

**STATEMENT OF  
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UNDER SECRETARY FOR HEALTH  
DEPARTMENT OF VETERANS AFFAIRS  
ON VA'S TREATMENT FACILITY INTEGRATION STRATEGY  
BEFORE  
THE  
SUBCOMMITTEE ON HEALTH AND SUBCOMMITTEE ON OVERSIGHT  
AND INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
U. S. HOUSE OF REPRESENTATIVES**

**JULY 24, 1997**

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

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

As you know, revolutionary forces are buffeting the entire American healthcare system. These forces are causing profound changes in private sector healthcare, as well as in government programs, and they necessitate the creation of new types of delivery organizations. The delivery model being pursued most widely, for a number of reasons, is the integrated service network (ISN) -- also known as an integrated delivery system (IDS) -- in which organizational entities

like hospitals and clinics, partner with physicians and other caregivers, as well as healthcare support functions, in creative ways to pool their resources and align them to better serve patient needs. These ISNs are taking many forms and are developing in different ways in response to the myriad antecedent conditions and specific circumstances driving their creation.

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

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

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

In considering these generic purposes it is important to also consider several other contextual points. For example, as noted above, facility integrations are part of a larger network integration strategy. Facility integrations do not necessarily produce a lasting end product, but instead are part of an ongoing integrative process that may involve circumstances and changes beyond the specific facilities involved. For example, the merger of the radiology services at two integrating hospitals may be superseded by a network-wide teleradiology

initiative. Similarly, the consolidation of the food service or laundry operations at two integrating facilities may be superseded by a network-wide bulk food preparation initiative or consolidation of all network laundry activities at a yet different facility. Unfortunately, the disparate circumstances prevalent at facilities and within the networks mean that these various activities are evolving from differing starting points and at different paces.

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

Treatment facility integrations are all different because they address different issues and circumstances. Indeed, despite the hundreds of hospital mergers and integrations that have occurred in the private sector, there is not yet an agreed upon integration process or template in the private sector. To quote from an article in the May 1997 issue of Healthcare Leadership Review, “There is no ‘right’ way to integrate.” The article goes on to say that, “It isn’t possible to develop a model that anticipates changes in the marketplace. Integrated delivery systems (IDSs) need to explicitly acknowledge and plan for change as markets develop and participants adapt and grow.” An article in the July/August 1997 issue of Healthcare Forum Journal further makes this point with its title, “One size doesn’t fit all ... The right way to integrate.” It is generally not possible to describe all of the long-term outcomes of facility integrations since the integrated facilities and their delivery systems are living entities that will continue to change and evolve over time as they address their unique mix of clinical, demographic, geographic, social, economic and cultural issues.

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

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

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

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

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

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

our experience to date, there appears to be 5 phases to the integration process. These phases are as follows:

- Phase I - Visualization, Conceptualization and Initial Exploration

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

- Phase II - Quantitative and Qualitative Analysis and Decision Making

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

- Phase III - Implementation Planning

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

- Phase IV - Implementation of Integration Plan

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

- Phase V - Evaluation

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

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

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

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