decentralized Hospital Computer Program (DHCP) databases,
- developing an organizational chart.

EVALUATING AND MONITORING THE PLAN

An evaluation and monitoring plan has been developed which has two major components a tracking of resources, FTEE, and positions by the medical center and HSR&D study of the integration process itself. This study is being supported by a nationally known economist consultant with background in evaluation of other health care institution reorganizations.

- customer service
- resources utilization
- quality of care
- access
- timeliness

REPORTS AND RECOMMENDATIONS FROM THE INTEGRATION COORDINATING COMMITTEE (ICC)

- Reviewed reports and recommendations from 7 of 14 ICC-chartered work groups for the following services and submitted recommendations and comments to the VA Chicago Health Care System (VACHS) Director: (***Bolded Italics**=recommendations approved by VACHCS Director and being implemented or awaiting additional approval. Portions of some reports/recommendations have been remanded to work groups for further information and analysis. Italics=report/recommendations submitted to VACHS Director and for review by ICC and STAG).*

-information resources mgmt.	*-nuclear medicine*	***-ambulatory care***
-nutrition & food	*-neurology*	*-medicine*
-pathology & laboratory	*-physical medicine & rehab*	*-psychiatry*
-diagnostic radiology	***-research***	*-surgery*
-anesthesiology	*-therapeutic radiology*	

- Reviewed reports and recommendations from 12 of 18 integration work groups for the following services and submitted recommendations and comments to the VACHCS Director: (***Bolded Italics**=recommendations approved by VACHCS Director and being implemented or awaiting additional approval. Portions of some reports/recommendations have been remanded to work groups for further information and analysis. Italics=report/recommendations submitted to VACHS Director and for review by ICC and STAG).*

-audiology & speech pathology	***-fiscal/MCCR (cost recovery)***	***-police & security***
-chaplain	*-hospital based primary care*	*-prosthetics*
-dental	*-library*	*-psychology*
-education	*-medical administration*	***-recreat'l therapy***
-engineering	*-nursing*	*-social work*
-environmental mgmt.	***-pharmacy***	***-voluntary***

- Recommended a VA Chicago Health Care System integration goal statement (approved)
- Recommended a VA Chicago Health Care System mission (approved)
- Endorsed consolidation of several administrative and clinical services, including audiology and speech pathology, chaplain, dental environmental management, hospital based primary care, information resources management (approved), neurology, nuclear medicine, nutrition and food services (approved), pharmacy (approved), police and security services, prosthetics and voluntary (approved) services.
- Recommended angiography equipment replacement at West Side and cardiac catheterization equipment replacement at Lakeside (both approved)
- Recommended integration of pathology and laboratory medicine services
- Recommended integration of ambulatory care services at the two divisions, including satellite outpatient clinic sites (Crown Point, Indiana, and 63rd and Stony Island, Chicago).

INTEGRATION IMPLEMENTATION ACTIVITIES RECOMMENDATIONS FROM THE STAKEHOLDERS ADVISORY GROUP (STAG)

- Single director (vs. two facility directors previously), VACHS.
- Merged Lakeside and West Side divisions clinical and administrative computer databases (DHCP-Decentralized Hospital Computer Program) into a single VA Chicago Health Care System computer database
- Consolidated medical care cost recovery section staff of Fiscal Service at West Side Division
- Consolidated payroll section staff of Fiscal Service at Lakeside Division
- Appointed single Chief, Information Resources Management Service for both divisions
- Appointed single Chief, Pharmacy Service for both divisions
- Appointed single Chief, Recreation Therapy Service for both divisions
- Appointed single Chief, Voluntary Service for both divisions
- Appointed one Information Systems Security Officer for both divisions
- Appointed two Decision Support System persons for both divisions
- Estimated cost savings identified to date in VACHS Director-approved work group reports: $691,000 (13.8 FTE)

STATEMENT OF
CHRISTOPHER F. TERRENCE, M.D.
CHAIRMAN, INTEGRATION COORDINATING COMMITTEE
VA CHICAGO HEALTH CARE SYSTEM
CHICAGO, ILLINOIS
JULY 24,1997

Mr. Chairman, other speakers and guests:

Good morning and thank you for this opportunity to discuss the Integration Coordinating Committee (ICC) of the VA Chicago Health Care System. On October 10, 1996, I was charged by Kenneth Kizer, M.D., MPH, Under Secretary for Health, to be the Chair of the Integration Coordinating Committee for the VA Chicago Health Care System. In his letter of appointment Dr. Kizer stressed that there were "no preset determinations. The process should be open and data driven, and that all reports and recommendations reviewed by the VISN Director, Joan E. Cummings, M.D., and subsequent review at the Under Secretary of Health level." One of the guiding principles that the Integration Committee shared early on in the process was the need for maximum involvement of the affiliates, the stakeholders, employees, and other interested individuals. As of today over 300 individuals in the VA Chicago Health Care System have had input into the ICC's process either as a member of the Committee, Subcommittee or Stakeholder Advisory Group.

At its first meeting, the Integration Coordinating Committee decided that we would proceed in forming chartered work groups with the approval of the Medical Center Director, Mr. Joseph Moore. These groups were service specific and were charged with developing a proposal for integrating specific services. The goal of the group was to produce a health system that would maintain the quality or enhance the overall service to the veterans while minimizing the costs inherent in operating two hospitals with similar missions in close proximity. The Committee decided to start with services that were relatively non controversial in order to prove that the process was valid, and could be accomplished in the context of the VA Chicago Health Care System. When a group completed its proposal, the proposal was submitted to the Integration Coordinating Committee for its review and subsequent recommendation to the Medical Center Director. The proposal was also reviewed at the Stakeholders Advisory Group by the chairmen of the various chartered work groups. The recommendations from the Stakeholders Advisory Group were brought forward to the ICC in order to provide maximal input into the deliberations of the Integration Coordinating Committee.

The various work groups were usually chaired by a chief of service, but in some instances such as surgery, medicine and psychiatry, the group was chaired by a University of Illinois School of Medicine representative or a Northwestern School of Medicine representative.

In order to keep the staff at the two divisions up-to-date on the process of the Committee, we have used a number of formats to achieve this goal. The Chair of the Integration Coordinating Committee has had four town hall style meetings at the Lakeside and West Side divisions. These meetings had two goals, (1) to present the activities of the Integration Coordinating Committee and (2) to seek information from the staff at the two divisions concerning the future process of the Integration Coordinating Committee.

These meetings were extremely well attended and were very informative. There has also been regular updates of the progress of the Integration Coordinating Committee in the VA Chicago Health Care System *Newsletter,* as well as publication of the Integration Coordinating Committee minutes in the decentralized hospital computer program (DHCP). At the most recent town meeting it was also suggested that we have a newsletter also put on the DHCP. This will be accomplished next month.

By July of 1997, over half the work groups will have presented their recommendations to the Integration Coordinating Committee. Up until now, most of the recommendations have been forwarded to the Medical Center Director with little changes. A few have been referred back to the service work groups and will be coming forward shortly with a final report to the Integration Coordinating Committee. As one can see the process is very time consuming, but the Committee believes that it is very worthwhile in that it involves the maximum number of people in the proposing process. Until the inception of the Integration Coordinating Committee, there has been very little active participation by the two divisions in coming up with joint plans as to consolidation.

As of this date the ICC has approved the Goals & Mission statement for the VA Chicago Health Care System. The ICC recommended the consolidation of the following administrative and clinical services: Audiology & Speech Pathology, Chaplain, Dental, Environmental Management, Hospital Based Primary Care, Information Resource Management (IRM), Neurology, Nuclear Medicine, Nutrition & Food Services, Pharmacy, Police & Security Services, Prosthetics, and Voluntary Services. In addition the Committee has also recommended the replacement of angiography equipment at the West Side division, and the replacement of the cardiac catheterization equipment at the Lakeside division. The Committee also approved the integration of Pathology & Laboratory Medicine Services. The Committee has also recommended the integration of Ambulatory Care Services at the two divisions which will include the satellite outpatient clinics at Crown Point, Indiana, 63rd Street & Stony Island in Chicago.

In the next few months we will complete the large service work groups. This will include such services as medicine, surgery, psychiatry, and nursing service. Although these are the largest services to be dealt with to date, I think the Committee has built up a track record of accomplishment that will allow us to deal with the thorny issues of affiliation interests and placement of bed service facilities. In order to facilitate the process among the bed service working groups, the Medical Center Director and I have been meeting with the Chairs of the bed service chartered work groups on a monthly basis to facilitate interservice planning that will be necessary for a coherent proposal.

In order to review what we have done in the Committee, there will be a proposal brought forward in the July meeting to develop measures of the integration process. We expect either in the Committee or in the various work groups to propose to the medical center management the types of measures that should be done in the future to ensure that the integration has achieved its stated goal of maintaining the quality and enhancing the access of care for the veteran in a cost effective manner. I expect these measures will include the usual quality

management activities, but I expect the work groups to also recommend very service specific measures.

In summary, I believe that the Integration Coordinating Committee of the VA Chicago Health Care System has worked very diligently in setting up a process and frame work for the integration of two tertiary care hospitals. This Committee would have never been successful without the support of the four medical school Deans, the union representatives who have contributed greatly, the chair and members of the stakeholders group and other veteran service organization representatives.

Thank you Mr. Chairman for the opportunity to present this brief overview of the Integration Coordinating Committee of the VA Chicago Health Care System.

CHRISTOPHER F. TERRENCE, M.D.
Chair, Integration Coordinating Committee
VA Chicago Health Care System
Chicago, Illinois

STATEMENT OF

JAMES A. GOFF, FACHE

DIRECTOR, VA PALO ALTO HEALTH CARE SYSTEM

VETERANS HEALTH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITEES ON HEALTH AND ON OVERSIGHT AND INVESTIGATIONS

HOUSE OF REPRESENTATIVES

July 24, 1997

Mr. Chairman and Members of the Subcommittees:

Thank you for the opportunity to present the experience and positive outcomes which resulted from the integration of the Palo Alto and Livermore VA Medical Centers.

The first question that needs to be asked in any proposed integration/consolidation/ merger (to me these terms are interchangeable and synonymous) is "Why do it?" In my opinion, there are only two possible answers to this question. One is to save money and the other is to improve the quantity and/or quality of patient care. Preferably both of these goals will be met, as they have been in the Palo Alto/Livermore consolidation.

The idea of consolidating Livermore and Palo Alto has been the subject of discussion and speculation since at least 1989 when minimal Stanford training programs were established at Livermore. When I was approached about being reassigned to my current position in late 1992, the Regional Director, Clark

Doughty, charged me with three major goals. One was to see that the construction of the new Palo Alto hospital progressed on schedule, another was to fully integrate the clinical and administrative activities of the Menlo Park and Palo Alto divisions which were functioning somewhat autonomously at the time, and the third was to work toward consolidation of the Palo Alto and Livermore VA Medical Centers. In retrospect, the full integration of the Menlo Park and Palo

Alto campuses was almost as much a challenge as the consolidation of the Palo Alto and Livermore facilities.

By 1993 there was already some interaction between Palo Alto and Livermore. Although no savings were realized, the Library Services had been consolidated. Some clinics at Livermore were being provided by staff from Palo Alto on a part-time basis, and Palo Alto was the major referral center for patients from Livermore. Although these relationships existed, the usual barriers between two free-standing organizations were evident and had some impact on the way patients were referred and treated.

In 1993 the Director position at Livermore became vacant. The Regional Director arranged to have Clarence Nixon appointed as Director at Livermore with the clear understanding that he was to work with me to facilitate the ultimate consolidation of the two facilities. Mr. Nixon was willing to do this since he had plans to retire within two years. We began the process with meetings at a site mid-way between Palo Alto and Livermore (the two campuses are forty miles apart). Shortly thereafter we included the Chiefs of Staff and Union Presidents in our discussions. We were moving ahead on a one to two year time table and involving all other stakeholders such as Veterans Service Officers, congressional representatives, affiliates, and staff when Clarence Nixon opted to take the buy out in June 1994, I was subsequently appointed Acting Director at Livermore while remaining in my position as Director at Palo Alto. Obviously this arrangement greatly expedited the consolidation process.

By the summer of 1994 it was common knowledge that we were working actively toward full consolidation of the Livermore and Palo Alto VA Medical Centers. In my opinion, it is at this point, when there is no doubt that a future merger is imminent, that the actions of those in leadership positions are most crucial. While circumstances and facilities may differ from one integration to the next, the phases they must pass through are essentially the same in every case, as are many of the actions which must be taken.

Because the Palo Alto/Livermore consolidation was the first in recent history (I believe the last one was at Portland/Vancouver in approximately 1980), and

because plans were being developed to consummate additional integrations across the country, the precedent-setting approval process proceeded slowly. During this time certain key actions were taken which, I believe, contributed significantly to the success of the Palo Alto/Livermore integration.

- The first important action was the designation of a single management to direct the organization in a consistent manner. Not only was it clear to everyone that I was the Director of both organizations (and subsequently the combined organization), but I also made it clear that there would only be one chief of each service and/or program in the organization. We were fortunate that several of the Service Chief positions as well as the Director and Associate Director positions at Livermore were vacant. The remainder were told they would no longer be autonomous services. The issues of leadership and management must be clearly, thoroughly, and quickly delineated from the beginning.

- Perhaps the most important tool in this or any similar process is communication. You can not over communicate. We used every avenue available to communicate with all stakeholders and kept the communication channels open for feed back and rumor control. We used town hall meetings, newsletters, bulletins, e-mail, phone calls, letters, regular meetings, special meetings, retreats with Service Chiefs and labor leaders, and one-on-one discussions throughout every day. While it is always important for management to be visible in the organization, during times like this it is critical. Regular tours of work areas at all integration sites, including talking with individual employees, is essential, It is also paramount that management be totally open and honest in presenting the situation to all stakeholders. It is often necessary to tell people things they do not want to hear, but it is much more productive to do so than to let them find out some other way.

- Throughout the process all stakeholders were kept informed, sometimes on a daily basis. Of extreme importance was the relationship established with the Unions at both Palo Alto and Livermore. Even before the consolidation I worked to establish identical Labor/Management Partnership agreements with both Unions so when the merger did occur we would not have to renegotiate

the terms of those agreements. In addition, we included our Union partners in everything we did related to the consolidation, including the ultimate need for a reduction-in-force and staffing adjustment in 1996. By doing so we significantly reduced staff resistance to the radical changes that were being made in both organizations. In 1996 Palo Alto was one of three VA facilities recognized by Vice President Al Gore for their Labor/Management Partnership efforts.

- Throughout the integration process it was imperative that we demonstrably improve services to veterans, especially at Livermore. This was accomplished in a number of ways, all of which were visible to both employees and veterans. Some of these included additional clinics at Livermore which precluded making veterans travel to Palo Alto for care, new equipment and adequate supplies, reduced waiting times, and improved provider quality. Improved patient care is, in my opinion, the most important benefit of any integration.

- One of the most difficult but important things to do in a merger such as this one is to integrate the computer systems, data bases, fiscal systems, and telephone systems. This can prove quite costly and at a minimum requires much effort and time. We were fortunate to have the necessary expertise at Palo Alto to accomplish this while the problem was still being studied at the national level.

- In 1994 we were unaware of the budgetary constraints that would occur in future years. Therefore, at the time the consolidation was initially proposed I promised the staff and the Unions that there would be no reduction-in-force resulting from the integration. Instead we would let attrition deal with the redundant positions. This approach worked for almost two years, when budget concerns forced us to conduct a reduction-in-force and staffing adjustment. While some of the positions impacted by these actions were left over from the consolidation, the reduction-in-force action was not taken as a result of the consolidation and this was understood by our Union partners. Had they not been involved from the beginning, as well as being involved in

our Executive Resources Board, it may have been impossible to convince them of this distinction and thus enlist their support for the staffing reductions that occurred in 1996.

- Quality Management was another area which, when consolidated, improved care at both Palo Alto and Livermore. In fact the Quality Manager who was at Livermore prior to the consolidation is now the Quality Manager for the entire Palo Alto Health Care System and has made significant improvements throughout the organization, utilizing the "best" of both Palo Alto and Livermore policies and procedures.

- One of the important actions that management must take in a merger situation is to clearly define the mission of the organization and that of the various campuses involved. For instance, in the Palo Alto/Livermore situation, Livermore was trying to be a full service hospital when that was not appropriate. Therefore, we made it clear early in the process that Livermore was to become a full service ambulatory care center with extended and long-term care inpatient facilities. Neither the volume nor the cost supported maintaining acute inpatient care at Livermore. We also discontinued accepting walk-in patients after normal working hours since the infrastructure was not available at Livermore to support this activity. A study showed only a few patients per week coming in after hours and those who were really sick were immediately referred to the nearest local private hospital at VA expense. We now operate a 24-hour emergency room only at the Palo Alto campus. Livermore is served by critical care transport, including helicopter service.

- Perhaps the biggest paradigm shift that must occur in any merger is that there needs to be only one business office or administrative headquarters for the entire organization. This means that all campuses other than the primary administrative campus must become and think of themselves as clinical campuses where only patient care and those administrative activities necessary to directly support patient care exist. While this may seem obvious and simple when stated, it is a difficult concept for people to accept in practice.

- Other seemingly mundane administrative actions are absolutely necessary and not always simple to accomplish. They include, but are not limited to, such things as a name change for the facilities that reflects the new organization, a new or consolidated station number for internal reporting, a new organizational chart, and notification to all headquarters and other entities, including many outside the Department of Veterans Affairs, that there is now a single organization where two or more previously existed. This impacts everything from organizational membership dues, to internal reporting, to congressional correspondence, to routing of routine reports, and mail.

- Throughout the entire integration process, management must be particularly sensitive to the feelings and perceptions of employees, especially those who are directly impacted by the changes. Those who comprise the most vulnerable group, and are most able to adversely impact the merger if they are not on board, are the mid-level managers, especially displaced Service Chiefs. It is essential that they be treated with sensitivity, dignity and respect. Every effort should be made to accommodate them and place them in a productive, rewarding position that capitalizes on their expertise. Displaced employees must know they are valued by management.

In summary, the Palo Alto/Livermore consolidation has been a huge success. Some things, such as a single affiliation and the opportunity for prior planning, probably made the situation easier to manage. On the other hand, the perception of a big institution gobbling up a smaller one, the decades of rivalry between the institutions, the major cultural differences between the institutions, and the administrative delays once a decision was made to consolidate, contributed to the challenges we faced. Some of the major positive outcomes of this facility integration follow:

- An immediate reduction of 78 FTE and elimination of approximately $500,000 in contract hospital costs at Livermore resulted in cost efficiencies amounting to approximately five million dollars. It is worth noting here that we are currently operating the entire Palo Alto Health Care System, which includes the previous Palo Alto and Livermore facilities plus new clinics in

San Jose and Monterey, with the same FTE numbers that were at Palo Alto alone four and one-half years ago.

- We are now serving more veterans than the combined facilities served prior to the consolidation, and Livermore has become a major ambulatory care and extended care facility which also serves as a feeder for the expansion of access points in the Central San Joaquin Valley.

- Waiting times in clinics have been reduced and, wherever possible, veterans have been redirected to the clinics that are closest to where they live.

- Not only are more services being offered at Livermore, there is also significant indication that the quality of those services has been improved and there is now a single standard of care across the entire Palo Alto Health Care System.

- When veterans must be referred between facilities, it is now an entirely seamless process with no road blocks to veterans wishing to access services at another campus.

- The efficiencies realized by the integration have helped us deal with tight budgets and increased medical care inflation without reducing care to veterans.

- Benefits have accrued to both Palo Alto and Livermore. Palo Alto staff now venture beyond the walls of the teaching hospital, which is essential in today's health care environment. Livermore has realized increased flexibility and access to the resources of a much larger health care system, which has contributed positively to the programs at Livermore. In my opinion, there is no down side to the Palo Alto/Livermore integration. I believe everyone has won in this process, and the most important winners have been the veterans we serve.

As we debate the pros and cons of integrating VA facilities, I hope we do not lose sight of the fact that consolidation is not an end in itself, but a means to attaining the larger organizational goal of improving services to veterans.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the Committees may have.

STATEMENT OF

DENNIS H. SMITH

DIRECTOR, VA MARYLAND HEALTH CARE SYSTEM (VAMHCS)

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEES ON HEALTH AND ON OVERSIGHT AND

INVESTIGATIONS

HOUSE OF REPRESENTATIVES

JULY 24, 1997

INTRODUCTION

Mr. Chairman and members of the Subcommittees:

It is my pleasure today to share with you the Department of Veterans Affairs' experience with integrating the VA Medical Centers in Maryland. These facilities are the Baltimore, Fort Howard, and Perry Point Medical Centers, as well as the Baltimore Nursing Home located on Loch Raven Boulevard and Cambridge Community Based Outpatient Clinic. On March 17, 1995, the Under Secretary for Health of the Department of Veterans Affairs officially announced that the VA Medical Centers in Maryland would be one of seven integrations approved nationally. Furthermore, our integration was one of two, involving three medical centers during this first round of medical center integrations.

FACILITY BACKGROUND

The Maryland integration includes three VA Medical Centers, one Free Standing Nursing Home Care Unit, and one Community Based Outpatient Clinic. The mission of each organization complements the other to form a comprehensive continuum of medical care for Maryland veterans. In fact, because of the complementary missions and geographical proximity, there has always been a natural pattern of interfacility patient referrals and shared services. Of the 38,396 veterans provided services at these facilities, at least 25 percent received services at 2 or more of the facilities. At this time I will briefly give you a descriptive profile of each.

Baltimore VA Medical Center – The Baltimore VAMC is a tertiary care facility which has 163 acute operating beds and provides comprehensive ambulatory care, medical, surgical, neurological, psychiatric, rehabilitative, geriatric (GRECC), educational, and research services in a modern state-of-the-art medical care facility. Connected both physically and functionally to the University of Maryland Hospital, the Baltimore VAMC is affiliated with the University of Maryland Medical, Dental, Pharmacy, Nursing and Social Work Schools. Last year we had 6,728 discharges from inpatient care and 264,640 outpatient care visits. The new medical center opened in 1993 and is located in downtown Baltimore approximately 17 miles from Fort Howard and 48 miles from Perry Point. It replaced the old medical center on Loch Raven Boulevard that is now the location of a new VA nursing home.

Fort Howard VA Medical Center – The Fort Howard VAMC is a subacute, rehabilitation facility which has 154 hospital operating beds and provides rehabilitation medicine, geriatric medicine, substance abuse rehabilitation, subacute care, and outpatient services. It operated a 47 bed nursing home care unit that was closed in 1996 with the opening of the new nursing home in Baltimore. Inpatient care provided for 1,750 discharges last year and 44,850 outpatient visits. This medical center is located in Baltimore County approximately 17 miles from Baltimore and 45 miles from Perry Point.

Perry Point VA Medical Center - The Perry Point VAMC is a psychiatric, long term care facility with 305 hospital operating beds which primarily provides comprehensive psychiatric and medical care with a focus on long term care. It also operates a 80 bed nursing home care unit and 25 bed domiciliary. Inpatient care provided for 2,830 discharges last year and 86,011 outpatient visits. The medical center is located in Cecil County approximately 48 miles from Baltimore and 45 miles from Fort Howard.

Cambridge Community Based Outpatient Clinic – The Cambridge clinic provides primary care services in addition to medicine, psychiatry, podiatry, optometry, psychology, and other support and ancillary services. There were

16,752 visits last year. The clinic is located on the Eastern Shore of Maryland in Dorchester County approximately 92 miles from Baltimore, 97 miles from Fort Howard, and 100 miles from Perry Point.

Baltimore Rehabilitation and Extended Care Center (BRECC) – The BRECC is a freestanding 120 bed nursing home that opened in August of 1996. Although it was not activated during fiscal year 1995, it was included in the planning and implementation process of the integration. It is located in Baltimore City at the old hospital site (Loch Raven Boulevard) approximately 7 miles from the Baltimore VAMC.

INTEGRATION PROCESS

The Maryland integration was approved March 17, 1995. In July 1995 the senior management of Baltimore and Fort Howard integrated and in November 1995 a single governance was formed under the leadership of one Director when Perry Point joined the integration with Baltimore and Fort Howard. This was a significant milestone and marked the formal beginning of the implementation process. Other significant milestones that occurred over the last 20 months include:

Milestone	**Date**
Data Base Merger	October 1995
Strategic Plan & Market Research	March 1996
Organizational Chart Approved	April 1996
Activation of BRECC	August 1996
Hospital Accreditation Survey by the Joint Commission on Accreditation of Healthcare Organizations	August 1996
Integration Labor/ Management Partnership Council	December 1996
Integrated Policies	April 1997
Committee Structure Totally Completed	June 1997
Integrated Medical Staff & Bylaws	July 1997
Integration Evaluation	Planned for August 1997

MAJOR ACCOMPLISHMENTS

The primary goals of the integration are to improve patient satisfaction, improve access, increase efficiency, enhance quality, and reduce cost. These goals were the driving force behind designing and implementing a new integrated organization and every accomplishment throughout the process can be directly associated with one of these goals. At this point I will inform you of major accomplishments within various categories and state associated cost savings when appropriate.

Consolidation, Mergers, & Outsourcing

Major Accomplishments:

1. Closed 232 inpatient beds and opened 120 nursing home care beds, 25 domiciliary beds, 29 hoptel beds and 32 substance abuse transitional residential beds.
2. Closed Fort Howard Nursing Home Care Unit made possible by opening the new Baltimore 120 bed nursing home and consolidating the two programs there ($2,800,000 savings).
3. Closed Physical Medicine and Rehabilitation beds at Baltimore and consolidated the program at Fort Howard ($240,735 savings).
4. Closed Medical Intensive Care Unit beds at Fort Howard and consolidated the program at Baltimore. Reduced Medical Intensive Care Unit beds at Perry Point and consolidated medical care units ($651,000 savings).
5. Consolidated laboratory test, changed ordering patterns, and consolidated reference lab contracts ($800,000 savings).
6. Consolidated Nuclear Medicine, tele-radiology, and imaging ($390,000 savings).
7. Consolidated three previously autonomous programs into one Mental Health program ($2,000,000 savings).
8. Consolidated Dentistry ($188,000 savings).
9. Centralized physician credentialing and privileging program to serve the integration through a unified medical staff office located in Baltimore.
10. Consolidated/merged all services except Police and Security Service.
11. Consolidated warehouse functions at Perry Point.

Savings & Reinvestment

Major Accomplishments:

1. Consolidated medical supply contracts ($85,000 savings).
2. Increased capacity of Same Day Surgery ($258,973 savings).

Personnel

Major Accomplishments:

1. Reduced 297 FTEE through attrition while opening the 120 bed nursing home (approximately $12,000,000 savings). Some of these savings are accounted for in the previous savings mentioned.
2. Reduced 25 supervisor positions between March 1996 and March 1997.

New Management Structure

Major Accomplishments:

1. Completed a major redesign of the organization into six product/service lines. Every employee was given a copy of the new organizational chart for comment before approval.
2. Consolidated Medical Administration Service and Information Resource Management Service into one service, Information and Health Benefits Service.
3. Totally decentralized budgets for all services and product lines to ensure accountability and effective use of resources. There are currently 26 decentralized budget units.
4. Decentralized positions in nursing and social work to product lines to improve continuity of patient care.
5. Established a management/labor integration partnership council in addition to the medical center partnership councils.
6. Eliminated 226 policies through consolidation and standardization of procedures.

Stakeholders

Major Accomplishments:

1. Effectively communicated to our employees, veteran service organizations, unions, affiliates, congressional delegation, and others through the implementation of a comprehensive communication plan.
    a. Employees were involved and informed through various mediums (i.e. newsletter, 1-800 hotline, electronic mail groups, work groups, open forums with top management, etc.). The proposed integration organizational chart was distributed to "All" employees for comment before approval.
    b. Veteran service organization representatives were involved through membership on the Integration Steering Council which met weekly to make key integration decisions. I also made numerous presentations to different veteran service organizations.
    c. The University of Maryland, School of Medicine was briefed monthly at my standing monthly meeting with the Dean and at the quarterly Deans Committee meeting. The University of Maryland, School of Medicine, has fully supported the integration effort.
    d. Union representatives were appointed to the Integration Steering Council. Separate meetings with union officials were also held concerning key issues, such as, closing the Fort Howard Nursing Home.
    e. Congressional staffs were kept informed through monthly update reports, meetings with Congressmen and Senators, and presentations to congressional staff members.
    f. Patients were informed through a patient newsletter, display posters, and informal dialogue with their providers.

Clinical & Administrative Programs

Major Accomplishments:

1. Received highest score ever for JCAHO accreditation at all three medical centers in August 1996. Averaged a score of 95.

2. The Baltimore VA Medical Center research program was ranked number 19 nationally within the Veterans Health Administration in fiscal year 1994. After integration, the VA Maryland Health Care System was ranked number 1 in fiscal year 1996 based on total number of research projects and funds received.
3. Met all VHA target performance measures for fiscal year 1996, and exceeded four out of the six incentives.
4. Increased patient satisfaction by 2 standard deviation points better than the national average in fiscal year 1996.
5. Expanded patient and employee transportation network.
6. Converted inpatient space to outpatient clinic space.

BENEFITS

In addition to the obvious benefit of the financial rewards I previously mentioned, the VA has transformed itself into a modern business entity capable of delivering quality services which meet community standards and address business trends. The savings generated through the integration process have enabled us to manage budget constraints without the need of implementing a Reduction in Force (RIF). More importantly, healthcare services available to veterans have been enhanced tremendously through the creation of a seamless continuum of care managed by one executive team. We are now in a better position to quickly respond to changes in the healthcare industry, changes in the workforce culture, and meeting the changing needs of our veterans.

CONCLUSION

In conclusion, we have accomplished cost savings of approximately $15 million dollars and reduced Full Time Equivalent Employees by 297 while simultaneously expanding and improving the quality of patient care services for veterans. We believe our efforts have met the intent of integration in a means that is mutually beneficial to all stakeholders affected. We have expanded our continuum of care to veterans, reduced duplication of services, enhanced quality of service, and shifted program emphasis from inpatient care to outpatient care.

However, we do not want to suggest that our accomplishments occurred without struggle. As expected in some cases we were presented with challenges in the areas of employee

compensation, labor relations, transportation, and employee morale. Each was effectively addressed and we have been able to move forward in a positive manner.

The ultimate measure of success will be determined by our ability to offer the right type of care, at the right level of care, at the right time to the veteran. We sincerely believe that the integration has enhanced our ability to meet this challenge. Our merged data base expands the access of medical information to providers to support the right type of care, a continuum of care has been created to assist in ensuring the right level of care is available, and we are continuously assessing access points to ensure care is provided at the right time.

That concludes my statement, Mr. Chairman. I will be happy to answer any questions you or members of the committee may have.

United States General Accounting Office

GAO

Testimony

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

For Release on Delivery
Expected at 9:30 a.m.
Thursday, July 24, 1997

VA HEALTH CARE

Lessons Learned From Medical Facility Integrations

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-184

Messrs. Chairmen and Members of the Subcommittees:

We are pleased to be here today to discuss preliminary results of our ongoing work on the integration of medical facilities operated by the Department of Veterans Affairs (VA). In general, a VA integration involves a restructuring of the services within two or more medical facilities into a seamless health care delivery system.

VA operates 173 hospitals and over 200 freestanding outpatient clinics nationwide at a cost of about $17 billion a year. Two years ago, VA created 22 networks to help improve service delivery to the 3 million veterans who use its medical facilities each year. Each network is responsible for overseeing between 4 and 11 hospitals. To date, networks have initiated integrations in 18 geographic areas, involving a total of 36 hospitals.[1]

Our work to date has focused primarily on VA's ongoing integrations in Chicago, Illinois, and in Alabama. Our review of the Chicago integration is being done in response to requests by part of the Illinois congressional delegation, including Congressmen Evans and Gutierrez, who serve on the House Veterans' Affairs Committee, and Chairman Bond of the Senate Appropriations Committee's Subcommittee on VA, HUD, and Independent Agencies. Chairman Everett has asked us to review the Alabama integration.

We have visited the four medical facilities being integrated in Alabama and Chicago and their respective network offices. Also, to gain a broader perspective, we discussed VA's other 16 integrations with network officials and others. In addition, we discussed integration issues with several private health care providers and consulting firms.

As you requested, my testimony focuses on (1) the role of facility integrations in reshaping VA's health care delivery system and (2) lessons learned that could help enhance VA's process for planning and implementing ongoing and future facility integrations.

In summary, facility integrations are a critical piece of VA's overall strategy to enhance the efficiency and effectiveness of health service delivery to veterans. VA's strategy is similar to how the private sector health care industry is evolving. In essence, integrations can allow VA to provide the same or higher quality services to veterans at a significantly reduced cost. In just 2 years, by unifying management and consolidating services, VA's integrations have produced millions of dollars in savings that can be reinvested in the system to further enhance veterans' care.

But VA also faces inherent difficulties in planning and implementing integrations, primarily stemming from the potential adverse impacts on stakeholders such as veterans, facility and medical school personnel, and members of Congress who represent these groups. For example, while integrations will generally enhance VA's ability to serve veterans, they will likely result in, among other things, fewer, less convenient, or less desirable (1) employment opportunities for VA and medical school employees or (2) training opportunities for medical school residents and students.

With so much at risk, it is imperative that VA plan and implement integrations to maximize their benefits and minimize the adverse impacts. VA's integration planning approach has many positive features. For example, local facilities currently plan and implement their integrations using work groups comprising VA medical facility employees and others, such as affiliated medical school employees. The involvement of local facility employees in planning activities appears to expedite the process, primarily because no two integration situations are alike.

Our work to date, however, indicates areas where improvements could be made. For example, integration decisions are generally made incrementally, that is, on a service-by-service basis, at varying times throughout the process instead of being made on the basis

[1]See app. for a list of the 18 integrations.

of decisions about all activities across the integrated facilities. Also, planning and implementation activities frequently occur simultaneously, which does not allow for consideration of the collective effect of such changes on the integration. In addition, stakeholders are involved at varying times in different ways but are not always provided sufficient information at key decision points.

Currently, VA is considering ways to improve its facility integration process. With that in mind, our work suggests that VA could achieve better results by

- adopting a more comprehensive planning approach,
- completing planning before implementing changes,
- improving the timeliness and effectiveness of communications with stakeholders, and
- using a more independent planning approach.

BACKGROUND

Generally, the 18 integrations, with one exception, share some common characteristics. For example, most of VA's integrations to date involve (1) facilities that have complementary missions, such as acute and mental health care; (2) one facility that is significantly larger than the other(s); and (3) only one or no facility(ies) with a strong medical school affiliation. By contrast, Chicago's Lakeside and West Side facilities have almost identical missions, are about the same size, and have strong affiliations with major medical schools.

VA's facility integrations use different ways to improve management, clinical, and patient support services. These include

- unifying management by creating a single team to manage all facilities instead of using separate management teams at each facility;
- consolidating a service by moving all employees and patients to one facility rather than continuing to provide the service at multiple locations;
- centralizing a service by moving some but not all of the employees associated with it to one of the facilities;
- contracting out some services that VA employees have historically provided; and
- reengineering service delivery by designing more efficient and effective ways to do business.

Of the 18 integrations, 5 have reported that all activities have been completed and they anticipate no additional changes to their management or delivery structure at this time. The remaining integrations are in various stages of planning and implementation, and several anticipate completion within the next several months.

FACILITY INTEGRATIONS PLAY A KEY ROLE IN RESHAPING VA'S HEALTH CARE DELIVERY

Facility integrations are a critical part of VA's nationwide strategy to restructure its health care delivery system to improve access, quality, and efficiency of care to veterans. VA's restructuring plan reflects, in large part, the changes that have been under way in the private sector health care system for some time. Profound changes in the health care environment brought about, in part, by technological advances, economic factors, demographic changes, and the rise of managed care are causing a dramatic shift away

from inpatient care and a corresponding increase in outpatient care. Toward that end, VA has been establishing new community-based clinics, emphasizing primary care, decentralizing decision-making, and integrating facilities to provide an interdependent, interlocking system of care. VA's progress to date indicates that integrations are having positive results, but it remains to be seen whether integrations will reach their maximum potential and accomplish what VA intends and veterans need.

Integrating health care facilities is a complex process that requires careful planning because it can have an adverse affect on many stakeholders, such as veterans, facility employees, and medical school personnel. For example, facility integrations will undoubtedly alter the way veterans receive health care. Historically, each VA facility has generally tried to provide veterans with one-stop service delivery, that is, to provide as many services as possible at a single location. After consolidating services as part of integration, more veterans may have to go to more than one location for care. For example, when acute inpatient care is moved from the Tuskegee hospital to the Montgomery hospital, veterans receiving primary care at Tuskegee will have to use the Montgomery facility when they need a hospital admission. These changes will generally bring VA service delivery practices more in line with those of the private sector.

Integrations nevertheless provide significant benefits to veterans primarily because VA can reinvest the money it saves in access and service improvements. VA estimates that integration of facilities has generated over $83 million in savings, which has been used, in part, to (1) provide new community-based clinics that expand veterans' access to primary care, (2) offer new services at existing medical facilities, or (3) make existing services more accessible through longer operating hours or shorter waiting times.

Facility integration has also had a significant impact on VA employees. Most savings are achieved by reducing the number of employees providing the same services at multiple medical facilities within the same geographic area. To date, VA has been able, for the most part, to accomplish this reduction through buyouts and routine attrition, although some reductions-in-force were or will be used. In some situations, employees will move from one medical facility to another or transfer to different positions within their current facility, which may require retraining.

In addition, medical school personnel are affected by the integrations. As VA reduces unnecessary duplication of services, medical schools may have to share management of integrated services, which would result in a reduction in the number of physicians employed and residents trained. In addition, some would have to travel to different facilities rather than continue to provide services at their present locations. For example, medical school employees and others may have to travel between the Lakeside and West Side facilities, a distance of about 6 miles.

LESSONS LEARNED THAT COULD ENHANCE VA'S FACILITY INTEGRATIONS

Because of the large reinvestment opportunities potentially available, facility integrations are one of the best ways VA has to improve quality and access to care for veterans while also increasing the efficiency of health care delivery. Currently, VA is considering ways to improve its facility integration process. On the basis of our visits to the Chicago and Alabama facilities and discussions with officials involved with the other 16 integrations, we also believe that improvements can be made to VA's integration process. Our discussions with several private sector health care providers who are involved with major facility integrations have indicated to us that adopting the following changes could bring VA's process more in line with private sector integration practices.

Using a Comprehensive Planning Approach

Integration of VA medical facilities may be more successful if done on a comprehensive planning basis. Such an approach could involve, among other things, a

thorough assessment of all potential resources needed to meet the expected workload over the next 5 to 10 years in a geographic service area. At present, VA does not always include these elements in its planning process. Consequently, integration planners are not always considering all viable options, changing conditions, and future investments. This could cause VA to miss better options, which could greatly lower the dollar savings and thus reduce reinvestment opportunities to improve veterans' care.

Comprehensive planning for integration of services that includes all VA facilities within the same geographic service area expands the options available for consideration. For example, in the Chicago area, four VA facilities within 35 miles of each other serve essentially the same veteran population. If veterans' current inpatient needs could be met in three rather than four locations, VA could save about $20 million annually in operating costs, although some of the savings may need to be reinvested to increase outpatient capacity at the three locations or in community clinics. Operating in fewer locations also could generate additional savings by avoiding future renovations and equipment replacement, and possibly through the sale or lease of excess capacity.

VA may realize greater results over the long run if it uses a longer planning horizon. This could enable VA to determine how its current workload will compare with its future resource needs. For example, as in the private sector, VA's inpatient workload has been decreasing and is expected to continue decreasing over the next 5 to 10 years. If inpatient workload continues to decrease, excess hospital space will increase. Thus, if it uses current workload as a basis, VA may decide that it is not viable to consolidate services, but if it uses future workload estimates, VA may conclude that it is viable to consolidate.

VA may also realize better results if its planning considers all potential resources needed over the next 5 to 10 years. If VA plans for veterans' current needs, it risks using funds for construction, renovation, and equipment that may yield short-term benefits only. For example, in Chicago, VA approved renovations of Lakeside's surgical intensive care unit and emergency room, and the replacement of its cardiac catheterization equipment. For West Side, VA approved the replacement of the angiography suite. If, within 5 to 10 years, the inpatient workload is consolidated at one facility, VA would have realized limited benefits from some of these investments.

Completing Planning Phase
Before Implementing Changes

VA's decision-making may be enhanced if it completed all planning for the integrated facilities before beginning to implement the integrations. Each of its 18 facility integrations involved between 2 and 35 work groups to develop proposals to integrate management, clinical, and patient services. VA currently begins implementing proposals as they become available from the various work groups, without first examining all proposals together for an overall perspective.

VA's integration process contains one common decision point–headquarters' approval of the initial proposal to integrate. With this approval, VA essentially decides to operate two or more facilities as a health care system using a single management team. Once an integration is approved, the director for the new system sets up governing boards to direct and oversee the integration process and decision-making. The boards establish work groups to analyze data and explore integration options. Typically, as each work group completes its planning, it submits an integration proposal to the board with recommendations to the director. Once the board approves the recommendations, the director generally begins implementing them.

This incremental approach runs the risk that later work group proposals could affect previously implemented actions. In addition, it is especially difficult, if not impossible, to assess the reasonableness of VA's decisions when they are made incrementally. For example, VA decided to relocate some administrative staff from the Montgomery to

Tuskegee facilities, primarily because VA concluded that sufficient space was not available at Montgomery. But VA had not yet determined how much staffing was needed for a number of other services at Montgomery before implementing these changes. This occurred primarily because, at the time, planning for those services was not completed. VA was still considering, for instance, several options for restructuring Montgomery's and Tuskegee's nutrition and fiscal services, which could greatly affect the availability of space in the Montgomery facility.

VA recognizes the need for a more structured process. Two months ago, it established a team to revise its integration guidance. VA is considering adopting a five-phase process that includes conceptualization, quantitative and qualitative analyses, implementation planning, implementation, and evaluation. These are logical phases in that the end of each phase seems to provide a decision point at which stakeholders may efficiently and effectively participate in VA's process. Moreover, this process suggests that decisions on the proposed integration of services on a facility-wide basis will be made only after planning is completed, because the next phase focuses on the implementation of the plan. As such, this approach should help VA make better integration decisions.

Providing a Detailed Integration Plan to Stakeholders Before Implementation Begins

Stakeholder participation in the process could be enhanced if VA provides a detailed integration plan before implementation begins. VA encourages local facilities to have early and continued stakeholder involvement. The local facilities have worked hard to involve stakeholders by using such techniques as meetings, letters, briefings, newsletters, and videos.

Stakeholders, however, have sometimes found it difficult to understand and support VA's actions because they were not provided sufficient information about the integrations, such as

- how services will be integrated,
- how potential changes will affect veterans and employees,
- why selected alternatives are the best ones available,
- how much the potential changes will cost to implement,
- how much the potential changes will save, and
- how VA will reinvest savings to benefit veterans.

For example, for the Montgomery/Tuskegee integration, VA decided to consolidate administrative services by moving most employees from Montgomery to Tuskegee. However, it made this decision before determining how many or which employees would be moved or what it would cost to renovate the space needed to accommodate the increased number of administrative staff at Tuskegee. Therefore, VA officials could not answer some key questions raised by congressional stakeholders.

VA's incremental planning approach contributes to these communication problems because it limits the amount of information available about the integration before implementation begins. Providing this information would enable VA to communicate more effectively with stakeholders. Moreover, presenting such planning results in a written document that could be shared with stakeholders would further enhance the opportunity for effective communication by allowing VA to obtain stakeholders' views and gain support or "buy-in" for its proposed integration activities.

Using an Independent Planning Approach

Objective facility integration planning based on independent judgment is critical to successful integrations. Making decisions to restructure medical facility services when the decisions could adversely affect the planners' own interests presents an inherently difficult situation. Many competing interests are at stake in VA's integrations, including those of VA employees, medical school personnel, and residents of affected communities. As planners, these groups may not aggressively consider all viable options and may avoid difficult choices by focusing only on marginal changes to the status quo. In such situations, VA integrations might yield less than their full potential benefit to veterans, needlessly limiting savings available for reinvestment.

For example, in the West Side and Lakeside integration, VA uses work groups to study integration of individual clinical services. Medical school faculty chair the work groups that will make proposals for how VA will integrate two of the more important services–surgery and medicine. The work groups are expected to address integration of management and consolidation of services. A potentially divisive issue is whether to consolidate clinical services and, if so, where the consolidated services should be located. Because the planners will be greatly affected by the outcomes, it has proven extremely difficult for the competing medical schools to address this issue.

To overcome this problem, a more independent planning approach using planners (full-time VA planners or consultants) with no vested interests in the geographic area could be used to develop data, explore options, and recommend actions to the network director.

In conclusion, VA has only scratched the surface in reaping the benefits of medical facility integrations; the greatest benefits are yet to be realized. Effective integrations involve difficult choices and, as we discussed today, the decisions should be objective and in the best interests of veterans. Toward this end, we encourage VA to continue improving its integration process, because every dollar saved by integrating in a more efficient way can be reinvested to better meet veterans' medical needs or serve veterans who might otherwise not be served.

This concludes my prepared statement. We will be glad to answer any questions you or members of the Subcommittees may have.

VA'S APPROVED INTEGRATIONS

VISN[a]	VA health care system	Integrated facilities
1	Connecticut	Newington, CT; West Haven, CT
2	Western New York	Batavia, NY; Buffalo, NY
3	New Jersey	East Orange, NJ; Lyons, NJ
3	Hudson Valley	Castle Point, NY; Montrose, NY
4	Pittsburgh	Pittsburgh (Highland Drive), PA; Pittsburgh (University Drive), PA
5	Maryland	Baltimore, MD; Fort Howard, MD; Perry Point, MD
7	Central Alabama	Montgomery, AL; Tuskegee, AL
11	Northern Indiana	Fort Wayne, IN; Marion, IN
12	Chicago	Lakeside, IL; West Side, IL
13	Black Hills	Fort Meade, SD; Hot Springs, SD
14	Greater Nebraska	Grand Island, NE; Lincoln, NE
14	Central Iowa	Des Moines, IA; Knoxville, IA
17	North Texas	Bonham, TX; Dallas, TX
17	Central Texas	Marlin, TX; Temple, TX; Waco, TX
17	South Texas	Kerrville, TX; San Antonio, TX
20	Puget Sound	American Lake, WA; Seattle, WA
21	Palo Alto	Livermore, CA; Palo Alto, CA
22	Southern California System of Clinics	Sepulveda, CA; Los Angeles, CA

[a]Veterans integrated service network.

(406142)

Testimony before the Sub-Committees on Health and on Oversight and Investigations for a Joint Hearing on July 24, 1997
at the 334 Cannon House Office Building

Good morning. My name is Paula Widerlite and I am the Senior Director for System Strategy of Adventist HealthCare. We are an integrated delivery network based in Montgomery County, Maryland. Our organization has annual revenues of over $400 million dollars and 5,000 employees, making us the second largest private employer in Montgomery County.

In 1993, the need to develop a vertically and horizontally integrated and coordinated system of care for the residents of Montgomery and Prince George's County, Maryland, was recognized by the leaders of the Adventist HealthCare organization. At that time, there were several governing boards responsible for two acute care facilities, four nursing homes, a home health agency and other affiliated health care services. Through a strategic planning process during 1993, it was agreed that those operating units would be integrated and operate under the governance of one board of directors, one president and CEO and one management team.

Since that time, the level of integration among those operating units has primarily focused on integrating management support functions; such as, finance, information systems, human resources, strategic planning and marketing. However, the objective was to produce a seamless continuum of care of which a major component would be clinical integration. The strategic plan that called for the integration of these operating units was implemented during the period of 1994 and 1995. At the end of 1995, the strategic planning process was initiated again with a planning horizon of another 24-month period. In just that short span of time new critical success factors and goals were identified and a changed course of direction was charted different than that which was set out in 1993.

The revised strategic plan that was approved by the board of directors in October of 1996 was revised sixty days later in December of 1996 because an important market condition had changed

for us and an opportunity had presented itself which led the President/Chief Executive Officer to go back to the Board of Directors and ask them to accept a modification to the strategic plan that they had just approved sixty days prior.

Those sorts of actions, those sorts of market condition dynamics exist almost on a daily basis for the health care industry, particularly in this region. Maryland and the Washington, D.C. market place has one of the highest penetrations in the country for managed care, which is the single most important market place condition that drives an organization such as ours to develop strategic initiatives to enable it to continue to provide the level of service and standard of care that the community has come to expect.

Some of the lessons that we have learned through this journey over the past four years have been that there is no one prescriptive method for integration that a health care organization can adopt. We received lots of advice, did lots of research on our integration efforts back in 1993. And over several months quickly found that we needed a much more customized, flexible and responsive approach to restructuring our organization. We have some unique features, being based in the State of Maryland; namely, operating in a rate-regulated all-payor system. So, when we get advice from experts and consultants and read the literature about integration efforts across the country, it becomes painfully obvious to us that those methods may not be effective or ones that meet our objectives as an organization.

In some areas of the country, managed care may be the driving force for market consolidation and integration. In other markets, preserving access to high quality, cost-effective services may be the need. In others, the need may be to reduce excess capacity, to rationalize services and thereby avoid duplication. Some may need access to capital to fund improvements. And perhaps others may be facing a combination of some or all of these factors. The most difficult steps of rationalizing scarce resources and refraining from duplication are seldom if ever accomplished. We're proud to have been among the few to achieve that goal.

Another lesson that we've learned is that the process of integration is just that. That it's a process. That it should not be an objective in and of itself. That it tends to proceed along evolutionary lines, first beginning with the integration of governance, then management support, then ultimately clinical and physician integration. Those first areas of governance and management support functions tend to be, and this could be obvious to most, significantly less complex than the issues of clinical integration. The importance of the process of integration is the participation, input and commitment from all of our stakeholders in this process. Ultimately, our objective, which is consistent with our mission as a faith-based organization is to enhance the patient's experience.

It may appear to some that as hospitals, nursing homes and home health agencies owned and operated by a common organization, that is the Seventh-day Adventist Church, integrating should be a relatively simple process. On the contrary, coming together to meet market-place demands, meeting patient expectations, reducing costs, improving efficiencies for the health care system in general, all of which can be improved through integration, was as difficult for us, if not more difficult, than organizations which were unrelated initially. It was a relatively smooth transition to develop a common mission and vision for our organizations. However, some of our organizations had 100 years of experience of operating independently and as free-standing institutions, developed independent cultures. The changes that would be required to blend disparate cultures were challenging for us and in some regards continue to be a challenge. We've seen some cycles of change concerning integration. First, there was buy in from the operating units in support of centralization and integration. Subsequently, a wave of a different culture began to emerge where separate identities was valued over a system-wide approach. Communities, physicians, and patients also tend to identify with hospitals and <u>not</u> systems of care. Now, another change may be surfacing whereby the benefits of integration can be realized by employees and community-based agencies.

We remain firmly committed to the notion that an integrated delivery system which enhances a patient's experience is ultimately the most effective care delivery model. To that end, we believe

that the network that we've developed meets our needs given the current conditions. We also fully expect that the model will be modified from time to time as is necessary. We expect to redefine what it means to be an integrated delivery network. Our strategic planning horizons seemingly continue to be shortened from five years to two years to sometimes down to almost six months at a time; however, we will continue the course of aspiring to develop a rational integrated system of care for our community.

Thank you for the opportunity to address your sub-committee.

Paula S. Widerlite
Senior Director, System Strategy
Adventist HealthCare
1801 Research Boulevard, Suite 300
Rockville, MD 20850
(301) 315-3033

Qualifications

Extensive experience in the health care industry with an emphasis on marketing, strategic planning, new business development and physician relations.

Experience and Career Achievements

Senior Director, System Strategy *1994 - Present*
Adventist HealthCare, Rockville, MD

Adventist HealthCare is an integrated delivery system providing the full continuum of services in Suburban Maryland. With operating revenue in excess of $400 million, Adventist HealthCare leads the region in market share in key service lines such as cardiovascular surgery (900 surgeries and 4,500 diagnostic and interventional procedures), maternal-child services (6,000 deliveries), oncology, behavioral medicine and prevention and wellness. The system consists of 553 acute care beds, 800 skilled nursing beds at 7 centers, 500,000 home health visits, 4 urgent care centers, assisted living and adult day care.

Responsibilities include:

Assisting the President and CEO on a daily basis in the system's overall strategy setting.

- Designed and implemented strategic planning on a service line basis during the formation of the integrated delivery system that facilitated clinical integration among operating units and resulted in enhanced market share from 1992 to 1996:

Overall:	22.8 to 23.2%	Psychiatry:	18.8 to 23.9%
Pediatrics:	16.6 to 31.7%	Oncology:	19.6 to 23.3%

- Established and gained approval for the system's goals, critical success factors, vision, mission and value statements.

Managing $1.6 million department budget for strategic planning, marketing and communications.

Supporting new business development and strategic alliances.

(2)

- ❖ Facilitated network development among specialty hospitals and community-based providers.

- ❖ Facilitated joint venture between primary organized care physician network and Adventist HealthCare.

Acting as the executive responsible for ensuring cohesion and strategic alignment for all system planning activities.

- ❖ Conducted comprehensive environmental assessments for key service lines and alternative health care entities from prevention and wellness to home health and long-term care.

Setting direction for the government relations program.

- ❖ Successfully lead regulatory process that resulted in award of CONs for comprehensive inpatient rehabilitation, neonatal intensive care unit and skilled nursing facilities.

Coordinating annual educational meetings for system board of directors.

Director of Strategic Planning and Professional Relations — *1992 - 1994*
Washington Adventist Hospital, Takoma Park, MD

Provided overall coordination of the planning activities for this 300-bed tertiary care hospital. Responsible to develop the official strategic plan and to facilitate the planning process for each service and department. Represented the hospital to external groups such as regulatory agencies and state health planning commissions. Directed the activities of the professional relations department which has as its focus programmatic initiatives to cultivate and maintain productive relationships with the medical staff.

Director of Marketing — *1988 - 1992*
Emergency Medicine Associates, Bethesda, MD

Directed the marketing activities of a multimillion dollar emergency medicine professional corporation. Responsible to identify opportunities for revenue enhancement, market penetration and profitability improvements. Assisted the group in developing and implementing diversification strategies such as drug-free workplace compliance programs as well as strategic planning and marketing consulting services to hospitals and private medical group practices. Duties included strategic management, planning, market research and analysis, promotions, demand forecasting and physician recruitment.

Hospital Service Representative *1985 - 1988*
Capitol Hill Hospital, Washington, DC

Served as the physician liaison for a local community hospital within the Medlantic Health Care Group multi-hospital system. Responsibilities included increasing inpatient and outpatient utilization rates from targeted physicians. This position required extensive trending and historical data analysis and results tracking as well as excellent communication skills.

- ❖ Designed and implemented physician relations programs (medical staff development, recruitment, retention and succession planning) that resulted in significant increases in inpatient and outpatient volume.

Director, Medical Staff Services *1981 - 1985*
Capitol Hill Hospital, Washington, DC

Managed the administrative functions of the medical staff organization. Responsibilities included credentialing, compliance with local and national regulatory agencies and quality assurance. This position demanded strong organization and leadership skills.

Professional Affiliations

American College of Health Care Executives, Associate Member, 1993
Capital Area Society for Health Care Planning and Marketing, 1992
Academy for Health Services Marketing of the American Marketing Association, 1990
American College of Health Care Executives Women's Forum, 1987 - 1991
National Association Medical Staff Services , 1982 - 1991

Education

B.A., Business Administration, Special Concentration in Marketing
Trinity College, Washington, DC

Honors

Magna Cum Laude, GPA: 3.89/4.0
Alpha Sigma Lambda National Honor Society

Faculty Appointment

Adjunct Faculty, Business Administration Department, Columbia Union College, 1995

References

Available upon request

ADVENTIST HEALTHCARE
1801 Research Boulevard • Suite 300 • Rockville, MD 20850 • (301) 315-3030 Phone • (301) 315-3000 Fax

July 24, 1997

Honorable Cliff Stearns, Chairman
House Veterans' Affairs Subcommittee on Health
338 Cannon House Office Building
Washington, DC 20515

Dear Chairman Stearns:

To my knowledge, Adventist HealthCare nor I have received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the July 24 hearing regarding the process of integrating a health care delivery system.

Respectfully,

Paula S. Widerlite
Senior Director
System Strategy

STATEMENT OF JAMES E. STARR, SENIOR ASSOCIATE, MCMANIS ASSOCIATES, INC.

ACCOMPANIED BY LINDA WENDT, PRINCIPAL ASSOCIATE

BEFORE A JOINT HEARING OF THE SUBCOMMITTEES ON
HEALTH AND OVERSIGHT
AND ON INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
REVIEWING THE VA'S PROCESS FOR INTEGRATING VA MEDICAL FACILITY MANAGEMENT,
CLINICAL SERVICES AND SUPPORT SERVICES

JULY 24, 1997

Messrs. Chairmen and Members of the Subcommittees:

Thank you for the opportunity to share my experiences and those of McManis Associates regarding the integration and consolidation efforts of Veterans Affairs (VA) medical centers. We appreciate the chance to discuss this important topic with members of Congress, VHA representatives, Veterans Service Organizations and other stakeholders.

McManis Associates is a management and research consulting company that specializes in the field of healthcare. We have assisted hundreds of healthcare institutions evaluate and implement mergers and affiliations across the country. I have been providing advice and consultation to the healthcare industry during the past five years, specifically in the areas of integrated system development, network affiliations, strategic planning and operations improvement. I have been working closely with VA medical centers over the past two years. This testimony is based on my experience in working with both private sector and VA healthcare institutions.

This country's healthcare delivery system is undergoing rapid and dramatic changes in both the way it delivers and finances healthcare in the private and public sectors. Today's healthcare consumers and payers are demanding higher quality and better access for lower costs. In addition, other factors such as the aging population and federal budget constraints have magnified these challenges. Healthcare providers in both the private and public sectors are seeking innovative solutions to these problems.

The private sector has responded to these challenges in several fashions. Managed care has increased its penetration nationwide from 36 percent in 1992 to 60 percent in 1996. This will increase even faster as government financed healthcare encourages beneficiaries to enroll in these managed care plans. Hospitals are rapidly creating new integrated delivery systems through affiliations and mergers. Physicians are forming large groups and corporations to better manage the care of their patients. Healthcare systems are examining ways to increase the

quality of care while reducing costs through aggressive care management, clinical pathways and other tools.

The VA is not immune to these challenges facing healthcare providers. Over the past two years, it has organized into integrated service networks and, with the implementation of the Veterans Equitable Resource Allocation, it has changed its funding model to guarantee that dollars follow the patient. These changes are in response to decreased funding levels and demands for better access. However, it is imperative that the VA continue to explore and implement ways to increase quality and access at reduced costs to ensure that those who have served our country receive quality healthcare.

Many of the Veterans Integrated Service Networks have explored and implemented "integrations" or consolidations of their Medical Centers. These mergers have achieved varying levels of results. We have found that there is not a standard cookbook approach to integrating medical centers in the VA. Several factors need to be considered: the populations served, the proximity of the facilities, the overlap of services, community resources, referral patterns, organizational cultures, and the viewpoints of concerned stakeholders. These considerations dictate how best to proceed in examining the potential integration of facilities.

Examining these issues is vital to the success of any integration and adds to its complexity. In addition, the VA has many stakeholders that need to be involved in the process. Other complicating factors include time (12 to 36 months depending on scope) and employee morale. When the VA decides to examine the potential of integration, employees' anxiety levels increase. The medical centers need to outline a clear vision and a high level plan quickly to begin addressing employee concerns and decrease the level of potential resistance. Lastly, any integration should not be approached as an endpoint, but more as a tool and process to effect significant and beneficial change in the way healthcare services are provided to veterans.

While there is no one right way to conduct an integration, we have developed a general process to ensure that the factors mentioned earlier are addressed. Our approach to the potential integration of VA medical centers includes three major phases: an assessment, creation of a vision and high level plan, and service specific cost/benefit analyses with ongoing implementation.

The first phase involves conducting an assessment of the overall market and organizational performance of the medical centers. This includes determining the current and projected populations served by the medical centers and their corresponding workload, examining referral patterns between the facilities, identifying duplicate and complementary services of the medical centers and assessing performance data such as cost and quality. A critical component of this phase is the involvement of stakeholders such as veterans, employees, affiliates, congressional offices and other key constituents. The focus is on identifying stakeholder concerns and potential barriers to change.

The outcome of the assessment is the determination of the appropriate level of integration: integrated information systems, integrated services and management, or full consolidation

and/or mission change. The compelling reasons for integration must be clarified and clearly communicated to all concerned stakeholders to gain their acceptance of the reasons for integration. This phase usually takes two to three months to complete.

Once a decision has been made to integrate and at what level, a greater degree of detail needs to be outlined. This is the focus of the second phase of integration: creating a vision for the integrated facilities. This involves identifying the specific areas for further study, developing the leadership and governance structure for the integrated facilities, and outlining a high level implementation plan that identifies the scope and timing of integration. We typically recommend that an integration board be established that is composed of administrative and clinical leadership of medical centers, union representatives and Veteran's Service Officers. This board should be facilitated by a third party such as a VA employee outside of the medical center's network or an outside consultant. Key outcomes of this stage are an overall vision, new leadership structure and a high level implementation plan. Stakeholder buy-in of these deliverables is vital to moving to the next phase of integration. We have found that this phase typically takes two to four months.

The last phase of integration is the most difficult and requires the greatest level of effort and time, generally six to thirty months. During this phase, specific work groups are established at the direction of the integration board and new leadership structure to examine the areas identified in phase two. The workgroups should include individuals providing the services being studied and key constituents. It should either be led or facilitated by an objective third party. This is crucial to ensure that those involved in implementing the changes are committed while the protection of parochial interests is minimized.

It is during this stage that specific cost/benefit analyses are conducted that examine the opportunities to improve service and quality, improve access and reduce costs or redirect savings. In addition to these opportunities, work groups should identify expected quantifiable outcomes and results. As recommendations are made, the leadership structure and integration board should move ahead with implementation in a timely manner. This is a key success factor for several reasons: resistance to change increases with time, changes are occurring at such a rapid pace that opportunities may be missed, and success breeds success.

Through our experience, we have identified several critical lessons:

1. **Communication with and involvement of stakeholders and employees is critical.** It is not enough just to communicate with stakeholders about potential changes and integrations. Stakeholders must be involved throughout the process in creating these changes and integrations. This is accomplished in the first phase through interviews and discussions with stakeholders. Key constituent representatives should be an integral part of the second and third phases through direct involvement on the integration board and work groups. Failure to involve stakeholders will contribute to the failure or minimal gains of an integration.

2. **Use an objective third party.** When integrating medical centers, there is too much vested interest and turf protection to generate solutions that provide the maximum benefit to veterans and overall cost reductions. Using a third party from outside of the concerned medical centers will minimize these risks.

3. **Demonstrate progress and results.** As integration moves ahead, employees, veterans, affiliates and other stakeholders need to see progress being made in the effort. A contributing factor to failure or to achieving only minimal gains is "paralysis by analysis," that is, taking too long to study the information asembled, cutting it in different ways, and gathering and reviewing data that are not relevant to the decisions being made.

4. **Have an overall plan to guide specific efforts.** While individual workgroups are studying specific areas, there needs to be an overall implementation plan to guide these efforts. In addition, the leadership or integration board needs to be able to see the systemic relationships between efforts and potential impact one work group's recommendations may have on current and future efforts.

5. **Don't expect significant results overnight.** Integrations cause major changes with how services are delivered, where people work and what people do. Because people are doing new things or doing them differently, and customers must orient themselves to new processes, improvements take time to materialize. This fact must be realized and communicated so that stakeholders do not have unrealistic expectations.

This concludes my prepared statement. We would be pleased to answer any questions. Thank you.

McManis Associates' Veterans Affairs Contracts
Relevant to this hearing
Fiscal Year 1995 through Present

VA MEDICAL CENTER OR VISN	CONTRACT AMOUNT
San Antonio Medical Center	$75,000
Pittsburgh Medical Center	$85,000
VISN 8 (Gainesville/Lake City)	$64,000

LINDA WENDT
Principal Associate

Linda Wendt has more than 20 years of experience working in healthcare management and consulting. She has extensive experience in the development of integrated healthcare organizations. She has formulated strategies for managed care organizations, network formations, and affiliation and merger initiatives. Ms. Wendt has facilitated the development of health maintenance organizations, physician groups and IPAs, and physician practice management companies.

Over the past 15 years, Ms. Wendt has held senior positions with three leading consulting firms, and has managed more than 250 engagements in 39 states. In addition to hospital and health system clients, she has worked with insurers, health maintenance organizations, medical group practices, and healthcare associations. She has assisted numerous clients in the development of certificate of need applications, and has testified in administrative hearings as an expert witness in five states

Ms. Wendt frequently conducts workshops, seminars and retreats with hospital boards and management, and physicians. She has addressed numerous healthcare associations, including the Michigan Hospital Association, the New Jersey Association of Healthcare Executives, and the American Hospital Association. She has assisted numerous clients in

Prior to consulting, Ms. Wendt held leadership positions with a health systems agency (HSA) where she was responsible for the development and implementation of population-based planning for a regional continuum of care. During her five years with the HSA, she also served as the agency's liaison with the state legislature.

Ms. Wendt received an M.H.A. in Health Systems Management from Tulane University and a B.A. in Economics from the University of New Orleans.

JAMES E. STARR
Senior Associate

Mr. Starr has been assisting healthcare organizations develop strategic plans, redesign core business processes, and manage change for the past six years. His areas of expertise include organization design, business process reengineering, strategic planning, change management, team development and continuous quality improvement. Mr. Starr's primary duties include developing and executing major organization redesign efforts by working directly with steering committees and design teams. He has performed organizational assessments, work flow analyses and structural assessments, and has helped organizations design and implement strategies to align core work, structure, and information with their strategy and core competencies.

His recent engagements include working with PacifiCare Health Systems, a California health maintenance organization, to redesign their healthcare delivery system and strengthen relationships with their provider network to create "virtual integration." This project has included working with several key provider groups to eliminate variability and redundancy between the groups and the health plan in areas such as joint planning and marketing, member education, member services, primary care physician access and the referral process. He then assisted them in developing a long-term strategy for building an information infrastructure.

Mr. Starr has managed and participated in projects for hospital systems to redesign their core work and support functions. He developed the overall reengineering strategy for Maryview Health System in Portsmouth, Virginia and worked closely with their steering committee and design teams. He helped them to identify outsourcing opportunities and radically redesign how they deliver inpatient care.

Mr. Starr assisted Charter Medical Corporation (now Magellan Health Services), headquartered in Atlanta, in redesigning how they manage their risk and quality management functions. Similarly, he assisted Waukesha Hospital in Wisconsin with their redesign effort. In Philadelphia, Mr. Starr developed a product line organizational structure for the Veterans Affairs Medical Center and created the strategic plan for the Veterans Integrated Service Network. He also assessed the feasibility of integrating two Veterans Affairs Medical Centers in Florida. He also implemented the integration of the Pittsburgh Veterans Affairs Medical Centers.

Mr. Starr holds an M.B.A. from Virginia Polytechnic Institute and State University and a B.A. in Organizational Communication from George Mason University.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1125
Jordan J. Cohen, M.D., President

on

Consolidation of VA Medical Facilities

Presented by

Jordan J. Cohen, M.D.
President
Association of American Medical Colleges

before the

Subcommittees on Health and on Oversight and Investigations
Committee on Veterans Affairs
United States House of Representatives
334 Cannon House Office Building
Washington, DC

July 24, 1997
9:30 am

Good morning. I am Dr. Jordan J. Cohen, President of the Association of American Medical Colleges (AAMC). I appreciate the opportunity to testify today about the integration of medical facilities within the Department of Veterans Affairs (VA) health care system. The AAMC serves as the national voice for the country's 125 medical schools, 86 professional academic societies, and nearly 400 major teaching hospitals, including over 70 VA medical centers. Currently, 139 VA medical facilities are affiliated with 103 medical schools. Each year more than 30,000 medical residents and 22,000 medical students receive a portion of their training in the VA.

The first priority of the VA must be to provide quality health care to our nation's veterans. Towards that end, I believe the VA's medical education and research missions add substantially both to the quality and accessibility of its health care services. Abundant evidence has accumulated over the more than 50-year history of VA-medical school affiliations of the countless advantages that stem from these partnerships. The VA's ability to recruit and retain high quality medical staff, the access of the VA's patients to the most advanced medical technology, and deployment of cutting edge research to problems of special interest to veterans are but some of the benefits that can be attributed to this historic partnership.

Affiliations are symbiotic arrangements that benefit not only the VA but its partner medical schools as well. While affiliations between VA medical centers and medical schools greatly enrich the patient care environment of VA medical centers they also enhance the educational and research programs of medical schools. Medical education depends, in substantial part, on hands-on experience by the learner under careful supervision. Effective education requires access to a diverse mix of patients who come to an academic medical center with the expectation that they will receive the highest quality, comprehensive, and compassionate medical care. In return for their participation in medical education, the patients at VA medical centers, like those cared for at all teaching hospitals affiliated with medical schools, gain access to talented faculty and state-of-the-art-treatment. The AAMC embraces the VA's primary purpose of providing quality health care to eligible veterans. We embrace it both because it is good for veterans and because it is good for students.

The AAMC is pleased to have the opportunity to work with the Congress and the VA to extend into the future the prominence of the Veterans Health Administration (VHA) as a comprehensive health care delivery system. If our nation expects the VA to provide effective and compassionate care for the bodies and minds of our nation's veterans, the VA should not be forced to limit its scope solely to those areas in which the VA has special expertise. One of the main reasons for the success of the VA's unique programs for patients with special needs is the infrastructure provided by comprehensive VA medical centers. This common support system is the necessary foundation upon which VA builds expertise in the specialized areas such as cardiac care, long term care, and substance abuse treatment. The new organizational structure in the VA should build on the foundation created by the joint medical school/VA partnership.

The future of the VA as a comprehensive high-quality health system currently faces serious challenges quite

similar to the ones that medical schools and teaching hospitals are encountering. The continued success and vibrancy of VA and academic medicine in the evolving health care delivery environment depends greatly upon our responses to these challenges over the next few years.

The VA intersects our nation's entire health care system at two crucial points, both of which deeply involve the VA's academic affiliations. First, the VA plays a critical role in the education and training of health care professionals who are destined to serve the entire nation. Second, the VA contributes in a major way to advances in medicine through a research program that has an impressive history of success and innovation.

Over the last few years, economic and competitive forces have begun pressing all medical centers to review their priorities and to provide health care more cost-efficiently. For academic medicine, the impetus for change has been the growth of managed care and the unwillingness of many employers and insurers to continue to pay their fair share of the costs associated with undergraduate and graduate medical education and with providing an environment in which research can flourish. For the VA health system, the impetus for change has been budgetary constraints in the face of considerable inflation in health care costs, the increasing needs of an aging patient population, and the need to keep pace with medical progress and innovation.

In response to these imperatives for change, both academic medicine and the VA are moving away from the traditional hospital-based model of health care delivery to one that emphasizes the delivery of care in ambulatory and out-of-hospital sites. Moreover, academic and VA medical centers are establishing new partnerships with other health care providers to increase efficiency, to rationalize resource distribution, and to manage effectively in the emerging health care marketplace.

The VA has developed an exciting new administrative structure for responding to the call for change and for implementing its various health-related missions. This new structure seeks to eliminate inefficiencies and duplication and to maximize the effectiveness of limited health care dollars and resources. Under the leadership of former Secretary Jesse Brown and Under Secretary for Health Kenneth Kizer, M.D., M.P.H., the Veterans Health Administration has organized its 171 medical centers into 22 regional systems know as Veterans Integrated Service Networks, or VISNs. Under each VISN umbrella, several VA medical centers and their associated or affiliated partners will work collectively to deliver health care to veterans in their region.

Among the attractive features of the new VISN structure is its emphasis on performance-based evaluation. VISN directors and other key leaders in the new system are informed prospectively about the goals they are expected to achieve and are systematically evaluated at an appropriate time to assess whether those goals were achieved.

The dramatic changes associated with the transformation of the VA health care system present significant challenges and great opportunities for the VA's academic affiliates. Affiliated medical schools are quickly adapting to the new VISN structure and are exploring new collaborative arrangements with all of the VA facilities and sometimes with other medical schools within their respective VISN. The AAMC is eager to continue to work with VA officials in Washington on national policies that

affect the health of veterans and that foster the affiliations between the VA and medical schools. The Association recognizes that decisions regarding the local administration of VA resources are best made locally. Although the task of altering long-standing relationships and forging new collaborations is never an easy one, maintaining a sharp focus on the primary purpose of academic affiliations -- to provide health care of unsurpassable quality for our deserving veterans -- remains our best guide to continued success.

I believe the VA's academic partners, especially the more than 100 medical schools currently affiliated with VA medical centers, can play a vital role in securing a strong future for the VA health system. In capitalizing on this potential, however, three facts are especially worth noting: (a) the rapidity and magnitude of the changes required to implement the VISN structure successfully, (b) the number of new individuals recently recruited to leadership positions from outside the VA, and (c) the VA's traditional and reconfirmed commitment to maintaining robust education and research programs. Given these facts, it seems clear that some special care must be taken to ensure that the inevitable stresses on the long-standing and successful partnership with its medical school affiliates do not hamper achievement of the VA's missions. To minimize this possibility, the AAMC would make the following suggestions:

1) Incorporate within each VISN director's annual performance contract specific goals that foster the education and research missions of the VISN

2) Establish an explicit and workable mechanism for ensuring routine consultation between the VISN leadership and the academic leadership (e.g., the medical school dean, university hospital CEO) of the medical school affiliate(s) to, at a minimum,

    a) guarantee timely communication by all parties of information relevant to the strategic and program planning of the VISN and the various affiliates;

    b) ensure optimal deployment of education and research resources;

    c) assess the impact on academic programs of consolidation and restructuring of the VISN's clinical services; and

    d) identify opportunities for cost-effective strengthening of the VISN's clinical services by contractual relationships with one or more of the academic affiliates.

I appreciate the opportunity to appear this morning and will be happy to answer any questions you might have.

STATEMENT OF JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE A JOINT HEARING OF THE HOUSE SUBCOMMITTEES ON
HEALTH AND OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
REVIEWING VA's INTEGRATION PROCESS FOR MEDICAL FACILITY MANAGEMENT AND CLINICAL AND SUPPORT SERVICES

JULY 24, 1997

Messers. Chairman and Distinguished Members of the Subcommittees:

The American Legion appreciates the opportunity to communicate its viewpoint on the mergers and integrations of Department of Veterans Affairs (VA) medical facilities. Today is a welcomed occasion for the "stakeholders" of the VA medical system to offer their perspective on the reorganized Veterans Health Administration (VHA). We are fortunate to have VHA officials present to offer their views on the process and to hear the specific concerns of members of Congress. The American Legion believes that continuous progress reports on the merger and integration process are essential.

Messers. Chairman, approximately two years ago VHA began planning the reorganization of VA health care facilities. From a system of 172 medical centers and four medical regions, 22 Veterans Integrated Service Networks (VISNs) were created. Each VISN comprises approximately 6 to 10 medical centers. As the Members of these Subcommittees know, the VISNs do not succinctly follow state boundaries and were created from previous patient referral patterns. Today all 22 VISNs are fully activated and are experiencing tremendous change.

Given the rapid pace of change in health care, VHA must adopt a new organizational structure and philosophy. It must become more flexible, innovative, responsive and patient-centered. The movement to the Veterans Integrated Service Networks is just one step in the continuous pursuit of a health care system responsive to the needs of veterans. The realignment and reorganization of VA medical facilities is a systematic attempt to optimally serve veterans within available resources.

There are various internal and external concerns surrounding the effort to integrate VHA programs and facilities. The integration process assumes a spirit of cooperation among facilities that never historically existed due to the manner in which facilities were previously funded. Also, long-standing university affiliations cannot be easily transformed. To be successful, mergers and integrations must be well planned and implemented over a period of several years. Unfortunately, lean medical care budgets require VHA to move precipitously ahead of a preferred integration/merger schedule.

Currently, 18 integrations, involving 38 medical facilities are either completed or in process. Considerable concerns have been raised by "stakeholders" and VHA employees regarding proposed and actual facility restructuring of clinical programs. Primarily, these concerns involve facility decisions to close various clinical programs without providing VA Central Office (VACO) with advance notice. Examples of these closures include nursing home care units, dialysis programs, and mental health programs; for example, in-patient substance abuse treatment units, and Post-Traumatic Stress Disorder (PTSD) Treatment units. Although VACO provided the VISNs communication involving notification of proposed closures, not all VISNs respond in a similar manner.

It is impractical for each "stakeholder" organization to be aware of all impending VISN changes. In our view, when VHA formed the Management Assistant Councils (MACs) to be a participant in the VISN reorganization process, the effort was poorly designed, and no initial input was sought from the veterans service organizations. The American Legion is now represented on all MACs. However, there is still no consistency in the MAC process across all

VISNs, the coordination of information from the VISN office to the MAC representatives is poor, and there is an insufficient process in place for the timely review and input of information. This assessment is not applicable, however, to all 22 VISNs. Some VISNs are more responsive to "stakeholder" interests than others.

The American Legion conceptually supports the planned VHA reorganization. The key objectives that VHA expects to achieve through the merger/integration process are desirable goals. Reducing operating costs, improving access to care, enhancing and standardizing the quality of patient care, and improving service satisfaction are worthwhile objectives. VHA's 30-20-10 objectives, originally established in the Fiscal Year (FY) 1998 VA budget proposal are five-year targets. Yet, the facility merger/integration process timetable is targeted for completion by the end of FY 1997. Again, in most cases, this schedule is very challenging.

Many VHA employees today are uncertain about their government careers. Significant reductions-in-force (RIFs) are occurring or planned throughout VHA. The anxiety experienced by the VHA workforce is consistent with the theme of moving forward with the merger/integration process too quickly.

The following principals put forth by the Under Secretary for Health are to be applied in each proposed merger/integration:

a. What are the general and specific goals that are to be achieved by the restructuring?

b. What are the specific outcome measures that will be tracked, and what is the process for monitoring those measures that will be used to determine if the goals are achieved?

c. How will the identity and functioning of national programs, for example, spinal cord injury, blind rehabilitation, prosthetics, etc.) be maintained if the restructuring occurs, and especially, how will standardized processes or procedures to provide service and the uniformity of services be ensured?

d. How will a continuum of care be assured?

e. How will quality of care be monitored and maintained or improved?

f. Who will provide medical and administrative leadership and insight for the program if it is restructured? How will adequate medical input to program decision-making be assured?

g. Who will have actual program "ownership" and responsibility, and how will program and provider accountability be assured if the program is reorganized?

h. How will patient satisfaction and customer service be monitored and maintained or improved?

i. How will program costs be evaluated and monitored?

The Under Secretary of Health also communicated that "The importance of being able to clearly answer the above questions cannot be over emphasized. Likewise, the need for full and open discussion with stakeholder groups and employees is of paramount importance."

In relation to the VHA merger/integration guidelines, management at each affected facility is to develop an evaluation and monitoring plan to measure patient satisfaction, the amount of resources redirected to patient care, expansion of patient services, waiting times for appointments and quality assurance factors. According to American Legion MAC representatives, VA employees and others, the guidelines announced by the Under Secretary are not being uniformly followed.

Moving from an inpatient model of health care to an outpatient model, VHA must develop an appropriate infrastructure to assist the process. Reduced staffing complicates the process. The American Legion is concerned that all of the unique problems associated with the rapid merger/integration process have not been resolved. The objective of having VHA become more

efficient is a common goal to both the Congress and The American Legion. When the pace of change is too rapid, a danger exists that the quality, quantity, and timeliness of care can be compromised.

The American Legion supports H.R. 335 as a method to better manage VHA's transition. H.R. 335 will allow VA to take a step back, consolidate its gains and refocus its future direction. The measure would allow for a moratorium of one year on further major change. The Commission established under H.R. 335 will evaluate the recommendations set forth by various studies, commissions, committees and proposed legislation, then design and establish demonstration projects at specific VA medical facilities to test the viability of the various recommendations and proposals.

The American Legion's "GI Bill of Health" would help to improve the major deficiency facing VHA today: medical care funding. The GI Bill of Health would benefit the current merger/integration process by encouraging veterans and dependents to enroll in a VA Health Plan, allowing the system to attract additional revenue. The increased revenue will help to offset inadequate health care appropriations, permit VHA to become more cost-efficient, and provide funding for new medical care programs and initiatives. Currently, most VHA resource savings gained through the merger/integration process are neutralized by existing budget shortages.

The American Legion is disturbed that the budget agreement negotiated by the congressional leadership and the administration, and passed by the House and Senate, will have a negative impact on VA health care funding. According to the terms of the agreement, federal funding for veterans health care programs will be decreased over each of the next five years -- disregarding medical inflation and employee cost-of-living adjustments. This potentially represents a significant reduction in medical care services to disabled and needy veterans.

The only significant increase in veterans' medical care funding over the next five years would be made conditional to the enactment of legislation to allow VHA to retain insurance monies and co-payments from veterans. For several years, The American Legion has advocated changes in federal law to permit VA to retain the money it collects from third-party insurance sources. However, this initiative was never intended to be a substitute for federal funding through the annual appropriations process.

For a variety of reasons, Medical Care Cost Recovery (MCCR) receipts for FY 1997 are lower than projected. The American Legion believes a mechanism must be established to provide necessary funding for VA health care should the Department prove unable to attain its MCCR projections.

Messers. Chairman, The American Legion strongly believes that VHA medical care resources are inadequate and further pressure will be applied over the next several years to reduce medical programs and services. The American Legion strongly urges you to favorably consider the "GI Bill of Health" and H.R. 335 as bold alternatives to the long-term success of the VA medical system.

Messers. Chairman, that concludes my statement.

POST-HEARING QUESTIONS
CONCERNING THE JULY 24, 1997 HEARING
ON VA MEDICAL FACILITY INTEGRATIONS

FOR KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS

FROM THE HONORABLE LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

Question 1: While your testimony states that there is no one right way to integrate it also lays out five purposes for integrations. Do you believe Headquarters ought to, at least, see how networks intend to achieve these goals as a baseline for approving future facility integrations?

Response: Yes.

Question 2: How are network directors being held accountable for the success or failure of their integrating efforts? Will the use of the facility integration process VA is developing be employed as a measure of performance for managers?

Response: All network directors are held accountable for how their networks function. This is built into the Network Director Performance Plan's Part A: Core Competencies. These elements apply to all network directors, not only those going through integrations. Clearly, the integrated sites must function effectively in order for the network director to be successfully evaluated against the core competencies.

A draft facility integration process manual contains a section on evaluation of integrations. The evaluation would provide information that could be used in assessing performance.

Question 3: How will product line management affect strategic plans for networks? Integrations?

Response: Like facility integrations, service lines are another way of providing integrated services. Service lines are an interdisciplinary method of patient care delivery.

Service lines are discretionary for networks. Only a few are ready to implement one or more service lines at this time. Network planning guidance, issued July 1, 1997, states that service line management should be addressed in the network plans. Network plans are due to headquarters on October 30, 1997. At that time, headquarters staff can better assess how service line management will affect the network strategic plans.

Question 4: What is the proper role of Headquarters in managing facility integrations?

Response: A supportive role that provides guidance, general direction and technical assistance. Headquarters can also facilitate information sharing and needed studies.

Question 5: Have the planning processes for any of the integrations that have occurred in VA facilities to date resembled the draft guidance for facilities integrations VA is developing? Which ones? Have any other systems used this approach?

Response: The integration phases outlined, are general. They include the: (1) idea, (2) analysis/decision, (3) plan, (4) implementation, and (5) evaluation. The draft guidance was derived from our experience with the early integrations. None of the existing integrations have entirely used every element of the guidance, however, I believe all have followed generally similar processes, to varying degrees, although different terms may have been used to describe the steps.

Question 6: Your strategic plans support the practice of decentralized management -- bringing decision-making as close to the veteran as possible. Does GAO's recommendation of using independent parties to make decisions about facility integrations run counter to that principle?

Response: The integration planning process must strike a balance between maintaining network decision-making; developing local buy-in to decisions that are critical for successful implementation; and obtaining an objective view of the costs and benefits of a facility integration. We believe that at a certain point in the process, consultation either from an internal VHA team (but external to the interests involved) or perhaps even an external private consultant may be appropriate.

Question 7: Dr. Kizer, you have made available to Committee staff an outline of the various steps VA must take to achieve a successful integration. Have you shared such a guideline with local and regional VA officials involved in consolidations or integrations? What has been the local and region reaction to such recommendations? To what extent have you sought input from the central office on the integration planning process?

Response: The outline of the phases of integration is currently in draft and is the result of a field-based work group that has worked on information I provided. The information has been shared with the Network Directors for comment, and we fully intend to share the document widely (VA staff and veterans stakeholders) for comment before finalizing. Although limited to date, comments from the Networks have been positive. Again, when the document is at a stage to disseminate, HQ staff comments and input will be solicited to enhance and improve the draft.

Question 8: Dr. Kizer, some union officials have expressed concern that the VA has not been consistent in its efforts to receive input from unions concerning possible integrations or consolidations at certain locations. How would you react to such criticism, and can you point out any

noteworthy successes or failures by the VA in this past regard?

Response: Each facility integration has its own, unique character, and, as such, must evolve in a slightly different manner from any other integration. Labor issues are handled locally to fully address concerns expressed by that particular stakeholder. Locally, through facility partnerships, concepts and plans are discussed. In many cases, labor is a participant in the integration planning and implementation process.

To date, 19 facility integrations (40 facilities) have been initiated and all are proceeding at various phases of implementation. I expect a general consensus among stakeholders should emerge before a recommendation to integrate is made. Stakeholders should be intimately involved in the iterative process of implementing the integration if a decision is made to do so. It is not realistic to expect that all stakeholders, including union officials, would agree on all aspects of the integration.

POST-HEARING QUESTIONS
CONCERNING THE JULY 24, 1997 HEARING
ON VA MEDICAL FACILITY INTEGRATIONS

FOR JOAN CUMMINGS, M.D., DIRECTOR
VETERANS INTEGRATED SERVICE NETWORK (VISN 12)
DEPARTMENT OF VETERANS AFFAIRS

FROM THE HONORABLE LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

Question 1: What are the missions assigned to West Side and Lakeside for the next five years?

Answer: Dr. Gerald Moss, Dean of the College of Medicine at the University of Illinois at Chicago, lead a subcommittee of the Integration Coordinating Committee (ICC) in drafting a mission statement for the VA Chicago Health Care System. The ICC approved Dr. Moss's mission statement on March 5, 1997, and the Stakeholders Advisory Group (SAG) concurred with the ICC at their meeting of May 7, 1997. The mission is:

"To provide seamless, comprehensive (primary and tertiary), compassionate, timely, and cost effective health care for the Chicago and Northwest Indiana Veterans at each of the two divisions, and clinics of the VA Chicago Health Care System."

"Together with our academic and staff affiliates to capture the innovative opportunities offered by the Integration of the two divisions in enhancing the delivery of state-of-the-art healthcare, education, and research."

"Develop programs and resources which enhance our ability to provide comprehensive services."

"Provide primary backup for active military personnel in war or in a national emergency."

I agreed with the statement and believe it is consistent with the VA's mission of improving the health of the served veteran population within an integrated healthcare delivery system. There is no expiration date on the Mission statement, however, I would expect that the leadership, clinical and administrative would review annually for any needed revisions. This is actually required as part of our update of the annual Business Plan for the VISN.

Question 2: How comfortable are you that the missions of the medical centers are consistent with your overall strategic plan for VISN 12?

Answer: VA Chicago Health Care System's new mission statement will be included with the update to VISN 12's Network Plan. The new mission is consistent with the VISN's goals of improving the health status of the served population, at reduced costs-per-patient, and to serve greater numbers of service-connected and lower-income veterans.

Question 3: Are current volumes of care in both West Side and Lakeside sufficient for maintaining quality standards at both surgical programs?

Answer: There are at present no indications of problems with the quality of surgical care at either Lakeside or West Side. There are multiple subspecialty surgical programs at both sites. The volume for various procedures will be monitored especially as the

facilities continue to provide more surgical care on an outpatient basis. The integration of the Medical Centers into a Health Care System will not reduce surgical services to veterans.

Question 4: You claim that, because positions have already been vacated due to buy-outs and attrition, halting implementation of working group recommendations at this stage of the planning effort will compromise the quality of care. Buyouts and attrition are rather non-directed means of downsizing your workforce. How confident are you that you have the right types of FTE to implement working groups' recommendations made thus far? In the absence of any prohibition on implementation, what are the plans and the timeline for integrating services to avoid compromising patient care?

Answer: While it is true that attrition is non-directed, the decisions to fill the resulting vacant positions have been made with the integration and its goals in mind. Thus a Service Chief vacancy occurring as a result of retirement or relocation would not have been filled prior to receiving the report of that particular work group. In contrast to attrition, all of the buyout positions were specifically directed to individuals occupying positions targeted for abolishment, either as a result of the integration or the change in the way care is being delivered. All of the ICC work groups review the knowledge and skills needed for their services. This is especially true of groups with rapidly changing technologies. For example, the Information Resources Management (IRM) group expects a need for more network specialists to manage future initiatives in telemedicine. The group eliminated one of the Chief positions (allowing the incumbent to accept a buy-out offer) thus freeing more resources for technical staff. This is one example of how the integration allows VA Chicago to restructure itself with the right types of FTE. I am very confident it will be repeated.

The Chair of the Integration Coordination Committee, Dr. Christopher Terrence, expects all of the groups to complete their reports by early October 1997. He has asked each group to include an implementation time-line as part of their report.

Question 5: Your testimony cites the example of your angiography program to validate your claim that savings can accrue to the VISN today. Could future decisions made by other working groups affect your decision to house the service at Westside? How is the ICC assuring that working groups dealing on associated issues are making consistent, complementary recommendations?

Answer: The membership of the work groups is the best assurance for consistent and complementary recommendations. The Director, VA Chicago HCS chose members from both divisions, the affiliated medical schools, the unions, and other facilities in VISN 12 to ensure coordinated planning. The groups freely exchange minutes and attend each others' meetings as required. The Chairs of some of the major clinical work groups have requested joint meetings with Dr. Terrence, and the Director to discuss common issues.

Question 6: Will the future RIF be tailored to maintaining a workforce that can implement your working group recommendations?

Answer: Any future RIF would be consistent with accepted ICC recommendations and would be tailored to not only further these recommendations, but also the Network-wide goals for continuing to move to more outpatient care and more effective resource use.

Question 7: Are you comfortable with your level of involvement in the planning process for the Chicago facilities?

Answer: Yes. I believe the current ICC and SAG structure strikes the appropriate balance of involvement for me.

Question 8: What was the original impetus for reviewing the mission of the Chicago facilities?

Answer: Dr. Moss requested a review of the mission at one of the first ICC meetings. Dr. Terrence subsequently appointed him to chair a subcommittee to draft a new mission statement. There had been significant misinformation, some of which appeared in local media, and this had caused concern among stakeholders. It was believed that the most appropriate way to continue the open dialogue was to have a formal review by the Integration Coordinating Committee of the mission of the two divisions. The subcommittee took each division's existing mission statement as information and developed the new mission. It was reviewed and recommended for acceptance by the ICC.

Congressman Evans to Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, U.S. General Accounting Office

1. You advocate a process for change that some have criticized as a "cookie-cutter" approach. Would you like to respond to this criticism?

The process we are advocating recognizes the uniqueness of each integration, but provides for a more structured, systematic, and comprehensive analysis than the one VA currently uses. In general, we are suggesting that facility-wide plans be prepared and shared with stakeholders before implementation of changes begin. Moreover, this plan should provide sufficient information to address such fundamental planning questions as:

(1) how will services be integrated?
(2) how will potential changes affect veterans, employees, and medical schools?
(3) why are selected alternatives the best ones available?
(4) how much will the potential changes cost to implement?
(5) how much will the potential changes save? and
(6) how will VA reinvest savings to benefit veterans?

We do not consider this to be a "cookie-cutter" approach because we expect the answers to these questions to be tailored to the unique conditions and availability of physical plant and equipment, mix of services, and other local factors for each integration. For example, integration decisions about a service such as surgery could include (1) consolidating all of the service at one location, (2) keeping the service at both locations but eliminating subspecialty duplication, or (3) keeping the service at both locations including all subspecialty service duplication. Moreover, we recognize that some integrations may develop options other than those cited above.

2. I share your view that it is important for VA to provide the rationale for integrating, especially in terms of how changes will benefit veterans, before implementing changes planned for integrations. Please explain why this type of communication is important.

It is important for VA to explain its rationale for integrating facilities or services so that stakeholders can understand the need for change and be assured that VA has selected the option which best meets veterans' needs. Without such an understanding, it is difficult, if not impossible, for stakeholders to be comfortable with VA's decisions and support or buy-in to the proposed changes.

Our work shows that stakeholders have struggled to understand VA's rationale in the facility integrations we reviewed. For example, in the Montgomery/Tuskegee integration, VA has not adequately explained to stakeholders why administrative employees need to be transferred from Montgomery to Tuskegee. As a result, stakeholders have not supported or bought-into VA's changes.

3. What role should stakeholders have in planning facility integrations?

Stakeholders may have varying roles. For example, certain stakeholders, such as employees, medical schools, and veteran service organizations, should be involved in the development of integration plans. Involvement of such stakeholders appears beneficial in that it expedites the process because those familiar with the operation of each facility are sharing their expertise. To its credit, VA is planning integrations using work groups composed of these stakeholders.

Other stakeholders, such as local and other public officials, should be involved at key decisions, such as when planning is done and implementation is ready to begin. This is important because stakeholders can provide views or insights to help strengthen VA's planning, as well as, provide invaluable support or "buy-in" for its proposed integration activities. Such involvement will also enhance the stakeholders' understanding of the changes.

4. What are the main problems that are impeding consensus on the West Side/Lakeside Integration? How is the integration different from others that have occurred without as much controversy?

The main problem appears to be the two medical schools desires to continue their individual affiliations with separate VA hospitals rather than sharing an affiliation in one hospital. The collocation of Northwestern University Medical School with VA's Lakeside hospital and the collocation of the University of Illinois Medical School with VA's West Side hospital has existed for 40 years. The extensive duplication of services exacerbates this problem because each school wants to maintain control over the same services. For example, both medical schools provide resident positions in general medicine and surgery, as well as 18 other subspecialties.

VA's integration decisions should be designed to reduce unnecessary duplication of services which will disrupt an "ideal" situation for each medical school. As a result, it will require medical schools to make some adjustments in clinical and educational practices. Both schools seem unwilling to do this and, as a result, their reluctance makes any decision about where to locate the consolidated inpatient services very contentious.

The primary difference between the Chicago integration and others is the involvement of two highly affiliated medical school stakeholders who have competing service interests. Each school has about 100 residents employed at VA, many VA-sponsored research projects, and many faculty members with part-time employment at VA facilities. By contrast, other integrations involved (1) only one medical school, (2) one highly affiliated medical school and one low affiliated medical school, or (3) medical schools which had complimentary rather than competing service interests.

5. What is the role of the academic affiliates in planning for the future of the two medical centers in Chicago? Do they have enough influence? Too much?

The academic affiliates have several roles which may afford them too much influence. First, medical schools employees are participating as chairs of work groups responsible for developing integration proposals, including such critical services as surgery and general medicine. This places them in an awkward position of having to decide whether to propose service delivery changes that better meet their interests or one that better meets veterans' interests (at the expense of the medical schools' interest).

- For example, medical schools interests may be best served by maintaining separate, duplicate services at each location. This may not be in the veterans' best interest because it may spend more resources than necessary for medicine and surgery, which will reduce the availability of resources to expand outpatient or other services for current and new users.

Second, medical school employees represent almost half of the voting members of the Integration Coordinating Committee–the organizational unit established by the network director to control how service delivery changes are developed, modified, and proposed. The Integration Coordinating Committee recommends changes to the director of the integrated facilities. Once again, medical schools are placed in an awkward position of influencing decisions which directly affect their interests and which may conflict with veterans' best interests.

6. What is the role of the network director in planning for the future of the two medical centers in Chicago? Does she have enough influence? Too much?

The network director has exerted varying influence on the planning efforts. Initially, her role involved defining the integration parameters; for example, deciding to limit the integration to the West Side and Lakeside facilities, rather than including Chicago's other two hospitals (Hines and North Chicago) in the integration process. This decision greatly influenced the potential integration alternatives that could be considered and the dollar savings that could be realized.

The network director's role also included establishing the process to be used, such as using work groups and an Integration Coordinating Committee chaired by an independent VA employee. Once these were operational, the work groups developed and presented integration proposals to the Integration Coordinating Committee. The committee reviews and approves the final recommended actions which are then forwarded to the integrated facility director and the network director for their review and approval.

7. What is the role of the VA Headquarters in planning for the future of the two medical centers in Chicago? Does it have enough influence? Too much?

The role of VA headquarters in Chicago has been to approve (1) the network's initial proposal to operate two facilities using a single management team, and (2) subsequent proposals to integrate service delivery. Headquarters has delegated decision making to the director of VA's Chicago Health Care System for any non-clinical services. Headquarters appears to have enough influence given the decentralized nature of VA's network management structure.

8. To your knowledge, has Chicago outlined goals for its integration such as cost savings, increased patient access or quality improvements? What are realistic goals?

In her July 24, 1997 statement, Dr. Cummings said the Lakeside/West Side integration is aimed at accomplishing five goals as articulated by Dr. Kizer. These are (1) increase access, (2) increase predictability and consistency of high quality of care, (3) optimize utilization of VA's physical plant and capital assets, (4) modernize VA health care, and (5) reduce unnecessary costs and increase the efficiency of operations. These appear to be reasonable goals.

9. How would you respond to the view expressed by some within VA that it would be unrealistic to expect VA to complete a comprehensive plan prior to beginning the implementation process?

We believe it is realistic to expect VA to complete a comprehensive plan because VA's current process includes all the work needed to achieve that objective. For example, work groups develop individual service plans, which are subsequently implemented on an incremental basis. In our view, a comprehensive plan would involve presenting all of the individual work group plans in a single coordinated document before beginning implementation. This appears doable because (1) VA does not need to implement changes to certain services before it can complete planning on others, and (2) all work group plans could be completed within reasonably comparable time frames; that is, there would not appear to be a need for any undo delays waiting for some service plans to be completed.

10. How would you define a successful consolidation or integration, and how would you assess the chances of VA achieving successful integrations at the facilities you have looked at?

I would define a consolidation as successful if it meets veterans needs by providing the highest quality care in the most cost-efficient manner. VA appears to have little chance of achieving this level of success in Chicago primarily because its current planning indicates that many duplicate services will be maintained, resulting in many unnecessary costs.

August 26, 1997

Lane Evans
Subcommittee on Health and
Oversight and Investigations
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Evans:

In response to your letter of August 18, please note the following answers to your questions:

1. **Question: Based on your experience with facility integrations, when is it a good idea to integrate?**

   Answer: The ideal time to integrate would be when there is a change in market conditions, or when a change in market conditions is anticipated, or when the opportunity for efficiencies has been identified.

   Question: What criteria should support the decision to go forward with an integration?

   Answer: There are a number of criteria, the most important of which would be to seek stakeholder support, (i.e., trustees, community, physicians, employees). Some organizations have developed compatibility criteria to assure that the organizations that are integrating have compatible mission, vision, values, etc. Another criteria that could support the decision to go forward with an integration is the level of managed care penetration in the market place which may not be applicable in the VA situation. In addition, some studies have found that the more medically complex the patients being served, the more necessity there is for integration. For instance, the senior population or those patients age 65 and older, who have significant care coordination requirements in the management of certain diseases (i.e., Alzheimer's disease, stroke, severe coronary disease, cancer). Another particular population that might lend itself to be cared for in a more effective way in an integrated system would be perhaps the pediatric population, those patients 0 to 14. Finally, the most important criteria would be that ultimately an integrated delivery system would add value to the patients' experience.

2. **Question: Your testimony states that the planning process for integrations must be evolutionary, but doesn't the leadership need to have a concept of where the organization should go and a justification for doing it?**

   Answer: Certainly leadership must have the vision of where an organization should be headed but it also can play an active role of shepherding it through the process. By "evolutionary" I was referring to the fact that the integration model may look very different from what was originally designed or intended.

3. **Question: How do you measure the success of an integration?**

   Answer: An enhanced level of clinical integration (i.e., the ability to offer one standard of care to the community from the integrated delivery system). Another measure would be the ability to rationalize health care services; that is to say, refraining from duplicating services and providing the full continuum of care in a rational manner. And ultimately, improved or preserved access among the defined population that is served should be a critical consideration.

Sincerely,

Paula S. Widerlite

Paula S. Widerlite
Senior Director, System Strategy
Adventist HealthCare

McMANIS ASSOCIATES INC.

MANAGEMENT CONSULTANTS

1900 K Street, NW, Suite 700
Washington, DC 20006
202.466.7680
Fax: 202.872.1898

REGIONAL OFFICES
Atlanta, Chicago, Dallas, Kansas City, New York

September 15, 1997

The Honorable Lane Evans
Ranking Democratic Member
U.S. House of Representatives
Committee on Veterans' Affairs
333 Cannon House Office Building
Washington, DC 20515

Dear Congressman Evans:

In response to your letter dated August 18, 1997 concerning our testimony at the joint Health and Oversight and Investigations Committees hearing on July 24, 1997, we have enclosed our responses to your questions.

Sincerely,

James E. Starr
Senior Associate

Melony J. Williams
Vice President

enclosure

QUESTIONS FOR JAMES E. STARR
SENIOR ASSOCIATE
MCMANIS ASSOCIATES, INC.

1. **What are the characteristics of successful integration processes in which you have taken part?**

We have found that successful integration is dependent on three key factors: careful planning and analysis, early communication with and involvement of key stakeholders, and a motivation toward action.

Careful planning and analysis is critical to determine if an integration of two or more Medical Centers is feasible and desirable. The first step of any integration should be a study to determine if integration will accomplish the desired outcomes. The outcomes of integration should improve patient care and quality, reduce costs, maximize access and minimize negative impact on employees. In addition, this step will identify the level of integration that should occur between the facilities. The level of integration can range anywhere from linking information and planning systems to integrated management, functions, and services.

Early communication with and involvement of key stakeholders (veterans, employees, congressional representatives, community stakeholders, etc.) is a vital component of integration. The communication and involvement of stakeholders should begin by inviting selected representatives to participate in a steering committee that will oversee the feasibility study discussed above. In addition, all stakeholders should be interviewed during the feasibility study. This ensures that their input and issues are an integral part of the decision making process in determining if an integration should take place and at what level.

Motivation toward action is needed to ensure that efforts to integrate move ahead once a decision has been made. In our experience, waiting too long for every detail and possibility to be analyzed will create unrest with employees, patients and other stakeholders. A prolonged study and subsequent implementation will further the resistance to change inherent in any change process. Therefore, leadership must be willing to act on integration recommendations as they are identified. For this to be successful, the leadership must have a "big picture" of the overall integration and recognize the systemic impact integration recommendations have on each other. For example, closing inpatient surgery beds in one facility creates space capacity for other uses such as primary care or ambulatory care at that facility.

2. **How are changes in the health care environment contributing to VA's need to consolidate?**

Several factors in the U.S. health care environment are causing the VA to examine its health care delivery system and how services are provided: increased managed care penetration, increased pressure to reduce costs, and the legislative changes in government financed health care.

Increased managed care penetration is occurring across the country. Over the past 16 years, HMOs have increased their enrollment 573%, serving 63,340,000 members as of July 1, 1996. This enrollment represents 24% of the United States population.

The increased managed care levels are a direct response to employers demands to reduce the costs of health care. Figure One demonstrates the level of expenditures associated with health care in the United States. In fact, health care costs consumed 13.7% of the GNP in 1994 and are expected to be 17.3% in 2000 at the current rate of expenditure.

Healthcare Expenditures Comprised 13.7% Of GDP in 1994 and Are Steadily Increasing

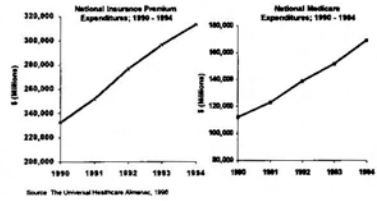

Figure 1.

Anticipate Continued Decline in Need for Hospitals and Inpatient Beds

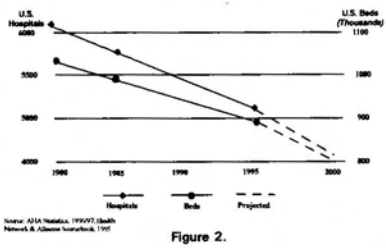

Figure 2.

The *increased pressure to reduce health care costs* has forced health care providers in the private and public sectors to re-examine the overall delivery system. The U.S. has seen a significant decline in the number of patient days as well as operating beds over the past 15 years, as shown in Figure Two.

This significant decline of inpatient utilization has caused healthcare systems to deliver services in a more cost-effective manner closer to where the patient lives and works. For example, many hospital systems are opening ambulatory surgery centers, diagnostic centers and outpatient clinics.

Downward cost pressures has also caused *legislative changes in government financed health care*. The role of Medicaid and Medicare has shifted as federal and state governments look for ways to control these growing costs of health care. The advent of managed Medicare and Medicaid, medical savings accounts and other measures are a reflection of this trend.

These and other pressures in the overall health care delivery system are having an impact on the VA. The VA must be held accountable for the costs of services to veterans and examine the role of the delivery system. This includes determining ways to reduce the cost of delivering services and moving from a hospital-based system to a system based on care management principles and preventive medicine. One significant strategy is to better align its facilities through integration and consolidation to accomplish this goal. In addition, the VA will need to move its services from the hospital to locations close to veteran populations. This includes converting inpatient beds to outpatient care, opening more outpatient based clinics, and contracting with community providers for primary and specialty care.

3. Your testimony stresses the importance of having an overall plan to guide specific efforts. Why is this so important?

As an integration commences, many activities will be taking place to study specific areas for integration. The "integrated" facilities will be examining all clinical and administrative services to determine what should be consolidated and where services and functions should reside. As integration recommendations are formulated and made, an overall plan that outlines the goals and desired outcomes of the integration provides guidance and direction

to the teams and individuals making the recommendations. In addition, an overall plan provides the leadership a blueprint for implementation of the recommendations. Most importantly, it provides leadership a framework to understand the systemic impact recommendations have on one another. For example, if laboratory services will be consolidated at one facility, new hiring for pathology services should be suspended at the other facility to ease implementation of the integration.

Association of American Medical Colleges
VA Integration and Consolidation
Congressman Lane Evans

1. *How has VA done in involving academic affiliates in the planning processes to guide their integration activities so far? Are there examples of successful involvement in your opinion?*

As you are aware, the Veterans Health Administration has restructured its regionally based health care delivery system into twenty two Veterans Integrated Service Networks (VISNs). Each VISN may have multiple affiliations with various medical schools within that network. Although I received a multitude of differing responses to this question, and while there were some very positive responses, the general consensus among the medical school deans is that VA makes decisions that are likely to affect the medical school's education or research planning objectives without medical school involvement or participation. This is particularly the case with respect to VISN leadership.

For example, many of our schools are presented with plans to reduce the number of residency slots at a particular VA medical facility with little or no input as to the changes these reductions may have on the medical school's ability to provide requisite education and training opportunities for medical students and residents. Many medical school deans express frustration that they are unable to be actively engaged and involved in the planning process and that meetings held with VISN directors are merely informational.

There is also concern about possible VA contracting processes. Details and explanations of the process and the underlying reasons for resulting decisions need to be provided to the medical school. The loss of a contract will significantly reduce the patient population and may have an impact the university medical center's residency training programs. While it is understandable that academic medical center hospitals must compete for contracts in a price efficient manner, if academic medical centers are to be true partners with the VA, educational concerns must also be given some measure of consideration when awarding service contracts. In order for the new organizational structure of the VA to remain actively committed to educational and research missions, it is imperative that the VA develop a system where by, at least for the university medical school affiliated VA hospitals, contract negotiations include some consideration of educational consequences.

Although most medical school deans report positive relationships with the local VA medical center, most deans interpret any lack of consultation by the local medical facility as a reflection of VISN leadership.

On the positive side, one dean, whose medical school is affiliated with VISN 11, believes that there has been an acceptable amount of consultation regarding residency allocations with both the local facility and VISN. Another positive example concerning planning involves the VA medical center in Providence, Rhode Island and its affiliated medical school which are cooperatively planning for the construction of a new research building due to open this fall. In VISN 17 the academic affiliates are actively involved in the VA integration process. Deans of the affiliated medical schools have been incorporated into the VISN Management Committee, and their input is actively solicited on all matters of mutual interest and strategic direction. The medical schools play an active role in consolidation decisions regarding management structure, graduate medical education realignments, and the establishment of outreach clinics. Additionally, the medical school makes its institutional distance learning and telemedicine network available to VA to support administrative, educational, and professional integration of remote facilities.

There are some medical school deans who think it is too early in the consolidation/integration process to make an accurate assessment of medical school involvement in the local planning process.

2. *What are the performance criteria AAMC wants in place to measure VISN directors' success in accommodating VA's education and research missions?*

Medical school deans believe educational and research priorities should be included in the VISN director's performance criteria. It is apparent that the restructuring of the VHA will have great impact on affiliated medical schools and the inclusion of such performance criteria is an important part of ensuring that research and educational missions of the VA are a priority. There is strong consensus among medical school deans that both the deans and VA medical center leaders should be included in evaluating the VISN directors on the issues that affect the local VA and medical school affiliation.

Medical school deans believe that VISN directors' commitment to research should be based on qualitative aspects of the relationship as well as research funding levels. The following are suggestions as to possible research performance criteria for VISN directors:

- measuring the director's research success by grant income, research productivity and joint publications between the medical school and the VA;
- measuring whether a focused research program has been developed that includes support for medical school collaboration between VA and the medical school which is locally negotiated; and
- measuring whether VISN directors seek the input of the leadership of the medical schools within the VISN as to the nature and interaction that exists between the VISN director and the medical school leadership.

Since education and research are statutorily defined missions of the VA and are important contributors to the value the system provides to the nation, VISN directors should be responsible for ensuring that the VA treatment facilities under their jurisdiction fully support these missions within the limits of the resources available to them. The AAMC would like for the VA policy governing the performance evaluation of VISN directors to state this clearly. At present, an assessment of the effectiveness with which the VISN directors are supporting and facilitating the education and research missions of the VA treatment facilities under their jurisdiction is not among the major criteria used to measure the performance of VISN directors. The AAMC would like for the instruments used in the evaluation of VISN directors' performance to include specific criteria related to the education and research missions.

The effectiveness of VISN directors in supporting and facilitating the education and research missions of the treatment facilities under their jurisdiction should be measured against specific objectives set forth in the academic affiliation agreement developed by the VA treatment facilities under their jurisdiction and the medical schools affiliated with these facilities. The Department of Veterans Affairs (DVA) guidelines for developing affiliations identifies six major categories that should be addressed by each treatment facility and its affiliated medical school. Included within these categories are a wide range of faculty affairs issues, and issues related to quality of educational experiences for medical students and resident physicians, integration of education and patient care activities, and collaborative activities involving the VA treatment facility and the medical school. The categories should be expanded to include specific reference to research issues. Since the VISN directors are required by DVA to provide guidance to VA treatment facilities in developing academic affiliation agreements and to approve the agreements, the VISN directors should be held accountable for the degree to which the objectives established in the academic affiliation agreements are met.

Many of the recommendations stated above can be captured and quantified by satisfaction surveys completed by deans, medical students, and residents. Specific questions regarding performance criteria include:

"If vacancies were filled for Director or Chief of Staff at an affiliated hospital last year, did you involve the affiliated medical school in the selection process?"

"Did the medical school dean 'sign off' on the VAMC's resident allocation request, thus assuring medical school input into the process?"

"What percentage of medical and other students rotate through VA treatment facilities?"

"What are the success rates for residents trained in a VA setting in securing Board

Certification?"

"To what extent do medical residents receive training in VA ambulatory settings?"

3. *How involved have the medical schools been in strategic planning for VA at the national, network and facility level?*

The responses received from the deans indicate that most of the medical schools have very positive relationships with the local VA medical facility. There is plenty of communication and information sharing at the facility level regarding strategic planning. This is due, in part, to the many VA physicians that also hold faculty positions at VA medical facility's respective medical school. Increased medical school and facility strategic planning is both desirable and achievable.

At the network level, there appears to be a break down of communication between the VISN directors and the medical school that leaves many of the medical school deans frustrated. Deans expressed concern over being invited to meetings at the network level to simply be informed as to what the network is planning. There is the perception among the deans that the network has not placed a high priority on medical school involvement in strategic planning.

The AAMC has frequent contact with VA Central Office through high level staff to staff meetings and through a VA/Deans Liaison Committee meetings. The VA/Deans Liaison Committee meetings provides an opportunity approximately twice each year for five deans from VA affiliated medical schools to meet with Dr. Kizer and other VA Central Office leaders to encourage positive communication and understanding of how VA national policy may affect the local affiliation. Through our staff to staff meetings the AAMC enjoys a very positive relationship that allows for the mutual exchange of information that serves to keep both parties abreast of new developments that affect VA national policy.

○

ISBN 0-16-056268-6