VA'S CAPITAL ASSETS REALIGNMENT PLAN FOR ENHANCING SERVICES TO VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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VA'S CAPITAL ASSETS REALIGNMENT PLAN FOR ENHANCING SERVICES TO VETERANS

THURSDAY, JULY 22, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:07 a.m., in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Spence, Brown, Hill, and Udall.

OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. Good morning. The Oversight and Investigations Subcommittee hearing will examine the progress the VA has made in capital asset planning. For the VA, capital asset planning basically means figuring out how it is going to restructure its vast health care system, which has thousands of buildings.

This subject is a matter of bipartisan congressional concern. This past March, Chairman Stearns of our Subcommittee on Health held a hearing on VHA's management of its capital assets. At that hearing, GAO testified that VA's asset planning indicated that billions of dollars might be used to operate hundreds of unneeded buildings over the next 5 years.

GAO also estimated that one in four medical care appropriated dollars will be spent on operating and maintaining its assets, one in four medical dollars. This translates into as much as $20 billion over the next 5 years. GAO strongly recommends that VA seriously consider such alternatives to current operations, such as consolidating services, partnerships with other health care providers, procuring care and services, and replacing obsolete assets with modern ones that address the health care needs of our veterans today and in the future.

During that March hearing, the VA healthcare delivery system was described as increasingly dysfunctional, ineffective, and having a staffing structure filled with duplication. Some older VA medical centers have more than fifty buildings. No other health care provider in America today can afford to operate with this kind of setup. It is expensive and it is wasteful. As Chairman Stearns said, "We should be taking care of veterans, not buildings."

I should note that the Veterans Affairs' Committee has proposed legislation that in part would assist the VA in its capital asset management. The bill, H.R. 2116, is known as approval. The VA

has committed to a disciplined independent analysis of the 40 locations the GAO identified with multiple health care delivery locations. Today, 4 months later, we will examine how much progress the VA has made to seriously address the future. We will also hear the shocking cost of this indecision, basically over a million dollars a day.

[The prepared statement of Chairman Everett appears on p. 32 and 34.]

Mr. EVERETT. Ms. Brown is temporarily detained and when she gets here we will give her the opportunity to have her statement. At this time I would ask the full committee chairman of Armed Services if he has a statement he would like to submit.

Mr. SPENCE. No, I don't.

Mr. EVERETT. All right. I would now like to ask all witnesses to limit their testimony to 5 minutes. Your complete written statement will be made part of the official hearing record. I would ask the panel to hold the questions until the entire panel has testified. I would now like to recognize Mr. Backhus, Director of Veterans' Affairs and Military Health Care Issues from the GAO, and ask him to come and introduce his staff.

STATEMENT OF STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY PAUL REYNOLDS, ASSISTANT DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE

STATEMENT OF STEPHEN P. BACKHUS

Mr. BACKHUS. Good morning, Mr. Chairman.

Mr. EVERETT. Good morning.

Mr. BACKHUS. Members of the Subcommittee. We are pleased to be here today to discuss the utilization of health care assets owned by VA. Currently, as you mentioned, about one in four health care dollars or about $4 billion a year is spent operating and maintaining or improving buildings.

Mr. EVERETT. And you are accompanied by Mr. Reynolds?

Mr. BACKHUS. Yes, I am. With me is Paul Reynolds. He is an assistant director in GAO. He has led this assignment and many others over the last 5 years upon which our comments today are based.

Mr. EVERETT. Please proceed.

Mr. BACKHUS. Thank you. VA operates over 4,700 buildings and also has 18,000 acres of land in its health care asset portfolio. Four months ago, we reported that a significant amount of money might be spent operating hundreds of unneeded medical facilities in VA. We concluded that VA could enhance veterans' health care benefits if it could take the money it spends on underused, inefficient or obsolete buildings and instead reinvests it in more modern facilities at existing or new locations closer to where veterans live.

We recommended that the VA develop asset restructuring plans on a market or geographic basis that identifies the veterans' needs and the assets that are necessary to meet those needs, and then secondarily compare the life cycle costs of the VA's current assets

against alternatives to identify the most cost effective way of meeting veterans' needs.

From our perspective, the asset restructuring plans would involve 106 geographic areas or health care markets. Forty of those markets have multiple health care locations. VA generally agreed with us and said it would take steps to restructure its assets. You asked that we be here today to provide some additional information on the utilization of hospitals within VA and to provide our assessment of VA's efforts to implement an asset realignment process.

In summary, Mr. Chairman, VA's hospital utilization has dropped dramatically over the last 10 years, particularly in the last three, falling from 49,000 to 21,000 patients per day. These declines stemmed primarily from changing medical practices that reduced hospital admissions and lengths of stay. Over just the last 3 years, the VA has removed some 24,000 beds from service.

VA hospital utilization will continue to decline significantly over the next 20 years because of a projected 36 percent reduction in the veteran population, or 9 million people. Currently, one in three VA hospitals operate in markets that have above average expected reductions in veteran population and with utilization already below what many private sector facilities have determined to be the minimum size for a viable venture.

Additionally, over 40 percent of VA's health care buildings are already past their normal useful life expectancy. As you can see, with such dramatic changes in demographics and medical practice that have taken place and are still on the horizon and with significant budget constraints facing VA there is a need for the VA to address its health care infrastructure in an urgent manner.

VA's progress to date, however, in our view, has been limited. On the positive side, they do seem to be leaning toward establishing a process which incorporates asset planning guidelines that are consistent with industry practices. But, on the other hand, based on our observations of previous attempts the VA has made in planning for hospital restructuring and consolidation, its current proposal has two major shortcomings.

First, it seems to rely too heavily on local stakeholders who have vested interests in maintaining the status quo and that would likely result in protracted debates and piecemeal decisions that are not in the veterans' best interests. Secondly, the proposal lacks uniform guidelines and criteria which are needed to conduct such assessments, necessary elements in order to gather consistent data and produce fair and equitable decisions.

We also believe that the VA needs to prioritize these assessments in order to realize the greatest return on its investment. In this regards it seems preferable that the VA should establish reviewing the 40 multiple market locations as its top priority. Within those 40 there are nine locations that offer four or more delivery locations and 46 in all within those nine.

So in conclusion, Mr. Chairman, we are concerned that potential shortcomings in VA's process as currently proposed with locally-led steering committees could result in VA not being sufficiently closer to having a restructuring plan by this time next year than it is today. Given the past experiences, it seems like a better option for realizing asset realignment decisions in a timely manner would in-

volve a more independent centralized planning model that provides stakeholders with sufficient information to understand and support the decisions.

Without firmer leadership, it seems likely that VA could take many years to decide on, much less accomplish, systemwide realignment. And as you mentioned in your opening statement, we estimate that the daily cost of unduly delayed decisions is unacceptably high. We estimate the VA could be spending $1 million or more each day to operate and maintain unneeded assets.

Mr. Chairman, that concludes my statement. Mr. Reynolds and I will be glad to answer any questions you or other members of the subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 38.]

Mr. EVERETT. Thank you very much and thank you for your testimony. How did GAO arrive at its estimate of $1 million a day cost of maintaining unneeded VA assets?

Mr. BACKHUS. We did this a couple of ways. As you might expect, until there are particular and specific market analyses done it is impossible to say precisely how much money could be saved in any one location. Much detailed work needs to be done. So we based our estimate on the following. We did quite a bit of detailed work in the Chicago area, VA's Great Lakes network, and based on that analysis were able to conclude that by restructuring the assets within that Chicago VA health care system approximately 10 percent of what they were currently spending on operating their buildings could be saved.

So we took that 10 percent and applied it to the national estimated cost of operating buildings of $4 billion. Ten percent of that equals $400 million, and that is a little bit over $1 million a day. Then we calculated the estimate in another way to validate or verify that number, as follows. A hospital that could be restructured or consolidated with another facility, a merging or consolidation of two facilities, can save approximately $20 million per facility by merging the two.

In the 40 multiple health care markets alone, just VA's 40 multiple markets, there are at least 40 facilities that already have utilization below what we have observed is a viable size to operate a medical facility. So if just 20 of those facilities, 20 of those 40 that are now low utilizers, were consolidated with others, that would be a $400 million savings right there, and it is, again, approximately $1 million per day.

Mr. EVERETT. In addition to the $1 million a day loss, what are the associated opportunity costs?

Mr. BACKHUS. That is a good question. There are a number of things that we didn't factor into the estimate that would tend to raise the potential savings that could be achieved. For example, what we did not put into our calculation would be a cost avoidance. Right now I think systemwide in VA there is an estimate of some $2 billion that is going to be needed over the next 5 years just for maintenance and upkeep. So if a particular facility was consolidated with another, the projected expenditure that would have to be made on maintenance would no longer have to be made, so there is a cost savings there.

There is also a possibility, a strong possibility, that if the VA could shed itself of some of its unneeded facilities and dispose of them, sell them, let's say, that there is revenue that would be associated with that sale, money that could be used to enhance the benefits of veterans around the country or in particular in those areas where their facilities could potentially be realigned.

And then there is the possibility that by taking an existing facility that is no longer needed for VA health care and leasing it perhaps to other organizations, government or non-government, there is revenue that could be achieved there and that money could in turn also be used to enhance the care.

Mr. EVERETT. What other uses might VA have for the estimated $400 million a year, more primary care units, more specialty care, reducing long waits, those kind of things? For instance, I would hope that this Committee, the full Committee, and the Congress would make sure that these dollars remain within the VA. Take Chicago, for instance, the $20 million a year there.

Mr. BACKHUS. Yes.

Mr. EVERETT. How many clinics could we open—what could we do in Chicago with the $20 million a year as far as getting those clinics into neighborhoods where those veterans actually live?

Mr. BACKHUS. Well, I think that is the point. The point is here that that money that could be saved by jettisoning unneeded or inefficient facilities could be reinvested to provide care closer to where the veterans live. And in the case of these community-based outpatient clinics, they do vary in costs depending on what size they are but they range from say $300,000 a piece to $1.5 million a piece so you can do the calculation. With $20 million you could open up many, many, many clinics closer to where these veterans live.

You know there are issues that are confounding the VA right now in terms of potential difficulties trying to maintain the capacity to treat the veterans with the special disabilities and waiting times might be creeping up. The solution to that problem in large part, I think, as it is for many of the problems they face is a money issue, and if this money would be available to reinvested into improving the care to veterans, I think that is a win-win situation.

Mr. EVERETT. How can VA structure its planning efforts to realize the greatest benefits for veterans and do that as quickly as possible?

Mr. BACKHUS. Well, you know, we think that there are some lessons to be learned from previous attempts that the VA has undertaken to try to do this. Now we may have a difference of opinion with the VA on this. In our view it comes down to probably maintaining more central control than what they now envision. We are concerned that putting the decisionmaking authority, certainly even putting the development of the alternatives and options in the hands of local stakeholders is almost equivalent to protracted delays.

Where there are self-interests, incentives to protect their own interests, people need, I think, to be separated from that in order to come up with the right decisions and the best decisions. That is not to say you don't keep stakeholders involved. Not at all. That is not what we are suggesting. It is critical that the stakeholders be given

enough information to understand the basis for the decisions and to buy in.

It is just that experience has shown that when the local stakeholders are the ones producing the plans they tend to be piecemeal and not to be in the best interest of the veterans.

Mr. EVERETT. My time has run out and we are going to have more than one round, but just let me say that while I absolutely want to keep the local stakeholders involved, I can also see very clearly that the local process is unlikely to reach a conclusion if those people who have a vested interest in keeping that facility open or maintaining those buildings are allowed to have the final word on whether or not it is closed.

And I would suggest that probably another obstacle to getting things done here, and I can think about last year on a certain facility they wanted to add $30 million to, and I spoke on the floor against that, is Congress. We have to have the courage to do what we need to do for our veterans. And I am not sure we have lived up to that over the years. I am going to yield to Ms. Brown now and I reserved time for your opening statement or you can go right into questions, whichever you prefer.

Ms. BROWN. Mr. Chairman, thank you. I would like to just go into questions and then give my opening statement later.

Mr. EVERETT. Absolutely.

Ms. BROWN. My question, and I want you to think about this, to what degree are the usage of VA health care facilities caused by health care budget reduction rather than the facility not being needed? In other words, just because a ward is empty does not necessarily mean that that ward is not needed. I know on a personal note that I had a brand new nursing home in Orlando, FL that wasn't opened because they didn't have the funds for the staffing although it was built and ready to go and ready to operate. So can you answer that question?

Mr. BACKHUS. That is a very important issue because I know there are locations around the country besides that that fallen into the same situation. There are locations which have budgetary constraints that preclude them from sufficiently addressing the needs of veterans. And I think the solution to that is to find more efficient ways to operate. So what we are suggesting is that the very first thing that needs to be done is to identify specifically what those needs are in every particular geographic location where either the VA now has buildings or where they should have buildings.

In other words, this is a needs-based determination that needs to be made. Each VISN, each of the 22 VISNs and their facilities within those VISNs, need to be able to establish clearly and articulate what the health care needs of their population are, what are the assets that are needed to accommodate those needs. Once that is established, once it is determined what assets are needed to meet those needs, then it is a matter of identifying the best available options.

It could be through existing facilities. It could be through purchasing the care if a facility doesn't now exist. It could mean modernizing existing facilities. It could mean partnering with another federal agency such as DOD where there are facilities closer to

where the veterans are. Identifying the most cost-effective source for that care. Once the best option is identified, then it is a matter of getting it done and the source of the money becomes the next issue—either, as you know, through the appropriation or by identifying the facilities that are no longer needed which VA can close or find alternative uses for.

Ms. BROWN. I agree with you. My question goes to the fact that some of those facilities are not being used as we speak because they don't have the money to run them. It is not a matter of running them efficiently. They just don't have operational monies. And of course you know the veterans are suffering. They can't get appointments. Facilities are being closed. It is tough out there.

Mr. BACKHUS. There are some of those, but we are suggesting that there are inefficiencies elsewhere in the system from where that money needs to come.

Mr. REYNOLDS. I think it would be hard to blame this entirely on the budget because the transformation that Dr. Kizer has led VA on over the last 3 years has really taken them down the same road as the private sector and he is really making VA health care delivery more closely aligned to the way it is delivered in the private sector. And that has been a major contributor to the downsizing of the bed needs, the inpatient bed needs. The things that VA has done, for instance, with their surgery programs, getting a lot of their surgeries on an outpatient basis.

The veterans are really showing in the satisfaction surveys that they like that and that it is really the way they want VA to go and that has really severely reduced the surgery beds, for example, so I think an awful lot of it is a better practice of medicine that has reduced the bed need.

Ms. BROWN. I don't know that the private sector is a role model that we want to hold up at this moment. I get a lot of comments about services with various HMOs and how long you have to wait. I am telling you what they are telling me when I go to the veterans meetings. They are just not happy, particularly in Florida where we have such a large population of veterans. They are having to wait for the services or can't get the services. They can't get an appointment for months. It is a problem.

Mr. BACKHUS. There has been an effort the last several years to try to move money within the VA to correspond with the movement of veterans.

Ms. BROWN. Good idea.

Mr. BACKHUS. And that is probably the strain that you are feeling down there in Florida.

Ms. BROWN. I think my time is about up. Are we going to have another round? Okay.

Mr. EVERETT. Chairman Spence.

Mr. SPENCE. Thank you, Mr. Chairman. You talk about unneeded facilities and you talk about restructuring, and I assume that when you say restructuring you mean that you might close some facilities altogether or realign with others like demolish some buildings, build new buildings. Is that what you mean by restructuring all that?

Mr. BACKHUS. All of those things plus some additional things. It can be as little as consolidating services, specific services among fa-

cilities, to merging entire facilities with another which would result in the closure of one. It could mean finding alternatives that are cheaper such as partnering with the Department of Defense to sharing more with each other, those kinds of facilities—those kinds of services within existing facilities or just purchasing care from the private sector.

We haven't at this point come to the conclusion necessarily that a BRAC-type process is necessary. I think that there are still options that ought to be tested here within the VA to see how much of this restructuring they can do on their own before I would be willing to suggest a BRAC-type process.

Mr. SPENCE. Did you find any place that is needed to be closed because it was under utilized, unneeded, a reason that we are still keeping it going when it can't justify its existence?

Mr. BACKHUS. Would I see any basis for doing that?

Mr. SPENCE. Did you find any place that we——

Mr. BACKHUS. We did a detailed analysis in the Chicago market, VA health care market, that we concluded about a year ago and our opinion was that there was at least one VA facility in the Chicago area that didn't need to stay open. We didn't identify what that particular facility was. We looked at four. We looked at the capacity that each of those four had.

We tried to identify as best we could those veteran needs in the Chicago area and concluded that there was sufficient hospital capacity in any three of the four that existed to justify the consideration that one of them ought to be closed and then suggested to the VA that they do the detailed analysis necessary to identify which one it should be.

And they are doing that and that analysis is under way. Beyond Chicago, we have not gotten into any other market and done that work. That is the point of this testimony and the one that we did last March which suggested that the VA needs to do this in every single one of their health care markets to identify what those veterans' needs are and match them up against the assets to figure out if there are other facilities that potentially they need to restructure.

Mr. SPENCE. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you. And just comment following up on what you had to say, Mr. Chairman, GAO did find that there is 5 million square feet of vacant office space that is costing $35 million a year to maintain. We are going to have a second round of questions here. Let me continue by saying your remarks describe a health care system that faces an asset management challenge. How does this compare to other management challenges within the VA?

Mr. BACKHUS. Well, in our view we think it is probably the biggest one and that in solving or at least working toward solving this particular problem will go a long way toward addressing other problems that the agency faces. You kind of alluded to this before when you said how could the money be used, the savings be used.

The other challenges facing the VA are things like potentially increased waiting times, trying to maintain the capacity to treat the veterans with the very special disabilities, trying to improve resource allocation to where it is most needed, the need to restructure even the medical school affiliations within the existing infra-

structure. Those are huge tasks that really require a right sized and efficiently sized, properly sized infrastructure.

Mr. EVERETT. You say restructure allocation. You are saying get the money where the veterans are?

Mr. BACKHUS. Precisely.

Mr. EVERETT. Do you believe the VA shares your view that a major realignment in its health care assets is urgently needed?

Mr. BACKHUS. I go back and forth when I think about that. There clearly are signs that they want to get at this. They really do want to address this issue and they realize the significance of the issue. On the other hand, I think there is considerable debate still occurring within the department as to how it ought to be done, who ought to be in control and in particular how it is going to work.

I think we had a lot of momentum. I felt personally like there was a lot of momentum coming off of the March hearing and that I guess I was expecting things to progress a little faster than maybe they have but then I don't want to underestimate the difficulty and the challenge that is ahead of them either. It is difficult. It is hard work. And I just hope that they will keep that momentum or pick that momentum back up.

Mr. EVERETT. There was an exchange of letters between GAO and VA on the subject. Would you provide those for the record?

Mr. BACKHUS. Absolutely.

[The information follows:]

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-282935

August 13, 1999

The Honorable Togo D. West
The Secretary of Veterans Affairs

Dear Mr. Secretary:

On March 10, 1999, we testified before the Subcommittee on Health, House Committee on Veterans' Affairs, on the management of health care assets within the Department of Veterans Affairs (VA).[1] In summary, we concluded that unless VA implements more effective capital asset planning and budgeting processes, it may may spend billions of dollars operating hundreds of unneeded buildings over the next 5 years or more. This report contains recommendations to VA for completing key actions necessary to meet these objectives. Our March 10th testimony is reprinted as appendix I. Among other things, the testimony describes the scope and methodology of our work, which was performed between July 1998 and February 1999 in accordance with generally accepted government auditing standards.

VA's Asset Planning Needs to Be Improved

VA's large, aged infrastructure could be the biggest obstacle confronting its efforts to transform itself from a hospital-based operator to a health care provider that relies on integrated networks of VA and non-VA providers to meet veterans' health care needs. Over the next few years, VA could spend one of every four of its health care dollars operating, maintaining, and improving capital assets at its 181 major delivery locations that encompass over 4,700 buildings on 18,000 acres of land nationwide.

The Office of Management and Budget (OMB) encourages federal agencies to develop long-term "asset plans" as part of their capital planning process and use these plans, among other things, to justify budget requests to the Congress.

To obtain the best use of capital resources, OMB guidelines suggest that agencies conduct market-based assessments to determine asset needs.[2] These assessments include

- determining a target population's needs,
- evaluating the capacity of existing assets,

[1] VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-63, Mar. 10, 1999).

[2] OMB, Capital Programming Guide, Version 1.0 (Washington, D.C.: OMB, July 1997).

- identifying any performance gaps (excesses or deficiencies),
- estimating assets' life-cycle costs, and
- comparing such costs with alternatives for meeting the target population's needs.

State and private organizations have achieved positive results using such planning processes.[3]

VA has delegated basic health care planning responsibilities to its 22 regional offices, each of which oversees from 5 to 11 major health care delivery locations. Each regional office has developed a 5-year business plan that includes management of the health care assets under its control.

These plans indicate that billions of dollars may be used to operate hundreds of unneeded buildings over the next 5 years or more. This is because VA plans to continue to operate and therefore necessarily maintain its 181 major delivery locations, even though most locations operate in markets that include two or more VA locations.[4] Also, VA does not systematically assess all life-cycle costs or logical alternatives for meeting veterans' needs before deciding that capital investment is necessary.

If VA followed OMB's guidelines, in our view, its planning would focus on assets needed to meet veterans' needs in 106 markets. These markets include

- 66 with a single VA location and
- 40 with multiple VA locations (between two and nine).

VA's 40 multiple-location markets yield great opportunities for asset restructuring and benefit enhancements for veterans because these markets have 115 delivery locations that

- have utilization significantly below inpatient capacity and
- compete with other VA locations to serve rapidly declining veteran populations.

VA's 66 single-location markets also could yield significant opportunities for restructuring and enhanced benefits for veterans. Like the

[3]Executive Guide: Leading Practices in Capital Decision-Making (GAO/AIMD-99-32, Dec. 1998) and VA, Capital Investment: Survey of Best Practices (Washington, D.C.: VA, May 1996).

[4]A market, for purposes of this statement, is defined as a geographic area with a high concentration of veterans, generally within 60 minutes of an existing VA major delivery location.

multiple-location markets, many single-location markets are in geographic areas that have rapidly declining inpatient workloads and veteran populations.

VA's Capital Investment Budgeting Needs to Be Improved

In our testimony, we also pointed out that VA's budgeting processes have weaknesses that could result in unwise capital asset investment decisions totaling hundreds of millions of dollars. Improvements are needed in VA's centralized budget development process to review and approve high-cost capital investments ($4 million or more) under its major construction appropriation as well as in its decentralized review and approval process that is used for less expensive health care capital investments under VA's minor construction and medical care (nonrecurring maintenance) appropriations.

To its credit, we noted that VA has significantly improved its centralized budget process by requiring more rigorous, systematic assessments of proposed major investments than VA has done previously. But this process, in our view, still relies on inconsistent or incomplete information. Improved data could allow VA to enhance the precision of its guidance for rating some decision criteria and thereby strengthen its asset management decision-making process.

We also expressed concerns about VA's decentralized assessment process for less expensive capital investments. VA's 22 regional offices use varying approaches, which are considerably less rigorous than that used in VA's centralized process. These investment decisions, for example, are generally made without systematically assessing ways to redesign or simplify work processes or explore lower-cost alternatives for meeting veterans' needs.

We find this troublesome because such decisions account for over 85 percent of VA's total health care investment dollars requested for fiscal year 2000. Some VA service delivery locations, for instance, opt not to submit investment proposals to VA's centralized process. Officials at some of these locations told us that there is a better chance of receiving funds, through the decentralized process, if a high-cost investment is divided into several less expensive investments that can be spread over several years. The decentralized process requires less information from locations regarding benefits, risks, or alternatives to a proposed investment.

Over the last 3 years, VA has significantly reduced the number of high-cost investment proposals, involving alterations or improvements, submitted for VA's centralized review and prioritization. This has resulted in a disturbing situation whereby VA's decentralized process has approved investments that VA's centralized process had found to be or would consider to be low priority or unsound.

Conclusions

VA could enhance veterans' health care benefits if it reduced the level of resources spent on underused or inefficient buildings and used these resources instead to provide health care more efficiently in existing locations or closer to where veterans live.

Recommendations to the Secretary of Veterans Affairs

We recommend that you develop asset-restructuring plans for all markets to guide future investment decision-making, among other things. These plans should comply with OMB guidelines and incorporate best practices of industry as well as those of VA's 181 delivery locations.

Until more effective capital asset planning is in place, we recommend that you

- require that a larger share of health care investment decisions be made using VA's centralized budget process or
- ensure that the fundamental principles underlying that process are rigorously implemented when making decentralized health care investment decisions.

To reduce subjectivity and thereby enhance the credibility of VA's centralized budget process, we recommend that you

- modify written guidelines to describe, in greater detail, minimum quantitative data required for each decision criterion and
- exclude from the prioritization process all capital investment proposals that fail to meet the information requirements.

Agency Comments and Our Evaluation

In commenting on a draft of this report, the Department of Veterans Affairs generally concurred with our recommendations. VA said that it and the Veterans Health Administration are considering several approaches for addressing our recommendations, but that no final decisions had yet been made. VA further noted that the Capital Investment Board will work with

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the Veterans Health Administration to achieve a balance in the centralized investment process and will obtain outside review to revalidate that process. We urge VA to develop such an approach as expeditiously as possible, because the cost of delaying realignment of VA's health care system is high.[5]

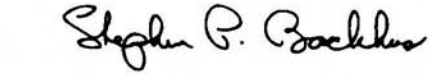
As you know, 31 U.S.C. 720 requires you as the head of a federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Reform not later than 60 days after the date of this report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of this report.

We are sending copies of this report to Chairman Stearns and Ranking Minority Member Gutierrez of the Subcommittee on Health, House Committee on Veterans' Affairs; Chairman Everett and Ranking Minority Member Brown of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs; Chairman Bond and Ranking Minority Member Mikulski, Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations; Chairman Walsh and Ranking Minority Member Mollohan, Subcommittee on VA, HUD, and Independent Agencies, House Committee on Appropriations; and the Director of the Office of Management and Budget. We will also make copies available to others upon request.

[5]VA Health Care: Challenges Facing VA in Developing an Asset Realignment Process (GAO/T-HEHS-99-173, July 22, 1999).

If you or your staff have any questions concerning this report, please contact me at (202) 512-7101. Other GAO contacts and staff acknowledgments are listed in appendix III.

Sincerely yours,



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

DEPARTMENT OF VETERANS AFFAIRS
ASSISTANT SECRETARY FOR PLANNING AND ANALYSIS
WASHINGTON DC 20420

JUL 8 1999

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military
Health Care Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

We have reviewed your draft report, ***VA HEALTH CARE: Improvements Needed in Capital Asset Planning and Budgeting*** (GAO/HEHS-99-145) and generally concur in GAO's recommendations. VA's Capital Investment Board will discuss these recommendations during its scheduled meeting in the middle of the month.

GAO recommends that the Secretary of Veterans Affairs develop asset-restructuring plans for all markets to guide future investment decision-making, among other things. This plan should comply with OMB guidelines and incorporate best practices of industry, as well as those of VA's 181 delivery locations.

Concur - VA's Capital Investment Board (VACIB) will work with VHA to develop an asset-restructuring plan. Numerous capital investment activities including Capital Assets Realignment for Enhanced Services (CARES), asset disposal, and other portfolio analysis initiatives need further coordination within the Department.

GAO also recommends that, until more effective capital asset planning is in place, the Secretary:

- **Require a larger share of health care investment decisions be made using VA's centralized budget process,**
- **Ensure that the fundamental principles underlying that process are rigorously implemented when making decentralized health care investment decisions.**

Concur - The VACIB will work with VHA on an appropriate balance between the centralized investment process and decentralization.

2. Mr. Stephen P. Backhus

To reduce subjectivity and thereby enhance credibility of VA's centralized budgeting process, GAO also recommends that the Secretary

- **modify written guidelines to describe, in greater detail, minimum quantitative data required for each decision criteria and**
- **exclude, from the prioritization process, all capital investment proposals that fail to meet the information requirements.**

Concur - The VACIB continually evaluates the capital investment process to ensure objectivity. We will retain a contractor to review and recommend modifications to the FY 2001 capital investment process, as part of our continuing revalidation of the process.

While these comments reflect the Department's position on GAO's recommendations, the Veterans Health Administration is still considering its approach to these issues. Accordingly, we shall convey any adjustments to the Department's position in our comments to your final report.

We appreciate the opportunity to comment on your report.

Sincerely,

Dennis Duffy

Mr. EVERETT. Why do you believe that the VA has not made more progress? Do you have an opinion on it?

Mr. BACKHUS. I do. First there is obviously still a significant amount of internal discussion.

Mr. EVERETT. Turf battles?

Mr. BACKHUS. Yeah, I think so.

Mr. EVERETT. We have turf battles going on. I mean we have seen it—as Chairman of the compensation and pensions subcommittee I certainly saw it——

Mr. BACKHUS. That is essentially it.

Mr. EVERETT (continuing). In the 104th Congress.

Mr. BACKHUS. That is one reason. Secondly, they are trying to develop policy guidance to send out to their field locations as to how they might want this capital asset restructuring planning done. They have been consulting heavily with stakeholders and are interested and truly believe that they need to have that detailed input from the stakeholders before they put a proposal together. That takes time. I think they would like to have more guidance——

Mr. EVERETT. Excuse me for interrupting, but on stakeholders, hopefully the VA is not using these stakeholders as a human shield to prolong the conclusion that they have to reach. Do you have an opinion about that?

Mr. BACKHUS. Well, only to the extent that we know from having examined what has transpired in Chicago and then some other locations. The heavy, heavy involvement of the stakeholders had protracted the decision and resulted in decisions that weren't very good frankly. They weren't in the veterans' best interest. I don't think that is what they intend. I don't. I really don't think that they intend to use it that way but I think we do have a difference of opinion as to what their role ought to be and how effective that heavy local stakeholder involvement can be or how ineffective it can be.

I know they are also looking for as much guidance as obviously you folks are able to provide. They are hoping that they will get some help here in terms of how to structure all of this. That is a reason why things haven't moved as far as they maybe could have. And the last reason I think is that there is a money issue here. To do these market analyses that we think need to be done will cost money. They need to make sure that they have got that money available before they begin.

Mr. EVERETT. I certainly agree particularly on getting the money where the veterans are, southeast and southwest, obviously, Florida in particular seeing huge veteran populations retire down there than the northeast and other sections of the country. In addition to that, we have this problem, well, it is not a problem, it is just a fact of life that we have this aging veteran population and it seems to me that the more clinics that we can get closer to these veterans the better served these veterans are.

I know that we had a clinic open 2 years ago I think, in Dothan, AL, near my home, and those World War II veterans had been having to drive sometimes 225, 250 miles to go to a VA hospital. And they would get up there and not have an appointment, I mean the appointment would be canceled and they would have to come back. And we are talking about 75, 76-year-old sick people.

We have to somehow bring the health care delivery system nearer to these aging veterans. It simply has to be done. I appreciate the progress that the VA is making in those directions. My time is up again and I will yield now to my ranking member.

Ms. BROWN. I think you have answered one of my questions concerning local steering committees or central facility management. How do you think this process should take place?

Mr. BACKHUS. I am afraid I might be repeating myself but we seem to think that some process that is more independent and centrally managed that keeps the stakeholders informed of the information so that they can understand it and hopefully eventually support the proposals is the framework we would choose. And the advantages of that are that it removes the people with the vested interests from protecting their own turf and results in decisions that hopefully are better and we suspect would be better for the veterans.

Ms. BROWN. You have noted that VA should prioritize its realignment plan. Would you discuss some of the criteria you would recommend for this prioritization process?

Mr. BACKHUS. Clearly the areas of the country that seem to have the most potential at this point for achieving a savings that could be reapplied or reinvested to improve veterans' benefits are those areas of the country that have multiple medical facilities very close to each other. We have identified 40 markets that have facilities that are within approximately an hour of each other, and in those 40 markets there are 115 locations that actually deliver health care. We think these markets offer a great possibility of restructuring and in some cases consolidating those facilities because I think there are nearly 60 of them that already have utilization far below what you would consider to be necessary to maintain a viable operation.

And the projections for the veteran population in those areas far exceed what the average projections are for the veteran decline. In other words, overall it is estimated that the veteran population will decline 36 percent over the next 20 years. In these particular locations you not only have low utilization but you have projections of veteran declines far in excess of 36 percent.

There seems to be an opportunity in those places to take the existing infrastructure and find better ways to meet the needs of veterans. So I would choose as criteria those as the ones to start with and make a complete assessment, and within even those 40 there are nine locations that we have called mega markets. In those nine alone, there are 46 facilities that are competing to serve the same veterans right now.

Ms. BROWN. Thank you very much.

Mr. EVERETT. Chairman Spence.

Mr. SPENCE. No questions.

Mr. EVERETT. Thank you very much. Let me say at this time I appreciate your testimony here today. It is clearly helpful to the subcommittee. Ms. Brown was correct when she said we talk to our veterans and they are very angry. They see that their health care system has failed for whatever reason. It is not working for them. It may be in some cases that the VA should be delivering more than the VA was actually promising, but it is clear to me that

again for whatever reason we have broken some promises to our veterans.

And certainly somehow or the other we've got to reach a conclusion here and come together for whatever vehicle that is out there and do what is right for the veterans. It has to be done. I thank you for your contribution here today. I am sure that the VA will have some answers and they would like to perhaps disagree with you. We respect that and we will listen to that. So thank you very much.

I would now like to recognize Mark Catlett, the Deputy Assistant Secretary for Budget, Department of Veterans Affairs, and Kenneth Clark, Chief Network Officer, Veterans Health Administration. Both are not strangers to this subcommittee and we welcome them back. Mark, if you would like to begin, please do so. I am sorry, Ken.

Mr. CLARK. Actually I will make the statement if that is all right with you.

Mr. EVERETT. Please.

STATEMENT OF KENNETH CLARK, CHIEF NETWORK OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY D. MARK CATLETT, DEPUTY ASSISTANT SECRETARY FOR BUDGET, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF KENNETH CLARK

Mr. CLARK. Mr. Chairman and members of the subcommittee, I submitted testimony for the record but I would like to make a brief opening statement. I am pleased to appear before you this morning to discuss progress in VHA's plans to improve the management of capital assets and in particular to comment on the CARES concept and our plans to address market-based studies for restructuring assets recommended by GAO.

Dr. Thomas Garthwaite, the Acting Undersecretary for Health, testified in March about the unprecedented changes that have occurred in VHA in the last 4 years, and acknowledged that in many locations our physical infrastructure no longer supports the optimal delivery of modern health care services. VHA recognizes the economic impact of continuing to operate and maintain excess and functionally inefficient buildings as reported by GAO.

Freeing resources currently devoted to maintaining unnecessary buildings will increase services to veterans by providing new and expanded facilities for outpatient care, improving access and enhancing health care services we currently provide to veterans. We also agree that the market-based planning studies in VHA's 106 health care markets are an essential element for capital asset restructuring plans in each of those markets.

Since the March hearings, we have attempted to better define and integrate the various capital asset management initiatives into a comprehensive policy for VHA which will include the capital assets realignment for enhanced services or CARES concept. This concept which was first envisioned in April by Dr. Kizer, then Undersecretary for Health, has evolved over the past 3 months in discussions with our stakeholders as well as VHA field managers.

We believe that involvement of stakeholders is an essential ingredient in our planning processes. The proposed Veterans' Millennium Health Care Act embodies the same capital asset management principles as does CARES and the legislation will have an obvious impact on the final form of any capital asset restructuring plans that VHA will develop. Over the past several months we have further developed the CARES concept which defines the need for broadened stakeholder involvement in network strategic planning processes, emphasizes market-based network planning for determining needed health care services to veterans, and focuses attention on the need to realign VHA's capital assets to more efficiently support the delivery of enhanced health care services.

A second initiative begun since the March hearing will improve network capital asset planning by responding directly to GAO's recommendation for a more rigorous review and evaluation of our decentralized capital investment decisions. This program defines criteria as well as a process to be used by the networks in evaluating their capital investment decisions. It introduces a concept of a headquarters capital oversight management board. The board will review selected decentralized capital initiatives for compliance with department strategic goals and objectives, strategic mission and network business plans to validate the capital investment decisions that are made at the local level.

A third initiative is development of a draft statement of work to be used for the market-based studies recommended by GAO and an action plan for completing these studies in all of the markets in which VHA operates health care facilities using independent consultants to perform market studies over a 5-year period. The draft statement of work for these studies will closely parallel the work that is currently in the study that is now underway in the Chicago area, as well as a similar study done in northern California. A VHA work group will finalize a capital asset management policy as well as develop a guidebook to be used by field managers in implementing this policy.

As part of the policy, we will integrate several capital asset management concept proposals including the mission realignment process, CARES process and concept, the network capital asset planning directive, recommendations and findings from the market-based studies, VA's capital investment process, and the network business planning into a single comprehensive capital asset management program which will provide a balance between the need for strategic health care planning at the local network level, stakeholder involvement in the process, and headquarters involvement at the corporate level to insure that departmental strategic perspectives are followed and consistent implementation of the CARES principles across all 22 networks and all 106 markets.

This integrated planning program will be completed by the end of this fiscal year and it is my expectation that by December the VISN networks will complete an implementation plan and establish capital asset planning committees to assist in their planning efforts and to assure active involvement of stakeholders. These steps will allow VHA to address key strategic capital asset decisions to insure that the veterans' health care system effectively utilizes its capital assets to meet the needs of our patients. Thank you

for the opportunity to comment and I will be glad to answer any questions that you have.

[The prepared statement of Mr. Clark appears on p. 50.]

Mr. EVERETT. Thank you very much. Let me begin by asking does the VA agree with GAO's assessment of $1 million a day of potential operations and maintenance savings? Is your figure higher or lower, and how did you arrive at your figure?

Mr. CLARK. Mr. Chairman, I don't have a specific figure. I can't confirm or refute GAO's figure. I will say simply that we acknowledge and agree that it does cost a considerable amount of money to maintain buildings that we agree are no longer necessary for our operation. I think that has to be viewed in context and that context was stated in the GAO testimony, that VA has made considerable strides over the last 4 years resulting in a substantial savings. And the fact that many of the buildings that we are talking about this morning are now empty because of savings in inpatient care that have occurred over the last several years.

Mr. EVERETT. Over 14 months ago, GAO recommended that VA could meet veterans' needs in Chicago by operating three rather than four hospitals. VA has yet to produce a plan or a date for realigning assets to enhance veterans' benefits. Why is this taking so long? I recognize the political implications of this but is that the only problem that we have there, the political implications?

Mr. CLARK. I wouldn't for a moment deny the political implications of that decision or any of those similar decisions. The reason that it has taken so long for the study to conclude is I think really the complexity of the study itself. We have had a study group that has been working with a consultant on the Chicago area project for many, many months. I expect to get a report—it has been committed to me that a report will be received by my office by the end of this month.

Frankly, the delay I think has more to do with the fact that the consultant that is working on that project has found the task to be more considerable than they originally thought and has requested additional time to do a thorough project. But again the chairman of that committee has talked to me within the last couple of weeks and expects to have a report prepared for me by the end of this month.

Mr. EVERETT. I appreciate that answer. The problem that I have getting by this particular location is the fact that if we repeat that nationwide it will be the year 3000 before we finally get something done because of the length of time it is taking. In the meantime we are wasting $1 million a day. It seems to me, particularly in Chicago, $1 million a day, that somehow or the other we could get it done. The savings is $20 million a year, and I am led to believe it would be, we could ask for legislation to make sure that $20 million stays there in that area, as I said earlier, so that we can reach out to these aging veterans and put these clinics in the neighborhoods where these veterans live.

This is a situation that we just have to move a little faster or, somehow or the other. Let me say how would VA's reinvestment of $400 million, assuming that is the figure, I will ask you to accept that in annual care for veterans, with more primary care clinics as I was saying about Chicago, specialty care, and reducing the long

waits. That is the same question I asked GAO a little bit earlier. What could you do to better use that $400 million a year?

Mr. CLARK. Well, I think all of those things and more. We have over just the last several years, opened in excess of 270 community-based outpatient clinics. And, you yourself have pointed out here today that that has brought health care much closer to where veterans live and where they work and that is really our objective. There are other areas that are underserved throughout the country that could benefit from community-based outpatient clinics that frankly we have not been able to place there because we don't have the funds to do that.

I would envision that savings from reducing costs of maintaining unnecessary buildings would be invested in additional outreach initiatives that would allow us to treat more patients and do it more conveniently. We also, as you well know, are experiencing some waiting times in various parts of the country. Clearly, savings in any part of our operations would allow us to redirect those funds to provide direct patient care services which is what we would do with funds that we would recoup from savings in this area.

Mr. EVERETT. GAO estimates there is 5 million square feet of currently unused space in the VA system. Would you agree with that figure? And also they estimate it is costing approximately $35 million a year to maintain that unused square footage.

Mr. CLARK. Again, Mr. Chairman, I couldn't confirm or refute that precise figure. I will certainly agree that we have a number of unused buildings. We have generated the underutilization of space principally because we have seen such a dramatic change in the way that we deliver health care services. We now operate fewer than half the beds that we operated just 3 or 4 short years ago. Our shift from inpatient care to ambulatory care as the primary vehicle for delivering health care services throughout the health care system has dramatically changed the kinds of facilities and resources, capital assets, that we need to provide those services.

So, yes, clearly we have a number of buildings that are not occupied. They will not need to be occupied in the foreseeable future because of the changes that are going on in health care. And I anticipate that although the shift from inpatient to outpatient care may be more modest in the months and years to come simply because we have come so far, I still think we will see additional shifts to less inpatient care and more outpatient care in the upcoming years.

Mr. CATLETT. Mr. Chairman, may I add to that response by Mr. Clark?

Mr. EVERETT. Yes, please.

Mr. CATLETT. Two points I would make. One is recognizing your sense of urgency and need to move with the broader restructuring within the authorities that we now have, particularly enhanced use. We are increasing the opportunities to use that several million square feet of unused space for other purposes in partnership with the private sector. In some cases, specifically for veterans' needs.

And we are seeing some good projects come forward more frequently and we certainly appreciate the support that both authorizing committees have provided in giving us that authority. The other thing I would add is a little broader in terms of the VA. We

are undergoing a vigorous review with VBA looking to satisfy their space needs on VA medical campuses.

And I would hope that in the near future, in the next budget, in fact, you will see specific projects co-locating the regional offices onto these campuses either in that unused space or possibly even in new structures. And you will certainly see evidence of a strong planning process within VBA, working with VHA to bring those regional offices onto medical center campuses. And that has gotten a good boost in this last several months as we have looked at this whole issue of utilizing this unused space. It is not only about getting rid of it but finding uses within the VA.

Mr. EVERETT. We are going to have a second round of questions. I will yield to my ranking member now.

Ms. BROWN. I am going to ask you the question that I first asked GAO, and it pertains to the facilities. What degree of not using the facilities pertains to budget reductions or just not being needed? Do you understand the question?

Mr. CLARK. Yes, I do.

Ms. BROWN. Okay.

Mr. CLARK. While there are instances where we have had some delays in activating certain facilities, that has been as much as anything else budget driven. However, the majority of the underutilized or underused buildings or vacant buildings that we were referring to this morning have much more to do and in most cases all to do with the shift in the way we are providing health care services.

I can't overemphasize the dramatic change in the delivery of health care services that have gone on in the health care industry, and as was mentioned earlier, our change has been probably more pronounced than the industry's change in the short period of time but it really parallels what has happened in the private sector. We have gone from a largely hospital-based system just 4 or 5 years ago to a basically outpatient-oriented health care system now, and that has resulted in a dramatic change in the use of the buildings that we have had with our system for years.

Ms. BROWN. So realignment is needed?

Mr. CLARK. Clearly realignment is needed. We support the conclusions in the GAO report that there is a need for substantial realignment and restructuring of our assets in the VA health care system.

Ms. BROWN. Let me just say one thing. I agree with you and with the report but the delivery of the services is so important to the veterans. They are not happy with some of the changes, and I don't mean inpatient services. I mean even outpatient services when they are not being able to get their appointments or treatments or just the reductions in the staff. So if we have shifted, where is the money? It is not necessarily that we have money for this new operational system that we have in place.

Mr. CLARK. Well, the money that has been shifted, saved, if you will, from reducing the amount of care that we provide in a hospital bed has been reinvested in additional primary care clinics, in the community-based outpatient clinics. The community-based outpatient clinics, the 270 some odd that I mentioned, have been entirely funded out of our medical care budget. We didn't get addi-

tional sources of money to open those. Those had been done simply by shifting money from one part of our operation to another.

The point you raise I think is very valid that many of the changes have been difficult for the patients in the veteran community to accept, and that is why we believe so strongly in involving stakeholders in important decisions like this. I think our disagreement with GAO would perhaps be only a matter of degree that we have, we feel, in making dramatic change in the health care system by and large because we have brought our stakeholders into the process and gained support from them in what we have tried to do, and that is really what we would want to do in this process as well.

Ms. BROWN. Mr. Chairman, I will yield back the balance of my time.

Mr. EVERETT. Thank you very much. Chairman Spence.

Mr. SPENCE. Thank you, Mr. Chairman. Mr. Clark, you say in your statement that the President's 2000 budget proposed the pilot program to improve the management of capital resources, and you went on to say that the program would allow the VA to dispose of excess and underutilized property and use 90 percent of the proceeds for infrastructure needs and so forth. In other words, are you more or less tracking what GAO has told you they found and trying to correct some of those problems with the authority you have in the budget?

Mr. CLARK. Let me defer to Mr. Catlett to answer that question. I think he is better able to do that.

Mr. CATLETT. Mr. Spence, what we are trying to do with that legislative proposal is to provide the incentive to locals—those in the networks, those at the medical centers, who have to bring about this change. They need to consult with their stakeholders in making these proposals and working through all the various interests out there. That incentive is to let them keep those revenues to reinvest in the system whether that is opening more clinics or hiring more doctors or whatever it may be.

But at this point the only avenue we have is to lease those properties as I mentioned earlier to the Chairman, in what we call the enhanced use program. This new proposal would allow us to sell all or portion of a facility and those revenues then be retained by the VA specifically for medical care needs. It is a legislative proposal that we have been spending quite a bit of time on. And again it is quite complicated by the issue of the McKinney Act. There has been a hold within the Administration on this proposal concerning the McKinney Act exemption since the proposal was made in the beginning of February within the President's Budget.

Mr. SPENCE. That is all I have, Mr. Chairman.

Mr. EVERETT. Let me read from your statement. Mr. Hill, I am very sorry. You came in here and I didn't notice you coming in. Would you have any questions? Yes, please go ahead, and I apologize for not recognizing you.

Mr. HILL. Thank you, Mr. Chairman. The VA health care system of course has a lot of stakeholders. There are medical schools that are reluctant to change longstanding business relationships, unions that are reluctant to support planning decisions that might result in a restructuring of services and of course your friends in Congress who represent districts where change is threatened. Unfortu-

nately, stakeholder pressure can lead to decisions that are not in the veterans' best interest. How will your planning process meet these challenges and remain credible?

Mr. CLARK. The stakeholders that you mention are important to us. Again, we feel that the changes that we have been able to make in recent years has been in large measure because we have garnered the kind of support that we felt we needed to make those changes from the stakeholders. They all have related but somewhat different interests and balancing those interests in gaining that support has been a challenge. I think my response to your question would be that I think we need a balance of opportunity for stakeholder involvement, direct participation and involvement, at a local level, but that has to be balanced with some centralized uniformity, consistency, development of criteria, and perhaps additional oversight so that the broad needs and interests of veterans and the objectives of the VA headquarters can be balanced with the interests and the needs of the local stakeholders.

Mr. EVERETT. Would the gentleman yield?

Mr. HILL. Yes.

Mr. EVERETT. That is an excellent question, and, Mr. Clark, I just have to tell you that I challenge that answer. I know, for instance, from personal experience that you had zero support from your stakeholders in combining the east and west campus there in Montgomery and Tuskegee. You had zero support. I don't know about across the Nation but I would suspect that those veterans there are no different than veterans across the Nation. And I appreciate the gentleman's question and also yielding to me.

Mr. HILL. Mr. Chairman, I have a second question. The General Accounting Office assessed the assumptions and data for proposals submitted for building improvements, for alterations to the VA's capital investment panel for fiscal year 2000 funding consideration. In general, the General Accounting Office found that the proposal information was neither uniform nor complete. With the credibility of your plan being so important to Congress, how do you respond to this?

Mr. CATLETT. Mr. Chairman, I would like to respond to that, please. The efforts that we have made in terms of improving the capital investment process I think have been significant. It doesn't minimize the point that you are making here that they can be improved, and we would agree with that. But the efforts that we have made to improve the data and the analysis reflects I think in part the recognition that we do need to restructure.

I would add for perspective that we have significantly reduced over the past few years the amount of money that we are putting into the major construction component of our capital investments. We have recognized under Dr. Kizer's leadership in the health administration the need to slow down capital investment until we get our act together better.

And I think we have made steps. Obviously, some could say do nothing until you have completely designed or developed a data analysis process that is complete and accurate; but I think frankly that is very tough to do in the government because of competing interests and perspectives. So, again, I would offer I think we have made progress. I think you will see progress in 2001 in terms of

our ability to analyze the data and make it more relevant to the future needs of improving service to veterans.

But I wouldn't try to blow smoke at you and say that it is perfect. I am not arguing that. I am saying we recognize the issues and we are making efforts to improve that and we have slowed down the amount of money we have invested in the capital, particularly the major construction component, while we are improving that.

Mr. HILL. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you for those questions. Mr. Udall.

OPENING STATEMENT OF HON. TOM UDALL

Mr. UDALL. Thank you, Mr. Chairman, and thank you members of the panel for being here today. I represent a very rural district in northern New Mexico that is bigger than the State of Pennsylvania. And one of the very successful programs that the Veterans Administration has initiated in the health care area is contracting with clinics in small towns to the tune of $400 or $500 a year per veteran to get their local health care needs taken care of at the local level.

And clearly this is a program that benefits the veterans. They can be taken care of at home. They don't have to travel long distances. Their needs are met immediately. They don't have to go down and wait in a line. Recently, I have been notified that this program is threatened and that they may have to cut back and these people, many of them are very elderly World War II veterans, are going to have to travel these long distances. They can't drive themselves so relatives are going to have to take time off of work and do it.

It really disturbs me hearing today in this GAO report that there are inefficiencies in your system and yet at the same time if you corrected those inefficiencies you could be addressing and possibly we could be putting monies into reaching veterans in rural areas. I just hope in the course of you re-evaluating this report and taking steps forward that you are going to put a priority on reaching veterans in rural areas and that you recognize in your evaluation of this report that many veterans live in rural areas and that they need to be taken care of closer to home, and I would like to know what your response is to that. Thank you.

Mr. CLARK. My response is that I agree. Again, the extent to which we have been able to move our service delivery system out to where the patients live through community-based outpatient clinics has been because we have realized savings elsewhere in the system and successfully redeployed those savings to outreach. Many, if not most, of the community-based outpatient clinics have gone to more rural areas that are in pockets of veterans population that have been underserved or could not conveniently get to VA facilities.

That would continue to be our strategic direction to try to reach those pockets of underserved veteran population through the redeployment of funds that come about from savings elsewhere in the system, and this is clearly one of those areas where we could realize some savings.

Mr. CATLETT. Mr. Chairman, could I——

Mr. EVERETT. The maintenance of those clinics is one of our highest budget priorities, or it should be for those rural clinics and clinics in general.

Mr. CLARK. Yes. Yes, clearly.

Mr. EVERETT. I am sorry. Mark.

Mr. CATLETT. No, sir, I just wanted to add a broader point that has been on my mind; I think we made this point in the March hearing before Chairman Stearns' subcommittee. When GAO speaks of this one in four medical care dollars or when you speak of the $1 million a day estimate, most of that savings is staff savings to be achieved because most of that money in maintaining our facilities in our staff.

So, again, not to offer an excuse but the employees are another stakeholder in this change. In order to generate savings, this is my perspective clearly and I don't think I am off on this, will require reducing staff. That doesn't mean reducing nurses or doctors. In fact, I would hope that means we are going to increase nurses and doctors. But the primary savings is reducing the indirect staff that supports this infrastructure.

As you know, we have reduced 25,000 FTE already in the system and I think to complete the efficiency that GAO talks about could mean thousands and thousands more being reduced as well. Again, you have to look at the net result because you are talking about adding nurses and doctors but reducing the blue collar workers and the wage grade workers that support these infrastructures. It is not just as simple as saying if you would sell that asset or lock up that building, you are going to save a lot of money.

Mr. EVERETT. Would some of that be achieved through retirement and attrition, that sort of stuff?

Mr. CATLETT. Well, we have used all the tools. We are seeking buy-out authority again and would like to see that extended.

Mr. EVERETT. Ms. Brown and I were talking and we both agree that there probably ought to be more money within the VA health care system. We might differ on the exact amount but we both are in agreement with that. You also know from the last 5 years starting with our computer situation, our concentration has been in the waste that we see in the VA, $97,000 for a basement to be water proofed, $26,000 for fish tanks and things like that.

But beyond that I get the sense overall that sometimes we don't know who is in control. Let me read from your statement, Mr. Clark. It says the Office of Facilities Management, the VHA Office of Policy and Planning, and the Office of Assistant Secretary for Financial Management are in the process of determining roles each will have in implementing the GAO market-based surveys.

I am recalling back to the 104th Congress when we went through the same kind of thing on modernization of our computer structure and trying to drop down the compensation claims processing waiting period then, which was I think around 170 or 180 days. The problem we have is that we didn't see a road map. We didn't have a road map, plus the fact I think you can recall that we didn't know who was in charge a good bit of the time, or at least I never found out who was in charge. I am wondering here who is in charge of this, who has the final say-so of these three different offices that are involved in it.

Mr. CLARK. The Undersecretary for Health, in this case the Acting Undersecretary for Health, Dr. Garthwaite, would have that final authority and all of those programs operate under the Undersecretary for Health. What I was trying to point out in the testimony is that, while I really don't believe that this is a turf battle, there are many offices involved. The Office of Planning is involved in strategic planning and capital asset planning.

Clearly, the Office of Facility Management has a stake in this. My office does as responsible for field operations. I think that adds a level of complexity to the process but our challenge is to bring those offices together to determine who can contribute in what ways to bring about a comprehensive program that is understandable and meets our objectives. But to directly answer your question all of that is under the responsibility of the Acting Undersecretary for Health.

Mr. CATLETT. Mr. Chairman, I would like to provide you some comfort. I have been part of many discussions with VHA, and Assistant Secretaries for Financial Management and Planning and Analysis. There is no conceptual disagreement about what we need to do and where we are headed on this. I would even suggest the differences in terms of technique or process are minimal or very small. I feel very comfortable in telling you, I am assuring you there is no delay because there is an issue about turf and who has the leadership on this.

We all recognize the need and we are all pulling together on this. And as I said, most importantly, there is broad conceptual agreement throughout the headquarters in terms of what needs to be done and moving ahead with it.

Mr. EVERETT. I am smiling because you tell me there is no issue of turf.

Mr. CATLETT. Yes, sir. I believe that firmly.

Mr. EVERETT. Let me tell you we can't ask the GAO to do a systemwide evaluation of what we need to do. That has to be done by the VA. And the frustration that you see coming out here is the fact that I don't think that we can wait another 5 or 10 years at a cost of over $1 million a day of veterans' health care money to get that answer. We need for you guys to appoint a special task force to make this a number one priority.

Something has to be done to get this thing on track and moving faster. I appreciate what has been done so far. I appreciate the leadership of Dr. Kizer. And I have the greatest respect, as each of you know, for the work that the VA officials up here are doing by trying to head in the direction to do it. But we cannot waste another $1 million a day over the next 5 to 10 years trying to find out what we need to know. We have to get there.

And one of the things I would ask you to do is go back and get some sort of higher priority placed on this and let's put it on some sort of fast track.

Mr. CLARK. We are committed to do that and I hopefully brought that out in my oral statement. I am frankly not satisfied with the progress we have made in the past few months on this. It is a complex issue trying to integrate all of our different strategic and capital asset initiatives. It is not an easy thing to do. We are, as we talked about earlier, committed to involving stakeholders in the

process. How much to involve them, how much participation or control over the process to allow them has been frankly a point of considerable contention within VA, and we are in the process of trying to sort that out.

This is being given a high priority. I am committed, as I said, to bringing this to conclusion as rapidly as possible so that we have a comprehensive plan that works for all of us, and I will commit to make that a high priority for VHA.

Mr. CATLETT. Mr. Chairman.

Mr. EVERETT. Yes.

Mr. CATLETT. I am sorry. I would add one other point. The third issue that GAO mentioned in answering your question about reasons for a delay as they see it concerns the funding of these studies. I can tell you that since that March hearing there has been interest on the Appropriations Committee staffs on both sides of the Hill. I am cautiously optimistic that we should see some funding for these studies in the 2000 budget.

We know they are interested. We provided information. We provided estimates. We provided technical assistance in terms of language to allow us to get the money this coming year and not wait another year. So, again, fingers are crossed that we will see some of this money needed to hire the consultants. So I am, hopeful that we are going to have some funding to assist us in this effort in the 2000 budget.

Mr. EVERETT. And I would hope so also, and I would also associate myself again with Mr. Hill's remark. In fact, I would hope you would find these consultants to be independent of the stakeholders who may have an interest and might not serve the overall interest of the veterans. I would hope you would give great consideration to having someone independent look at this, rather than someone who moves more by emotion than they do practical reasons. Before I read my closing statement, does any other member—Ms. Brown.

Ms. BROWN. Yes, Mr. Chairman. First of all, let me thank you for your leadership in this area and I want to note particularly that we don't disagree at all as far as the additional money. I will take any amount that we can get. But also the situation as far as the waste is concerned deeply concerns me and you have been a leader on that. And I am also concerned about this $1 million a day that everybody is talking about. That is a lot of money.

And I have some written questions that I would like to submit to Mr. Clark and please can I get a timely response and not the next time we have a hearing, not that I am talking about you but I do have some written questions. I would also like to submit my official statement, to the record.

Mr. EVERETT. Without objection.

Ms. BROWN. And back to that $1 million. I think that just $1 million a day, that is a lot of money. That is a lot of money. And you don't really—you don't know how they came up with the figure, you don't know whether it is accurate. I think we need to get on top of that. I could use the money in Florida.

Mr. CLARK. I understand. We clearly want to move the CARES process forward.

Mr. EVERETT. The gentlelady will always let you know about Florida.

Ms. BROWN. So thank you, Mr. Chairman, for having this hearing, and I think we need to get some answers.

[The prepared statement of Congresswoman Brown appears on p. 36.]

Mr. EVERETT. I thank you. GAO's testimony this morning demonstrates how urgent the situation with the VA hospital system has become. The government's health care system for veterans has become grossly inefficient: waste at the rate of a million dollars a day or more, five million square feet of unused space, thousands of empty, underutilized or obsolete buildings, and hospital utilization that has dropped 50 percent in the last decade. This is the picture of a health care system in a steep decline.

The VA must deal with this crisis as rapidly as the complexity of the situation permits. Huge amounts of money are being wasted, when those dollars could be reinvested to improve access and quality of veterans' care. And I for one would say that if we need to pass legislation to make sure that this money stays within the VA, I would certainly be willing, and I am sure this Committee would be willing to do that. Capital asset planning sounds like something only an accountant could get excited about, but it is a key element in providing for veterans' health care.

The planning has to be more than an exercise in rearranging the deck chairs. It won't work that way. It must be objective and realistic. It must be geared to today's and tomorrow's health care markets. By becoming more efficient, the VA could in effect increase its budget by a million dollars a day.

Working with our committee leadership, I expect to continue having oversight hearings on VA's progress in restructuring its health care system for veterans. I suppose we could just let it fall apart, time will take care of that, but the responsible way is to plan for these changes for the maximum benefit of our veterans. And I am not talking to just the VA here. I am talking to the Congress also.

Without objection, members will have 5 legislative days in which to submit statements and questions for the record. The hearing is adjourned. Thank you very much.

[Whereupon, at 11:30 a.m., the subcommittee was adjourned.]

APPENDIX

U.S. House of Representatives
Committee on Veterans Affairs
Subcommittee on Oversight and Investigations

Oversight Hearing on VA's Capital Assets Realignment for Enhanced Services for Veterans

CHAIRMAN TERRY EVERETT

OPENING STATEMENT

The hearing will come to order.

Good Morning! This Oversight and Investigations Subcommittee hearing will examine the progress the VA has made in capital asset planning. For the VA, capital asset planning basically means figuring out how it is going to restructure its vast health care system, which has thousands of buildings.

This subject is a matter of bipartisan congressional concern. This past March, Chairman Stearns of our Subcommittee on Health held a hearing on VHA's management of its capital assets. At that hearing, GAO testified that VA's asset planning indicated that billions of dollars might be used to operate hundreds of unneeded buildings over the next five years.

GAO also estimated that one in four medical care appropriated dollars will be spent on operating and maintaining its assets. This translates to as much as $20 billion dollars over the next five years.

GAO strongly recommended that VA seriously consider such alternatives to current operations, such as consolidating services, partnerships with other health care providers, procuring care and services, and replacing obsolete assets with modern ones that address

the health care needs of our veterans today and in the future.

During that March hearing, the VA healthcare delivery system was described as increasingly dysfunctional, archaic, decrepit, inefficient, and having a staffing structure filled with duplication.

Some older VA medical centers have more than fifty buildings. No other health care provider in America today can afford to operate with this kind of setup. It is expensive and wasteful. As Chairman Stearns stated, "We should be taking care of veterans, not buildings."

I should note that the Veterans Affairs' Committee has proposed legislation that in part would assist the VA in it capital asset management. The bill, H.R. 2116, is known as the Veterans Millennium Health Care Act, and it awaits House approval.

The VA has committed to a disciplined independent analysis of the forty locations the GAO identified with multiple health care delivery locations. Today, four months later, we will examine how much progress the VA has made to seriously address the future. We will also hear the shocking cost of indecision.

I now recognize Congresswoman Corrine Brown, our Subcommittee Ranking Democratic Member.

CLOSING STATEMENT

GAO's testimony this morning demonstrates how urgent the situation with the VA hospital system has become. The government's health care system for veterans has become grossly inefficient. Waste at the rate of a million dollars a day or more, five million square feet of unused space, thousands of empty, underutilized or obsolete buildings, hospital utilization that has dropped over 50 percent in the last decade: this is the picture of a health care system in a steep decline.

The VA must deal with its quiet crisis as rapidly as the complexity of the situation permits. Huge amounts of money are being wasted when those dollars could be reinvested to improve access and quality for veteran's health care. Capital asset planning sounds like something only an accountant could get excited about, but it is a key element in improving veteran's health care.

This planning has to be more than an exercise in rearranging the deck chairs. It must be objective and realistic, and it must be geared to today's and tomorrow's health care markets. By becoming more efficient, the VA could in effect increase it budget by about a million dollars a day.

Working with our Committee leadership, I expect to continue having oversight hearings on VA's progress in restructuring its health care system for veterans. I suppose we could just let it fall apart -- time will take care of that -- but the responsible way is to plan these changes for the maximum benefit of our veterans.

Without objection, members will have five legislative days in which to submit statements and questions for the record.

The hearing is adjourned.

STATEMENT OF CORRINE BROWN
RANKING DEMOCRATIC MEMBER
VETERANS' AFFAIRS SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

Hearing on Department of Veterans Affairs' Progress
In Developing Its Capital Asset Realignment Plan
July 22, 1999

Mr. Chairman, I commend you for holding this important hearing on VA's progress in developing its capital asset realignment plan.

The Veterans' Affairs Subcommittee on Health laid a good foundation with its March 10th hearing on capital asset planning. I am anxious to hear from GAO and VA regarding the structure of the planning process, the direction it is going, and the pace it is moving.

I recognize the enormity of VA's task, with over 4,700 buildings -- 40 percent of which are more than 50 years old. And I appreciate the challenge of satisfying affiliated medical center deans, unions, and, of course, Members of Congress who represent districts in which changes need to be made. It is important, however, that this Subcommittee help VA do what it must to fix its health care system. And VA must do it in a way that gives Congress confidence that VA's decisions are based on a thorough and rational analysis.

Capital asset planning is a real case of "time is money". One-fourth of VA's health care budget is spent on operating, maintaining, and improving its property. GAO will tell us this morning that VA could be spending $1 million or more a day to operate and maintain unneeded assets.

It is critical that VA accept its stewardship responsibility and bring Congress a creditable plan in a timely fashion. It is terrible to think that VA might be short-changing the delivery of health care services so that they can heat empty, obsolete buildings. Budget resources for health care next year are scarce and may well fall short of the mark necessary for even adequate service. VA must not delay its planning process.

It is also important that VA protect those programs that are so special to its mission, such as traumatic brain injury, spinal cord injury, and blind rehabilitation.

Some of the decisions VA must make will be painful to its stakeholders, including Members of Congress. It is vital to the success of realignment that this Committee support VA in restructuring its resources and allow a truly "patient-centered" health care system to emerge.

I am sure that witnesses this morning will want to talk about VA facilities in the Chicago area, an issue effecting several Members of the Committee on my side of the aisle. The critical point with Chicago, as with any other service-delivery market being considered, is that the process be impartial. Stakeholders must have an adequate opportunity to provide input.

Mr. Chairman, no one said that governing was easy, but it is the responsibility of this Subcommittee to see that it is done fairly and efficiently. To that end, I look forward to hearing our witnesses on this important matter.

United States General Accounting Office

GAO

Testimony

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

For Release on Delivery
Expected at 10:00 a.m.
Thursday, July 22, 1999

VA HEALTH CARE

Challenges Facing VA in Developing an Asset Realignment Process

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

GAO/T-HEHS-99-173

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss utilization of health care assets owned by the Department of Veterans' Affairs (VA) and operated by the Veterans' Health Administration (VHA). VHA spends about one of every four health care dollars operating, maintaining, and improving buildings and land at 181 major delivery locations nationwide—in all, more than 4,700 buildings and 18,000 acres of land.

Four months ago, we reported that VHA's asset plans indicate that billions of dollars might be used operating hundreds of unneeded buildings over the next 5 years or more.[1] This could result because VHA does not systematically

- evaluate how veterans' needs relate to asset needs on a market (or geographic) basis or
- compare assets' life-cycle costs and alternatives, such as purchasing care from other public or private providers, to identify how veterans' needs can be met at lower costs.

We concluded that VHA could enhance veterans' health care benefits if it reduced the level of resources spent on underused, inefficient, or obsolete buildings and reinvested these savings, instead, to provide health care more efficiently in modern facilities at existing locations or new locations closer to where veterans live.

We recommended that VHA systematically develop asset restructuring plans for all medical care markets in a timely manner. From our perspective, such assessments would involve 106 markets, including 66 that have a single VHA delivery location and 40 with multiple locations. Overall, these markets include 165 VHA hospitals.

VHA agreed, in general, with our evaluation and said, at that time, that it would take the steps needed to restructure its portfolio of health care assets. In light of VHA's commitment, you asked us to provide (1) additional information on VHA's hospital utilization and (2) an assessment of efforts to implement an asset realignment process.

[1] VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).

My comments this morning are based on our studies completed over the past 5 years that involved

- visits to over 100 VHA health care delivery locations,
- visits to VHA's headquarters and VHA's 22 regional offices, and
- discussions with over 500 officials.

Also, we reviewed reports by inspectors general of VA and the Department of Health and Human Services (HHS), as well as private sector consultants regarding hospital utilization.

In summary, VHA's hospital utilization systemwide has dropped dramatically (about 58 percent, or 28,000 patients a day) during the past decade, with most of this decline occurring over the past 3 years. Furthermore, hospital utilization is expected to continue to decline significantly over the next 20 years, primarily because of a projected 36-percent (9 million) reduction in the veteran population Currently, utilization of individual VHA hospitals varies widely, ranging from an average of 4 to 389 patients per day. About one in three hospitals serves markets experiencing the highest declines in veteran population and lowest utilization among VHA's hospitals (fewer than 50 patients daily in rural hospitals or 150 in urban hospitals).

Over the past 4 months, VHA has made limited progress toward implementing a realignment process. To date, VHA's efforts have focused on discussions of who should lead such a process, how stakeholders should participate, and how decisions are to be made. On the positive side, VHA seems to be leaning toward a process that would allow for stakeholder participation and incorporate asset planning guidelines that are consistent with industry practices. When implementing this process, however, VHA could rely too heavily on local stakeholders who may have vested interests in maintaining the status quo. VHA's past experience suggests that this could result in a protracted decision-making process that continues the expenditure of scarce resources on unneeded buildings, at a rate potentially as high as $1 million a day.

BACKGROUND

Within VHA, 22 regional offices, referred to as Veterans Integrated Service Networks, have primary responsibility for health care delivery to more than 4 million veterans. In each network, a director and a small staff perform a wide range of activities, including asset management.

VHA's 165 hospitals provide a wide range of medical and mental health services. More than two-thirds (110) provide primarily medical and surgical services, whereas the rest provide primarily mental health services—both shorter-term (fewer than 30 days) and longer-term.

In October 1995, VHA began to transform its system from a hospital operator to a health care provider that relies on community-based, integrated networks of VHA and non-VHA providers to meet veterans' needs more efficiently and effectively.[2] The most notable initiatives involved shifting veterans' care to appropriate outpatient and residential settings, reengineering administrative and clinical processes, and closing services, including medicine or surgery, primarily because of low utilization.

In fiscal year 1999, VHA received a $17 billion appropriation to serve veterans' health care needs; VA requested a comparable appropriation for fiscal year 2000. VHA could spend as much as $4 billion annually for asset operations and maintenance costs, which is generally referred to as the cost of asset ownership. Such ownership costs include utilities and services such as security, grounds care, fire protection, waste collection, pest management, and custodial work. Of note, VHA has more than 5 million square feet of vacant space, which could cost as much as $35 million to maintain annually.

MOST VHA HOSPITALS HAVE LOW, DECLINING UTILIZATION

VHA hospital utilization dropped dramatically over the past decade, falling from 49,000 patients a day in 1989 to 21,000 in 1998. Almost half of this decline has occurred over the past 3 years. During this time, VHA experienced comparable declines in medicine and mental health patients.

These declines stemmed primarily from changing medical practices that reduced inpatient admissions and lengths of stay.[3] VHA hospital admissions decreased from over 1 million in 1989 to about 600,000 in 1998, a decrease of about 40 percent. Patients' average lengths of stay per

[2] VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

[3] VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

medical admission dropped from almost 20 days to about 10 days during this time.

As utilization declined, VHA reduced the number of beds that it kept in service. The average VHA hospital size declined from 415 beds in 1989 to 158 in 1998. Over the past 3 years, VHA has removed about 24,000 beds from service.

Hospital utilization and operating beds are expected to continue to decline over the next 20 years. Nationwide, the number of veterans (25 million) is declining and their average age (58) increasing. VHA estimates that the veteran population will number 16 million by the year 2020, a 36-percent decline from today's level. All VA hospitals project a declining population base for their primary market areas with two-thirds expecting declines greater than 33 percent.

Over the next 20 years, most of VHA's health care buildings will approach or pass their normal useful life expectancy. More than 40 percent, for example, have already operated for more than 50 years, including almost 200 built before 1900. Many organizations in the facilities management environment consider 40 to 50 years to be the useful life of a building.[4]

To gain a perspective on VHA's hospital utilization, we examined hospital closure studies that have been issued annually by the HHS inspector general since 1989.[5] These studies show that about 600 of 5,400 private hospitals have closed over the past 10 years.

The findings from these studies of hospital closures were similar. Closed hospitals were small, as measured by numbers of operating beds, and had low patient utilization. When the hospitals closed, few patients were affected, primarily because they could get medical care nearby.

The inspector general's latest study, for example, showed that 10 rural hospitals and 28 urban hospitals closed during 1997. Of the rural ones, 6 had fewer than 50 beds.

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[4]Price Waterhouse, Independent Review of the Department of Veterans Affairs' Office of Facilities Management, final report (N.P.: June 17, 1998).

[5]HHS, Office of the Inspector General, Hospital Closure, series 1989 through 1997 (Washington, D.C.: 1991-99).

By contrast, 24 of the urban hospitals had 150 beds or fewer.

Our assessment of VHA's 165 hospitals showed that 74 have operating beds comparable, in numbers, to private sector hospitals that closed. Nearly half of VHA urban hospitals (64 of 136) have fewer than 150 inpatient operating beds and more than one-third of rural hospitals (10 of 29) have fewer than 50 operating beds. As previously noted, VHA's hospitals include longer-term mental health patients, whereas private sector hospitals generally do not. Thus, if VHA's longer-term mental health patients are excluded, a larger number of its hospitals would likely be considered to have low utilization.

On average, VHA's urban hospitals had about 133 patients a day, with 72 percent (89 hospitals) averaging less than 150 patients a day. Rural hospitals averaged about 75 patients a day, with about half (15) having fewer than 50 patients a day.

Of note, nearly three-fourths (56) of the 74 smaller urban and rural hospitals serve a veteran population base that is projected to decline more than 33 percent over the next 20 years. In addition, most of these hospitals have health care buildings that are or will soon be more than 50 years old. Over the past 3 years, utilization of those hospitals has dropped by about 50 percent.

VHA'S PROPOSED REALIGNMENT PROCESS FACES IMPLEMENTATION CHALLENGES

Over the past 4 months, VHA has worked to design a process for developing asset realignment plans, although progress has been limited. These efforts have focused primarily on discussions between VHA officials and stakeholders. As of last week, VHA officials stated that a decision would be made within 2 months regarding how its asset realignment process will be designed and implemented. They told us that an initiative, referred to as Capital Asset Realignment for Enhanced Services (CARES) had been proposed but that some changes are being considered.

This proposal, as explained to us, appears to be consistent with VA's stated desire to use the Office of Management and Budget's capital asset planning guidelines to systematically develop asset realignment plans. CARES, for

example, would direct each region to perform a comprehensive assessment of existing markets that would focus on

- current and future utilization rates;
- asset location, capacity, and condition;
- congruence between need for asset and veterans' demand for services; and
- alternatives to current service delivery modes, including purchasing care from other public or private providers, partnering with such providers or replacing obsolete assets with modern ones.

As they currently envision it, VHA officials expect locally led steering committees to be established in each of VHA's 22 networks and serve as the key management entities in the realignment process. They anticipate broad stakeholder membership on these committees, including heads of state veterans' agencies, medical school deans, and representatives of veterans' groups, as well as regional VHA officials. VHA leadership of the committees is not assumed but is to be determined among each committee's members.

VHA officials also expect that each steering committee will (1) independently determine its operating and policy guidelines; (2) use private consultants to collect, verify, and analyze data needed to develop realignment options; and (3) recommend ways that health care assets should be realigned. Officials told us that decisions on recommendations would ultimately be made by top managers in VHA or VA. The steering committees will have the latitude to set their own timeframes for completing work, although VHA expects to require periodic progress reports, such as on 6-month intervals.

To be successful, VHA will need to overcome several critical challenges. Foremost, it seems inevitable the locally led steering committees could struggle to achieve consensus on difficult decisions affecting the status of VA hospitals and other health care assets. This is because the steering committees could (1) have considerable discretion to make critical decisions concerning how studies will be designed and conducted, (2) be composed

primarily of major stakeholders, and (3) not be under the leadership of key VHA managers. In our view, this arrangement could lead to conflict among the various stakeholders sitting on the committees if they attempt to protect their interests at the expense of the overall process.

Our work has shown that VHA's environment contains a diverse group of competing stakeholders, who, quite naturally, could oppose some planned changes that they feel are not in their best interests, even when such changes benefit veterans.[6] Medical schools' reluctance to change long-standing business relationships, for example, has sometimes been a major factor inhibiting VHA's asset management. Unions, too, sometimes appear reluctant to support planning decisions that result in a structuring of services. This is because operating efficiencies often result in staffing reductions.

Two years ago, we reported on lessons learned from VHA's efforts to integrate the management and services of 36 hospitals in 18 markets.[7] In general, we noted that objective facility integration planning based on independent judgment and appropriate stakeholder participation was critical to successful integrations. Making decisions to restructure medical facility services when the decisions could adversely affect the planners' own interests presented an inherently difficult situation.

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. We concluded that in such situations VHA integrations might yield less than their full potential benefit to veterans, needlessly limiting savings available for reinvestment.

To overcome this problem, we suggested a more independent planning approach using planners (full-time VA planners or consultants) with no vested interests in the geographic area to develop data and recommend options for improving VHA hospitals' operation, in consultation with stakeholders. We also encouraged VA to provide all

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[6]Veterans' Health Care: Chicago Efforts to Improve System Efficiency (GAO/HEHS-98-118, May 29, 1998).

[7]VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July b24, 1997)

stakeholders with sufficient information to understand and support integration decisions.

Another challenge VHA could face involves inherent difficulties in achieving consistent results among the 22 networks without uniform guidelines and criteria on how to conduct market assessments. If steering committees are given wide latitude to develop their own guidelines and criteria, as CARES currently suggests, it seems likely that a variety of approaches to gathering data, assessing information, and decision-making could emerge. As a result, it may not be possible to determine, and therefore ensure, that fair and equitable decisions are made systemwide.

Steering committees may also find it difficult to complete their work in a timely manner. This is because VHA believes that it is essential to use private sector consultants to perform most of the market assessment work, and resources may be available to do only a limited number of markets at one time. VHA estimates, for example, that contracts could cost between $700,000 and $1 million for each market that has multiple VHA locations.

As a result, VHA may find it necessary to prioritize its market assessments in order to realize the greatest return on its contracting investment. In this regard, it seems preferable for VHA to establish the 40 multiple location markets as a top priority. Of these, nine have 4 or more delivery locations competing to serve the same veterans; these markets have a total of 46 locations, including 12 with low utilization and rapidly declining veteran populations.

Completing asset realignment plans for these markets first could also help VA to address its financing challenges for conducting other market assessments. This is because such markets should provide an opportunity to dispose excess or underutilized properties or to develop initiatives that could result in an enhanced use by other public or private organizations. The Congress is currently considering proposals that increase VA's opportunities to retain revenues from the disposal or enhanced use of unneeded buildings. These proposals are compelling because they could provide VA with much needed incentives to make difficult asset realignment decisions in a timely manner.

In recent years, VHA has realized little success with a locally led planning model, like CARES, that relied heavily on stakeholders' involvement. Almost 4 years ago, VHA's New England network began efforts to realign assets among its five delivery locations in the Boston market. Similarly, about 2 years ago, the Great Lakes network initiated efforts to realign services among two of its four delivery locations in the Chicago market.[8] Both of these efforts were characterized by time-consuming debates among stakeholders that resulted in piecemeal decisions. In neither market has VHA yet reached decisions that are in veterans' best interest.

By contrast, VHA had notable success using a more centralized planning model when assessing the needs of veterans in the Northern California health care market during 1997. In general, a private contractor, in consultation with stakeholders and others, collected data on veterans' needs, existing VA assets, and lower-cost alternatives and presented options to VHA's central office, which also consulted with stakeholders. This approach allowed veterans' needs to be met without building a previously proposed $200 million hospital addition. These results were achieved in a shorter time than VA experienced in Chicago and Boston.

Of note, VHA has initiated a new asset realignment effort in Chicago that does not heavily involve local stakeholders. A steering committee composed of high-level officials from several regions was established to review data collected by a private consultant and recommend realignment options to VHA's central office. However, VA has delayed announcing its decision and therefore the success of this approach is uncertain at this time.

These experiences suggest that constituting steering committees with major local stakeholders may invite protracted conflict. This conflict could delay VHA's realignment progress if entrenched yet opposing interests dominate the workings of the steering committees. In addition, investing stakeholders with decision-making authority could lead to incremental decision-making if consensus cannot be reached on difficult issues. In such cases, conflict could frequently lead to suboptimal decisions.

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[8] Veterans' Health Care: Chicago Efforts to Improve System Efficiency (GAO/HEHS-98-118, May 29, 1998).

Prolonging decisions, in our view, is not in the best interest of veterans because it will delay the identification of resources that could be better reinvested to enhance services. Given VA's current and proposed budgets, it seems inevitable that VA's ownership of unneeded assets will eventually compromise veterans' health care services. In contrast, restructuring its capital assets could reduce budget pressures or generate revenues that could be used to enhance veterans' health care benefits.

While it is not possible to say with certainty what the level of operational savings could be, it seems plausible, based on our assessment of VA's Chicago market, that annual savings could reach $400 million nationally. In Chicago, we found that VA could save $20 million annually (about 10 percent of asset operations and maintenance costs) if it met veterans' needs in three rather than four hospitals.[9] As previously stated, VA could spend about $4 billion annually for asset operations and maintenance nationwide.

Prolonging the completion of market assessments also increases the pressure on VA's capital asset investment process to ensure that scarce resources are not invested in assets that VA will vacate in a few years. VHA's existing plans show that individual locations' needs range between $4 million and $38 million, including about 50 with asset needs exceeding $10 million. Recently, we recommended, and VA agreed, that its capital investment decisions should be subjected to a more rigorous management review.

CONCLUDING OBSERVATIONS

We are concerned that VHA's limited progress toward establishing an asset realignment process needlessly delays the reinvestment of scarce resources to enhance veterans' health care. Furthermore, potential shortcomings in VHA's process as currently proposed--locally-led steering committees that have heavy stakeholder involvement--do not instill confidence that VHA will be significantly closer to having a restructuring plan by this time next year than it is today.

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[9] VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

Given VA's past experiences, it seems that a better option for realizing asset realignment decisions in a timely manner would involve a more centralized planning model that is based on consultant or field information and that is free from undue influence from local stakeholders. Without firmer VHA leadership, it seems likely that VHA could take many years to decide on, much less accomplish, systemwide asset realignment. The daily cost of unduly delayed decisions is unacceptably high, given that VA could be spending $1 million or more a day to operate and maintain unneeded assets.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

(406176)

Statement of
Kenneth J. Clark
Chief Network Officer
Department of Veterans Affairs
Before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives

July 22, 1999

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Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to discuss our plan and progress we have made to more accurately assess our current and future capital asset needs, and to involve stakeholders in these key VHA decisions. One such initiative is the development of the Capital Asset Realignment for Enhanced Service to Veterans (CARES) concept, which Dr. Kenneth W. Kizer, the former Under Secretary for Health, proposed two months ago. Additionally I would like to outline for you plans to undertake the "market-based plans for restructuring assets" recommended by GAO at the March 10 Subcommittee on Health hearing on the management of capital assets.

Then Deputy Under Secretary for Health and now Acting Under Secretary for Health, Dr. Thomas Garthwaite, testified before the Subcommittee on Health on March 10, 1999, about VHA's planning, budgeting, and management of its diverse capital assets. At present, VHA owns and/or operates an extensive inventory of capital assets located in all 50 states, Puerto Rico, the Virgin Islands, Guam, and Samoa. These assets include over 22,000 acres of land, 4,700 buildings, and 140 million square feet of owned or leased space at over 1,200 locations. The replacement value of buildings supporting VA's healthcare mission is estimated at $35 billion. The average age of VHA facilities is about 38 years. Dr. Garthwaite's testimony to the Subcommittee and subsequent testimony regarding H. R. 2116, the proposed 'Veterans' Millennium Health Care Act', highlighted the unprecedented change that has occurred in VHA in the past four years

and acknowledged that in many locations, our physical infrastructure no longer supports the optimal delivery of modern healthcare services.

During the March 10th testimony, VHA agreed to conduct studies of the multiple-location healthcare markets that GAO identified in its testimony to the Subcommittee on Health. We also agreed that such studies should involve our stakeholders and that consultant support would significantly facilitate completion of these studies. For reference, the following initiatives of the past four months will impact on the multiple market reviews:

- GAO Recommended Capital Asset Restructuring Plan – GAO proposed that VA perform comprehensive market-based assessments in all 106 of its markets, identifying the greatest potential for savings in the 40 multiple-location markets, to determine the need for "restructuring" capital assets owned and operated by VA in those markets.
- Proposed H. R. 2116, the 'Veterans Millennium Health Care Act' – This bill, proposed by the House Veterans Affairs Committee, is particularly germane to this hearing because it contains elements targeted at capital asset management issues, such as improving access through facility realignment and extended enhanced use applications. Enhanced stakeholder involvement is a critical element of this legislation.
- Capital Assets Realignment for Enhanced Services (CARES) committees – VHA developed a draft policy that would establish capital asset planning committees in each VISN to focus attention on planning for capital asset realignment that would result in enhanced services for veterans and assure appropriate stakeholder involvement.
- Mission Realignment Proposal – A study was undertaken by VHA field managers to develop a proposed process and criteria to aid with decision making about programs and capital assets. The criteria include workload, demographics, and proximity to other healthcare providers. This proposal is still under discussion, and will be the subject of an upcoming stakeholder working session to further refine it.

- Capital Asset Disposal Initiative – The President's FY 2000 Budget proposes a pilot program to significantly improve VA's management of capital resources. This program would allow VA to dispose of excess and underutilized property and use 90 percent of the proceeds for infrastructure needs. (10 percent would be transferred to the Department of Housing and Urban Development's Homeless Assistance Grants Housing account.) The sale of VA property is a potential outcome of significant mission realignment. The use of this disposal tool would allow most of the revenues from disposal of real property to be used to enhance veterans' healthcare.

Following the March 10th hearing, the Subcommittee on Health developed legislation, now included in the proposed 'Veterans' Millennium Health Care Act' that would provide guidance for conducting these studies. As you know, this bill was reported out of the House Veterans' Affairs committee last week. Since the March 10th hearing, we have worked toward defining the various capital asset management proposals and initiatives and have begun formulating a comprehensive capital asset management/strategic planning policy that encompasses and embodies all of these initiatives. Additionally, we have sought input from Veterans' Service Organizations as well as Congressional Offices and are in the process of evaluating stakeholder input on these capital asset management initiatives. I have scheduled a working meeting with Veterans' Service Organizations and VHA staff to gain insight and suggestions about capital asset planning and overall asset restructuring. Following this, VHA will finalize a comprehensive capital asset management policy that will determine how to combine the CARES concept as well as other concepts and initiatives identified in the Mission Realignment Proposal and the proposed 'Veterans' Millennium Health Care Act' (were it to be enacted) and integrate them into VHA's strategic planning guidance. This guidance includes identifying underutilized space to determine the feasibility of conversion to long term care activities. Additionally, to ensure rigorous management of VHA's capital assets, my office will be developing a guidebook for VHA network directors to follow in implementing these capital asset management policies.

Although stakeholder input is an integral part of any capital asset management program, meaningful stakeholder involvement takes time. CARES envisions broadening

stakeholder involvement, and will result in the development of options and plans that clearly show how service to veterans can be enhanced by restructuring capital assets. Each VISN will have an oversight committee to monitor planning efforts and to ensure active involvement of stakeholders in the capital asset planning process. The charge to these committees will be to review current and projected patient needs and healthcare delivery requirements within the VISN, describe current capital assets and their ability to support service delivery, recommend reconfiguration requirements for assets, and consider alternatives to current service delivery modes that might allow the VISN to enhance services to veterans or serve more veterans. Our goal is to develop the best alternatives that will benefit veterans by realigning imbalances or inequities between VA capital assets and veterans needs.

VHA plans to accomplish the 40 multiple market studies that GAO identified at the March 10 hearing, but also intends to broaden the approach with enhanced stakeholder involvement. Consultants will gather and evaluate data, and develop options for consideration by the capital asset planning committee. As previously noted, we have identified the amount of funding that will be needed for consultant support of these studies. We have developed an outline of a proposed approach to the 40 multiple-location market studies. We also agree that ultimately we should conduct studies in all of the 106 markets that GAO identified.

We will be examining available resources and other competing priorities. Following this review, we will assess which of the 40 studies can be completed in the near term and which studies must await additional resources in subsequent budgets. In an ideal situation, approximately 20 studies per year could be completed, starting with those that offer the highest potential for savings and finishing with those single facility markets with the least potential for asset restructuring or efficiencies. Anticipated savings include savings in annual operating costs, FTEE savings, as well as avoidance of costs for operation and maintenance of inefficient or underutilized facilities.

Currently underway is a study of the VISN 12 Chicago-area facilities (one of the nine mega-markets identified in the GAO report). Having considered demographics, workload projections through FY 2010, and VSO, affiliate, and other stakeholder concerns, the steering committee for this study is nearing completion of the 12-month

market based evaluation of the Chicago market. The scope of the VISN 12 study will likely be the basis for future market studies.

The initial 20 markets to be studied in the first year would consist of the remaining eight mega-markets identified in GAO's March 10 report to the Subcommittee on Health and twelve of the remaining multiple location markets.

We anticipate that most of the savings from such market-based asset restructuring plans will be reinvested within that VISN, and would be used to enhance veterans healthcare benefits in the form of increased quality, improved access, and increased services.

Over the next 60 days, the CARES concept and overall capital asset management program will be more fully discussed with our stakeholders and internal VA staff, leading to the finalization of a complete VISN-level strategic planning process. By December 1999, each VISN will complete an implementation plan and establish a capital asset planning committee to assist in their capital asset planning efforts and to assure active involvement of stakeholders.

VA has already begun discussions internally for the GAO-recommended studies. My office, the Office of Facilities Management, the VHA Office of Policy and Planning, and the Office of the Assistant Secretary for Financial Management are in the process of determining roles each will have in implementing the GAO market-based studies. VISNs have been informed about the capital asset restructuring concept, and are anxious to begin the process of more effectively aligning assets with healthcare delivery requirements. A conceptual format for the scope of a study has been outlined, based on the VISN 12 options study. VHA is prepared to enter into the studies, once legislative issues are resolved and funding decisions are made.

I will be glad to answer any questions you may have.

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July 28, 1999

Honorable Terry Everett, Chairman
Subcommittee on Oversight and Investigations
U.S. House of Representatives
334 Cannon House Office Building
Washington, DC 20515

Dear Chairman Everett:

The American Legion appreciates the opportunity to submit written testimony for the hearing record of July 22, 1999, before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives.

Mr. Chairman, The American Legion does not believe that any strong case has been made to close one VA medical center. According to VA, there are currently five market locations out of 40 within VHA with the potential to completely integrate and absorb the closure of a VA medical center. These sites are Boston, Chicago, Los Angeles, New York and San Francisco. While no decisions have yet to be made to close any VA medical center, the possibility exists that future studies could recommend closure as one of several realignment options. On this issue, The American Legion supports the provisions contained in H.R. 2116, the "Veterans Millennium Health Care Act." This bill, proposed by the House Veterans' Affairs Committee, is particularly germane because it contains elements targeted at capital asset management issues, such as improving access through facility realignment and extended enhanced use applications. Enhanced stakeholder involvement is a critical element of this legislation.

The American Legion does not believe there are any unneeded VA facilities. However, we do not object to impartial studies that examine if VA can better utilize its assets in major market areas. The American Legion suggests that if any VA facilities are considered as underutilized, it is incumbent upon VA and Congress to develop plans that would increase the utilization of all VA facilities.

Mr. Chairmen, the families of older veterans are desperate to find long-term care solutions for their loved ones. Military retirees are searching for medical treatment options to replace military facilities that have closed. Americans everywhere want good, affordable health care. Providing increased access to the VA health-care system can solve the health care concerns of many citizens. This is one of the principal reasons The American Legion developed the GI Bill of Health, which would bring more paying customers into VA health-care.

Today, VA is several years away from completing its Capital Assets Disposal Initiative. The Veterans Health Administration (VHA) recently developed a draft policy that would establish capital planning committees in each Veterans Integrated Service Network (VISN) to focus attention on planning for capital asset realignment. It is estimated by VHA that it will require up to three years completing a capital assets review of all 40 health care market areas. The ultimate objective of the Capital Assets Disposal Initiative is to allow VA to dispose of excess and underutilized property and use 90 percent of the proceeds for infrastructure needs. The sale of VA property is a potential outcome of significant mission realignment. The use of this tool would allow most of the revenues from disposal of real property to be used to enhance veterans' healthcare. Ten percent of the assets from the sale of VA property would be transferred to the Department of Housing and Urban Development's Homeless Assistance Grants Housing account. All of these market studies will require approximately $35 million to complete.

Many VA buildings were built in the 1950's and it will require considerable investment to make these buildings functionally effective. In many cases it is more efficient to replace existing buildings with new state-of-the-art outpatient clinics. There are also patient safety and building modernization requirements. Additionally, a recently mandated review determined that VA has 69 patient care buildings, totaling 2,300 beds that require seismic corrections. VA estimates it will cost $1.8 billion to provide corrections to all seismically deficient buildings.

The American Legion realizes that certain facility realignments and mission changes may be necessary to improve the efficiency and effectiveness of VHA. However, we do not support realignment that is budget driven and we do not support closing VA medical centers without there being a credible alternative for veterans to obtain necessary health care. It is sensible to allow VHA to complete its Capital Assets Disposal Initiative, and allow each VISN to establish its Capital Assets Realignment for Enhanced Services (CARES) Committees to work closely with VHA in charting the future course of the Veterans Health Administration.

Sincerely,

Steve Robertson, Director
National Legislative Commission

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