After years of study and analysis, the Department of Veterans Affairs is poised to launch a far-reaching restructuring of its mammoth, $26 billion-a-year health care system. The impact will be felt by veterans and communities nationwide.

The new organizational plan is titled “Capital Asset Realignment for Enhanced Services,” or CARES. It shapes up to be the most comprehensive overhaul of veterans’ health care facilities ever conducted.

The government has not yet reached decisions about every aspect of the CARES plan. In fact, VA officials and members of a blue-ribbon outside review commission were still struggling with key issues late in 2003. The expectation was the panel’s findings would be decisive in VA decisions this year.

Even so, the question is not whether there will be dramatic change, only when and in what specific ways.

At present, the VA operates 163 major hospitals and some 5,000 other buildings on almost 20,000 acres of land.

It was during the Clinton Administration years that the Department of Veterans Affairs recognized it had no choice but to restructure these facilities. The agency began transforming itself into a more modern health delivery system by emphasizing outpatient care and setting up many more clinics in veteran-population areas.

Even so, the changes did not go far enough. According to a 1999 report by the General Accounting Office, a Congressional watchdog agency, VA still was wasting up to $400 million a year by maintaining old, decrepit, and underused facilities.

What Money Can Do

This was duly noted by VA Secretary Anthony J. Principi. That money, said Principi, “can buy a lot of health care and state-of-the-art ambulatory clinics and sophisticated bed towers and surgical suites and more digital technology so a doctor on the West Coast can be diagnosing a patient on the East Coast.”

In June 2002, Principi formally launched the CARES process, and VA officials went to work. The draft national CARES plan was completed last August. It makes hundreds of recommendations to realign and modernize VA health facilities over the next 20 years.
Among the highlights is the VA’s determination that it should shut down seven aged inpatient hospitals. They are in Brecksville, Ohio; Canandaigua, N.Y.; Gulfport, Miss.; Lexington, Ky.; Livermore, Calif.; Pittsburgh; and Waco, Tex.

Under the CARES plan, the VA would also build large new facilities. These include new hospitals in Las Vegas and Orlando, Fla., new centers for the blind in Biloxi, Miss., and Long Beach, Calif., and new spinal injury centers in Denver, Little Rock, Ark., Minneapolis, and either Albany or Syracuse, N.Y.

The VA would open at least 48 new outpatient clinics and close or consolidate many other small facilities.

The aim of all this activity, said Principi, is not mere cost-cutting, as wary veterans suspect, but, rather, to make VA’s care more efficient and accessible by closing older, underused hospitals and opening modern units where needed most. According to Principi, the redistribution of VA resources should reflect veteran-population shifts in recent years (and projected shifts) and allow VA to take full advantage of new treatments and technologies.

“We’ll either be on the cutting edge of medicine in the 21st century” via restructuring, said Principi, or “on the trailing edge of the past century.”

He went on, “We have a responsibility to make changes, ... much like the private sector has to its systems, and to make sure the extraordinary amount of dollars the American people send us are being spent wisely.”

After Principi launched CARES, health officials in each of the VA’s 21 regions, now called Veterans Integrated Service Networks or VISNs (pronounced “visens”), were to review facility needs and recommend moves to dispose of underused buildings and property and to propose new ones. Computer models were available to help predict veteran-population trends and demand for services.

In June 2003, however, VA officials decided the VISN recommendations were not aggressive enough. They ordered changes aimed at closing and consolidating even more facilities.

Blowback
Every lawmaker or community resists closing the local VA facility. Such closures affect not only care for veterans but also the state of the local economy. As the CARES process reached its summer conclusion, many lawmakers who thought they knew how it would affect their districts were unpleasantly surprised. The final draft, prepared by Robert H. Roswell, VA undersecretary for health, was different from what they had been led to believe in the VISN briefings.

In hindsight, VA chief Principi conceded, “I might have directed [Roswell] to spend a little more time with Congressional delegations [affected] by the plan.”

Release of the draft plan (http://www.appc1.va.gov/cares/) moved the CARES process into a new phase. With Congress critical of the VA action, Principi created an independent panel that would review the plan and give it more credibility within the veterans community.

For its chairman, Principi selected Everett Alvarez Jr., a retired Navy aviator, eight-year Vietnam prisoner of war, and VA deputy administrator during the Reagan Administration. Each of the panel’s 16 commissioners have broad experience with health care or veterans issues. They began visiting VA facilities even before receiving the draft report.

Alvarez has faulted the draft CARES plan for including so many last-minute changes. “It caught everybody off guard,” he said, “including the political people on the Hill.” He went on, “What came out of headquarters were proposals counter to the VISN plan. They should have handled it with a little more sensitivity. I guess they were pressed for time.”

The Alvarez commission began work in August. It held 38 public hearings, visited 68 VA medical facilities, and received 175,000 written comments from anxious veterans and community leaders. They drew crowds of thousands to meetings held in areas where hospitals are set to be closed, Alvarez said, attesting to the level of concern. These individuals want their hospitals to remain open. However, said Alvarez, what they really need is more information.

“When they first hear about it, it’s ‘Oh, they are closing up our hospital! They are going to throw us to the wolves!’ ” said Alvarez, “but the whole objective is to increase and enhance their care, with tomorrow’s medicine—not [by keeping open] 70-year-old facilities. It doesn’t help that Congressmen and Senators are up there leading the charge.”

Alvarez said that even the draft CARES plan addresses the real health care needs of veterans far more thoughtfully than one would conclude just by reading newspaper articles about hospitals “on the chopping block” and so forth.

The unease felt by veterans and politicians lessens, he said, once the facts are known. As an example, he pointed to plans to close the VA hospital in Waco, a town not far from President Bush’s ranch outside Crawford. The shuttering of this hospital and the one in Canandaigua, N.Y.,...
Anger on Wheels

In October, as the commission held its hearing in Waco, a rally of vets on motorcycles traveled from Waco to Crawford in protest. The Waco mayor, Linda Ethridge, complained to local media that the VA intentionally left the community with little time to react.

What the VA sees at Waco, said Alvarez, is an old, large hospital and surrounding campus, built in 1932, delivering far more outpatient than inpatient care, and with only 109 beds, most of which are for psychiatric patients. When one of those patients becomes physically ill, VA must transfer him immediately to a nearby civilian hospital. There he stays until he is stable or until he is sent to the Olin E. Teague Veterans’ Center in Temple, 35 miles away.

The VA wants to transfer those 109 beds to Temple now, with its full range of services, Alvarez said, and offer employment there to current Waco hospital employees.

“All the rest of the care—93.5 percent of the workload of that facility—will stay in Waco,” said Alvarez. All ambulatory care and special programs would be moved into modern leased or new-construction buildings, rather than remaining on the old 127-acre campus.

The veteran population in both Waco and Temple is sliding, and, in Texas, Austin is where demand for services is rising, he said. Alvarez believes that the VA and the University of Texas Medical School should jointly build a new hospital in Austin.

“When you build a hospital today, it should be rightsized and it should be for today’s research, today’s medical training, [and able to handle] complex cases,” he said.

In Canandaigua, the 23-building VA campus has its own fire department, bowling alley, and laundry, even though the hospital has only 200 inpatient beds, down from 1,700 at one time. Most are for psychiatric patients. Outpatient services won’t be affected by closing the hospital, Alvarez said. “The question is, in the next 10 to 15 to 20 years, when do you take the small number of inpatients beds you have, consolidate them, and unload a major [campus] that is draining you?”

Principi seconded that statement.

“Some facilities, we inherited from the Army at the turn of the 20th century,” Principi said. “At their peak, these facilities may have had 2,000 patients [apiece]. Today, there may be fewer than 200 patients, and we’re maintaining 200, even 350, acres of land.”

Alvarez agrees that expansive campuses are anachronisms, suited to an era when almost all surgical procedures entailed a hospital stay. Today, he said, 70 percent of surgeries nationwide are outpatient procedures.

Alvarez said that, while the panel agreed with much of the draft national plan, it is not without flaws, and the commission decided to propose changes.

The commissioners questioned the reliability of the models used to project demand for care, had concerns about proposed uses of vacant space, and questioned whether community-based outpatient clinics can provide the required level of services.

Commissioners strongly supported greater sharing of Defense and VA medical support services.

Alvarez noted that the job of the commission was “to look at the strategic plan in terms of whether or not it makes sense, whether or not the recommendations can withstand scrutiny, are defensible, and to make sure quality of health care does not fall as we go through the process.” He added that the plan would take years to execute.

Careful Review

Principi promised a careful review of commission recommendations and could send some back for further work and consideration. He hoped to announce the final restructuring plan within a month of receiving the commission’s work.

How successful that CARES plan becomes in restructuring VA health care ultimately will depend on VA budgets, year to year, and how well Congress funds initiatives to close, consolidate, and build facilities.

“Money is very important,” said Alvarez.

“I have the authority” to execute a plan, Principi said. “I don’t perceive Congress blocking me. I may be wrong.”

The VA chief is optimistic that through the CARES process, VA will reshape health care for the future. Reaction overall has “gone as well as one could hope for, given the gravity and comprehensive nature of this report,” Principi said.

Meanwhile, he said, veterans service organizations “are keeping an open mind and have not tried to sabotage this effort in any way. They recognize that health care has changed, and the demographics of the veterans population have changed.”