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TESTIMONY OF

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ON

MEDICAL CARE PLANNING AND CONSTRUCTION PLANNING IN THE VETERANS ADMINISTRATION

Mr. Chairman and Members of the Committee,

I am pleased to be here today at the request of the Committee to share with you our views on:

--VA's medical care and construction planning processes;

--Booz, Allen & Hamilton/RTKL's recent study of VA's construction processes;

--VA's proposed merger of the Department of Medicine & Surgery and the Office of Construction; and

--VA's sizing of surgical suites in new and replacement hospitals.

At the request of this Committee, we recently completed a review of VA's major financial management processes, focusing on medical care and major construction. Our report addresses both

the strengths and weaknesses of those processes, and the data on which they rely. The report is now with VA for agency comments. With the exception of my comments on surgical suites, my statement primarily reflects the results of that review.

Our review was conducted using a model that views financial management as four distinct, but interrelated phases linked by reliable, useful information. Those phases are: planning/programming; budget formulation/justification; budget execution; and audit/evaluation. Accurate, timely, and useful information is the very foundation of any effective management process, and weaknesses in that information can adversely affect management decisionmaking.

OUR FINANCIAL MANAGEMENT PROFILE REPORT

Earlier, we provided the Committee with copies of our financial management profile of VA, which contained an inventory of VA's financial management systems and identified a number of weaknesses that affected the accuracy and reliability of the information produced by those systems.[1] A major finding of that study was that many of VA's systems are antiquated, slow, and often unable to produce accurate, useful information when needed for decisionmaking, cost-control, and effective program management. Many of these findings have been confirmed by VA's own annual reports produced in compliance with the Federal

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1 Veterans Administration: Financial Management Profile (AFMD-85-34, September 20, 1985).

Manager's Financial Integrity Act of 1982. Additional problems, and VA's plans to correct them, are also discussed in VA's 5-year Automated Data Processing Plans.

SOME MAJOR ISSUES IN MEDICAL CARE AND CONSTRUCTION PLANNING

I would now like to discuss some of the major issues we found in VA medical care and construction planning as part of our review of VA's major financial management processes. As the members of this Committee well know, VA faces an enormous challenge in planning to meet the medical care needs of veterans in the next two decades--especially the needs of veterans 65 and older, whose number is expected to triple between the years 1980 and 2000. To meet that challenge, VA needs two basic things: (1) decision processes that managers can use to systematically identify cost-effective ways of meeting specific and realistic medical care and construction planning objectives and (2) reliable, useful information to support those processes. In both areas, VA's medical care and construction planning could be improved. VA is aware of many of the issues discussed in this testimony and has efforts underway to address some of them.

In our view, VA medical care and construction planning should address the following issues:

--How many veterans in which eligibility categories are now receiving VA medical care and where?

--For what illnesses are they being treated, using what resources, and at what cost?

--What changes does VA expect in veteran demand for care by eligibility category and geographic location?

--What changes does VA expect in the types of illnesses for which veterans seek care (for example, is an increase in the demand for care from veterans 65 and older likely to result in an increased demand for long-term care)?

--What clinical resources and facilities will be needed to provide that care at least cost and where?

MAJOR FINDINGS OF OUR REVIEW

We found that VA does not fully address some of these questions in either medical care or construction planning. VA also lacks the reliable per patient clinical and cost data essential for assessing the current use of medical care resources and evaluating future needs.

Improvements Needed in the Medical Care Planning Process

VA assesses the future medical care needs of veterans through its Medical District Initiated Program Planning process, called MEDIPP. To assess which veterans are now using VA health care, and to project future demand for care, MEDIPP uses age groups, not categories of eligibility for care. A major reason is that the goal of MEDIPP, at least through the 1984 MEDIPP cycle, has been to provide medical care to ALL eligible veterans requesting care.

Age groups are certainly one useful way of assessing future demand. As veterans age, the types of care they need are likely to change. Veterans over 75, for example, are the most likely to need nursing home care.

However, one reason for using eligibility categories in MEDIPP is that law and regulations provide that access to VA health care be on a priority basis, as determined by a veteran's

eligibility for care. Veterans with service-connected disabilities have first claim to VA health care when budgets do not permit serving all eligible veterans requesting care. By its own estimates, VA does not now have the resources to serve all eligible veterans seeking care, and if current budgetary trends continue, VA is not likely to be able to do so any time soon. Thus, VA's medical care planning goal of serving all eligible veterans requesting care may be unrealistic in the current budgetary environment. If VA assessed future medical care needs by eligibility category, it could identify those veterans least likely to be served within specific budgetary limits.

To improve MEDIPP, VA introduced a number of changes into the process for the preparation of the November 1985 and subsequent MEDIPP plans. (The 1985 MEDIPP plans will be used in developing the fiscal year 1988 budget.) One of those changes is the introduction of annual operating plans in which medical planners identify priorities using three different budgetary assumptions--no changes in the 1986 operating budgets of all medical facilities in the district, a 5 percent budgetary increase, and a 5 percent decrease. This change may provide VA a basis for establishing more realistic goals, clearer priorities, and a better link between MEDIPP and the budget. In the past, MEDIPP planners have not been required to consider budgetary limits in setting priorities.

VA does not systematically try to estimate the types of illnesses (i.e., the "casemix") for which veterans may be

expected to seek care in the future. While the Department of Medicine and Surgery (DM&S) has provided medical districts a casemix projection model for inpatient care, districts are not required to use it in developing their MEDIPP plans. Yet, the types of illnesses for which veterans seek care, not just their numbers, determine the clinical resources and facilities needed to provide care and, thus, the costs to provide the care.

According to recent testimony by the Chief Medical Director, one objective of MEDIPP is to provide within each medical district the full range of medical services that VA expects veterans within that district to need. However, VA has no consistent basis for identifying what medical services should be provided at each facility in a district because VA has not yet defined the basic range of medical services that should be available at its primary, secondary, and tertiary care hospitals.[2] Such definitions are useful in construction planning and design as well as medical care planning.

Data Improvements Needed in MEDIPP

Even if VA revised its MEDIPP process to do the kinds of analyses just discussed, its efforts would be hampered by inaccuracies in available clinical and cost data.

The Importance of Per Patient Clinical and Cost Data

Perhaps most importantly, VA does not currently have

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2 In general, these can be thought of as a continuum. Primary care hospitals provide relatively simple medical services, while tertiary care hospitals are capable of treating the most complex cases.

reliable per patient clinical workload and cost data. Such data are the foundation of not only effective health care planning, but efficient hospital management as well. This is because, as previously noted, the illnesses for which patients are treated, not just their numbers, determine the clinical resources and facilities needed to treat them and, thus, the cost of that treatment. Without this per patient data, it is difficult to assess the most cost-effective ways of providing quality care for any specific mix of illnesses.

The importance of per patient clinical and cost data has been highlighted by VA's implementation of its Casemix-based Resource Allocation Methodology for allocating a growing portion of each hospital's operating budget. Under this system, hospitals are essentially reimbursed a specific amount for each type of illness they treat. If a hospital's costs exceed VA's national average, it will lose funds. But VA's current workload and accounting systems do not provide reliable information on the actual costs of treating any specific patient or illness. Therefore, hospital managers and medical care planners find it difficult to identify ways of reducing those costs by reducing, where appropriate, the resources used to treat those illnesses.

Clinical and Cost Data Used in Medical Care Planning Are Inaccurate

The current clinical and cost data used by VA in health care planning are not always accurate, but VA is working to improve them.

Clinical Data: VA recent hired SysteMetrics to conduct a

study of its primary inpatient data base, the Patient Treatment File (PTF). Using 1984 data, that study found an error rate of about 35 per cent in the major diagnoses (the diagnosis responsible for the major portion of a patient's length of stay in the hospital) recorded for hospitalized patients. The major diagnoses recorded in the PTF are used to assign patients to Diagnosis Related Groups, or DRGs. DRGs are the basis for measuring each hospital's inpatient workload in VA' Casemix Allocation Methodology, which is used to allocate a growing portion of each hospital's operating budget. Consequently, hospitals are trying to lower the number of errors in the PTF, especially those that may understate their actual workload as measured by DRGs.

There are errors as well in the outpatient work load reported in VA's Automated Management Information System (AMIS). Out-patient visits, for example, are understated in AMIS. One reason for this is that outpatient clinic visits by certain categories of inpatients, such as nursing home patients, are not recorded in AMIS. Errors in both the PTF and AMIS affect health care planning because the data in these systems are used to assess current workload at each facility and project future demand for health care.

Cost Data: MEDIPP estimates program costs using the quarterly RCS-10-141 cost reports. These reports reflect quarterly program cost estimates, not actual program costs captured in VA's accounting systems.

The costs reported in the RCS-10-141 reports are also the costs used in VA's Casemix Resource Allocation Methodology to measure hospital efficiency. The same costs are also used to develop a portion of VA's medical care budget. In its guidance to hospitals on the implementation of the Casemix Methodology, VA cautions that the process of allocating program costs for the RCS-10-141 reports is "highly sensitive to error." Because of their use in the Casemix Methodology, hospitals have an incentive to improve the accuracy of the costs reported in the RCS-10-141.

However, VA recognizes that there are limits to its ability to improve the cost estimates in the RCS-10-141 reports and to the usefulness of these reports as a means of controlling costs. Therefore, VA is working to develop a system for capturing the essential per patient workload and cost data it needs for effective health care planning and hospital management.

CONSTRUCTION PLANNING

At the time we began our review, VA had hired Booz, Allen & Hamilton/RTKL Associates to conduct a comprehensive study of VA's construction processes. We understand that VA largely agrees with the major findings and conclusions of the report, but not necessarily with its recommendations. We reviewed the methodology and workpapers used in that study, and we concur with its major findings and conclusions.

Issues in the Construction Planning Process

The Booz, Allen & Hamilton study identified three principal issues in VA construction planning:

--VA's health care planning and construction planning have not been effectively integrated. One key reason, the study concluded, was that MEDIPP did not produce a national health care strategy with a set of clear medical care priorities to guide construction planning and priority setting. We have already noted some of the reasons why that is so.

--No clear, national construction strategy or generally reliable and up-to-date supporting data exist to guide construction planning, priority setting, design, and construction. Booz, Allen & Hamilton concluded that this was largely because construction planning tends to focus on individual projects rather than on developing a national construction strategy. This approach does not provide an adequate foundation for carrying out effective long-term planning. The result is inefficient use of resources, poorly coordinated construction activities at individual facilities, and ineffective project planning.

--There was no clear point of accountability for the results of the construction process, including planning, below the VA administrator.

Construction Planning and Priority Setting Data Need to be Improved

Both our review and the Booz, Allen & Hamilton study identified potential improvements in the data used in VA's construction planning and priority setting process. For example:

--Our review identified two types of data whose absence has

affected VA's ability to develop medical care priorities in MEDIPP or develop a national construction strategy. VA has not had either comprehensive, current clinical inventories for each of its medical care facilities, or a comprehensive, current assessment of the physical condition of each. VA has efforts underway to develop both. Each is important because VA chooses construction projects on the basis of both the medical care needs the project will serve, and such physical considerations as the fire and safety conditions in its hospitals.

--One finding of the Booz, Allen & Hamilton study affects not only construction planning, but medical care planning as well: Due in part to a lack of definition within the Department of Medicine and Surgery, VA does not have facility planning standards that reflect current medical operating modalities (i.e., treatment patterns). VA's ability to update facility planning standards, if it had them, is limited by its lack of reliable clinical workload data for specific illnesses. Such data are also needed to develop functional workload and design standards for such hospital functions as laboratory, radiology, and pharmacy. When fully operational, the clinical data from the Decentralized Hospital Computer Program, now being installed in 169 VA hospitals, should provide much of the data needed to develop both treatment

modalities and functional workload and design standards.

All these factors affect VA's new prioritization methodology, completed after Booz, Allen & Hamilton had issued its final report. Using a series of weighted factors based on the medical care needs projects will serve and the physical condition of existing facilities, the new methodology ranks construction projects. This is clearly a step in the right direction. But, the methodology must rely on currently available data, which is not always reliable.

The Proposed Merger

We believe that the Booz, Allen & Hamilton study highlights some important issues in VA construction planning, design, and construction that VA should address in a systematic and comprehensive fashion. VA is proposing the merger of the Office of Construction and the Department of Medicine and Surgery under the authority of the Chief Medical Director. This merger would provide a point of accountability below the Administrator, as recommended in the Booz, Allen & Hamilton report. But the merger will fall short of producing fundamental improvements, unless it is accompanied by a phased comprehensive strategy for improving VA's construction processes and the data on which they rely. VA's proposal does not indicate if or how VA proposes to develop that strategy.

SIZING OF VA SURGICAL SUITES

Our recent work on the sizing of VA surgical suites provides

another example of how VA could improve its construction planning by developing criteria based on actual and projected workload at a facility. In March 1981, we reported that VA's criteria for determining the number of operating rooms it needed in new or replacement hospitals was resulting in the construction of too many rooms.[3] We recommended that VA use a model (such as the one we presented in our report)[4] that focused on the unique surgical workload of each medical center instead of building 1 operating room for every 28 surgical beds planned for the hospital. VA agreed with the principle, but not the model we had developed.

Last year, we began a separate review of how VA has been determining its operating room requirements since our 1981 report was issued and, in view of the absence of any revised criteria since 1981, whether the number of operating rooms planned or under construction was consistent with that derived using our 1981 model. We found that VA was still using the same criteria it used in 1981 (1 operating room for every 28 surgical beds) to determine its operating room needs. Applying our model to 24 construction projects planned since October 1982, we determined that VA is planning to build 29 unnecessary operating rooms, at a cost of $5.8 million.

In May 1983 VA began developing its own model (which we understand is now completed and under review in the Department of

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3 Better Guidelines Could Reduce VA's Planned Construction of Costly Operating Rooms (HRD-81-54, March 3, 1981).

4 Ibid.

Medicine & Surgery). We have two concerns about VA's new model. First, it does not use a preset use rate to determine how much operating rooms will be used. We recommended in 1981, and continue to believe, that VA should use an 80 percent use rate. Second, the proposed model would allow VA planners to adjust workload projections to reflect possible changes in several planning factors, such as Medicare policies or the facility's mission, but it does not call for central guidance or monitoring of those adjustments.

We have drafted our report on this review and have received comments from officials in VA's facility planning and construction offices as well as officials who developed VA's new model. We expect to issue the report shortly.

That concludes my statement, Mr. Chairman. We would be happy to answer any questions you or other members of the Committee may have.