

GAO

Report to the Honorable
Ron Marlenee, House of Representatives

February 1987

VA HEALTH CARE

**Support Lacking for
Mission Change at
Miles City, Montana,
Medical Center**



038158



United States
General Accounting Office

Denver Regional Office

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February 13, 1987

The Honorable Ron Marlenee
House of Representatives

Dear Mr Marlenee

This report presents the results of our review of the Veterans Administration's (VA's) proposal to change the mission of the Miles City, Montana, medical center from a predominately acute care to a predominately extended care center. We obtained and incorporated into the report the VA Administrator's written comments.

We are sending copies of this report to the Director, Office of Management and Budget, the Administrator of Veterans Affairs; the chairmen and ranking minority members of the congressional committees concerned with VA, and other interested parties. We will make copies available to others upon request.

Sincerely yours,

David A. Hanna
Regional Manager

Executive Summary

Purpose

The Veterans Administration (VA) has proposed to change the mission of its medical center at Miles City, Montana, from providing predominately acute care to providing predominately extended care. The proposed mission change would close the inpatient surgical service, decrease the number of medical beds, and increase the number of long-term care beds. Veterans requiring inpatient surgery would be sent elsewhere, usually hundreds of miles away.

Representative Ron Marlenee asked GAO to examine the justification for the proposed change, whether the change would be in the best interests of area veterans, and how easily the change could be implemented

Background

The VA medical center in Miles City is a 120-bed facility employing about 200 people and operating on an annual budget of about \$8.5 million. In an effort to more economically provide needed services to area veterans, the medical center director proposed in 1985 to close the 19-bed surgical service, providing instead only outpatient surgery; reduce the number of acute medicine beds from 62 to 30, increase the number of nursing home beds from 26 to 60; increase the number of intermediate medicine beds from 10 to 20; and open two outreach clinics in Billings and Wolf Point, Montana.

To respond to Representative Marlenee's questions, GAO reviewed VA's justification for the mission change proposal and documentation supporting it. GAO also spoke to VA officials and representatives of various veterans' groups.

Results In Brief

VA's proposed mission change would offer increased access to area veterans needing extended care services, but would decrease convenient access to VA care for veterans needing surgery. GAO found, however, that (1) costs VA used to justify the mission change were not accurate and cost-saving estimates were inconsistent and did not recognize all costs, (2) VA's planning projections showed a need to increase rather than eliminate surgical beds, and (3) VA's justification did not compare the relative advantages and disadvantages to area veterans of converting the Center from essentially an acute care to an extended care facility.

Because VA has not adequately addressed these issues in its justification for the mission change, GAO does not believe that VA has demonstrated that the mission change is in the best interests of area veterans.

Additionally, VA raised concerns about the quality of the Center's inpatient surgical service. VA said the Center's surgical workload and case mix are inadequate to maintain the competency of a surgeon and are, therefore, potential threats to the quality of patient care. Because these concerns were not documented in VA's mission change proposal and were not brought to GAO's attention until the conclusion of its review, GAO does not know what importance VA places on them as it decides whether to approve the mission change.

GAO found that, if VA were to close the inpatient surgical service, the local community hospital could provide emergency surgical services, and other VA hospitals in Denver, Salt Lake City, and Fort Harrison could handle elective surgery. However, in obtaining elective surgery, veterans could experience travel hardships and might incur personal expenses because of constraints on VA travel funds

GAO's Analysis

Proposal Contained Inaccurate Cost Data and Questionable Cost Savings

VA cited cost-effectiveness and workload considerations as primary factors in proposing the closure of the inpatient surgical service.

VA's estimates of savings from closing the surgical service ranged from about \$412,000 to \$1.7 million. However, GAO identified several inaccuracies and inconsistencies in the Center's cost allocation reports, similar to problems cited in a recent GAO report on the VA-wide cost allocation system. (See p 12.)

GAO also identified additional costs not recognized in the mission change proposal that caused GAO to further question the estimated savings. Costs not considered by VA or that appeared questionable included those associated with outpatient surgery, patient transfers, emergency surgery, remodeling, and costs that would be incurred at other VA hospitals where Miles City patients would be sent (See p. 14.)

Mission Change Inconsistent With Other Plans

Although VA's district planning showed a need for increased numbers of inpatient surgical beds into the next century, and the district had a goal of providing care as near to a patient's home as possible, VA did not address these apparent conflicts in proposing to close the inpatient surgical service. (See p 19)

Trade-Off Analysis Not Made

Veterans in the Miles City service area would undoubtedly benefit from increased extended care services. However, VA did not provide an analysis to show the relative advantages and disadvantages of switching from a predominately acute care to a predominately extended care facility (See p. 20.)

Proposed Change Can Be Implemented, but Some Difficulties Could Occur

In response to specific questions raised by Representative Marlenee about VA's plans and ability to implement the proposed mission change, GAO found that

- the community hospital has the capability to handle emergency surgical referrals from the Center;
- some VA hospitals to which nonemergency surgical patients would be referred have the capacity to absorb the increased workload;
- increased travel could present certain problems to veterans even though the medical district has implemented revised procedures designed to minimize these problems;
- VA travel fund constraints might cause veterans to pay for their travel to other VA hospitals or obtain care from other sources;
- the Center had the authority to set up outreach clinics in Billings and Wolf Point; and
- the Center has implemented aspects of the proposal that did not require central office approval; that is, it has decreased the number of acute medicine beds, increased the number of intermediate medicine beds, established two outreach clinics, and begun performing more outpatient surgery. As of January 21, 1987, it had not, however, officially closed the inpatient surgical service. (See p. 26.)

Recommendation

GAO recommends that the VA Administrator address the cost, planning, and trade-off issues raised in this report, as well as the potential quality-of-care issue, before making a final decision on the proposed mission change.

Agency Comments

In a December 19, 1986, letter, the VA Administrator said that VA's actions since receiving GAO's draft report thoroughly addressed all the issues raised and implemented GAO's recommendation. The Administrator said the original data and subsequent data trends indicate the mission change proposal was proper at the time it was made and continues to be so, and warrants prompt implementation. VA did not take

exception to any of the information presented in GAO's response to the Congressman's specific questions.

Based on GAO's analysis of the details provided in VA's response, GAO continues to believe the issues discussed in this report remain unresolved and should be addressed by the Administrator.

Contents

Letter		1
<hr/>		
Chapter 1		8
Introduction	Miles City Mission Change Proposal Objectives, Scope, and Methodology	8 10
<hr/>		
Chapter 2		12
Unresolved Issues	High Costs Cited for Inpatient Surgery Are Not Accurate	12
Relating to the	Differences in Cost Estimates Have Not Been Reconciled, and Not All Costs Have Been Recognized	14
Elimination of	Elimination of Inpatient Surgical Services Is Inconsistent With Prior Planning Projections	19
Inpatient Surgical	VA Did Not Compare the Trade-Offs Between the Center's Inpatient Surgical and Extended Care Capabilities	20
Services	Comments of Regional and Central Office Officials	22
	Conclusion	22
	Recommendation	23
	Agency Comments and Our Evaluation	23
<hr/>		
Chapter 3		26
GAO's Responses to the	Question 1	26
Requester's Questions	Question 2	27
About the Mission	Question 3	28
Change Proposal	Question 4	30
	Question 5	31
	Question 6	32
	Question 7	34
<hr/>		
Appendixes	Appendix I: Comments From the Veterans Administration	36
<hr/>		
Tables	Table 2.1: Miles City VA Medical Center Surgical Per Diem Rates	13

Contents

Abbreviations

FTEE	Full-time Equivalent Employee
GAO	General Accounting Office
MEDIPP	Medical District Initiated Program Planning
VA	Veterans Administration

Introduction

The Miles City, Montana, Veterans Administration (VA) medical center is a 120-bed facility located in an eastern Montana community of about 10,000. Employing about 200 people and operating on an annual budget of about \$8.5 million, the Center provides primary and secondary care to patients with acute medical and surgical conditions; it also provides long-term care through (1) a 26-bed nursing home care unit and (2) contract nursing home beds. The Center serves an area of about 77,000 square miles in 31 counties. 23 in Montana, 5 in North Dakota, and 3 in Wyoming. Over 40,000 veterans reside in the service area, with the largest veteran population (about 15,000) being concentrated in Yellowstone County, Montana (where the city of Billings is located). Travel to the Center is primarily by automobile or bus.

Miles City Mission Change Proposal

According to the Medical District Initiated Program Planning (MEDIPP) mission change proposal, prepared in early 1985, the Center's director proposed to change its mission from "predominately acute care to predominately extended care while maintaining total bed levels at approximately current levels." Specifically, the change would eliminate the Center's 19 surgery beds; thereafter, it would provide outpatient surgical services only. Under the proposal, veterans requiring emergency inpatient surgery would be referred to Holy Rosary Hospital, a private facility located about 6 blocks from the Center. Veterans requiring non-emergency inpatient surgery would be transferred to VA facilities in Denver, Colorado (about 625 miles from the Center); Salt Lake City, Utah (about 700 miles); or Fort Harrison, Montana (about 350 miles).

Corollary changes included in the mission change proposal involved reducing the number of "acute medicine" beds from 62 to 30, increasing the number of nursing home beds from 26 to 60, and increasing the number of intermediate beds¹ from 10 to 20. Along with the proposed mission change, the Center planned to open two outreach clinics² in Montana: one in Billings (about 150 miles west of Miles City) and another in Wolf Point (about 170 miles north).

According to VA documents, the impetus for the mission change proposal was the need to economize in an era of federal fiscal constraints, while

¹Intermediate beds are used by the Center in evaluating facility placement for geriatric veterans and in providing additional services, such as hospice care, respite care, and beds for other medical programs

²An outreach clinic provides primary health care, referral, and posthospital follow-up services to veterans residing in isolated rural areas

better meeting the special needs of the aging veteran population in the Miles City service area. Specifically, the proposal cited (1) that surgery at the Center was not cost-effective, given the decreasing number of major surgical procedures and the increasing number of minor ones—primarily diagnostic procedures, (2) a declining need for and above-average cost of medical (nonsurgical) beds, (3) an increasing need for intermediate beds; and (4) an increasing need for extended care (nursing home) beds.

The proposal further said that closing the inpatient surgical service would not have a negative effect on patient care because the Center planned to handle more surgical procedures on an outpatient basis. Patients requiring inpatient surgery would be handled either by the nearby community hospital (for emergencies) or by other VA facilities (for nonemergencies).

The Center's mission change proposal was approved by the district³ and forwarded to VA's central office in September 1985 for review and approval. The proposal was consistent with the central office's 1985 MEDIPP guidelines. The MEDIPP process was implemented by VA in fiscal year 1981 to help formulate changes necessary to meet future health care delivery needs in all elements of VA's health care system. The process emphasizes field involvement and requires coordination among personnel in VA's health care facilities, medical districts, regions, and central office.

The 1985 MEDIPP guidelines called for all VA districts to conduct a "rigorous assessment" of facility missions. In particular, the districts were to seek opportunities for increasing the cost-effectiveness of services, consolidating or sharing services, and eliminating "less essential" bed services. The guidelines pointed out, however, that a "mission change" (i.e., "a proposal which adds or deletes a bed service at a VA medical center or establishes or closes a satellite or independent outpatient clinic") required central office review and approval.

In VA's December 19, 1986, response to our draft report, the Administrator stated that the mission change proposal warrants prompt implementation. As of January 21, 1987, the mission change was awaiting the Administrator's final approval.

³VA's health care system is divided into 27 districts. District 23 includes VA medical centers in Miles City and Fort Harrison, Montana, Denver, Fort Lyon, and Grand Junction, Colorado, Cheyenne and Sheridan, Wyoming, and Salt Lake City, Utah.

Objectives, Scope, and Methodology

At the request of Representative Ron Marlenee, we reviewed VA's proposal to change the mission of the Miles City, Montana, VA medical center. Mr. Marlenee was particularly concerned about the aspect of the mission change that would close the Center's inpatient surgical service, and he asked us to analyze the proposal. He also asked several questions about the feasibility of implementing the change and about how the proposed inpatient surgical closure might affect area veterans

In analyzing the proposal, we reviewed planning documents prepared by VA in support of the mission change, including MEDIPP proposals and related documents. We also visited the Center and examined its workload statistics and cost reports primarily for the period covered by the proposal. We reviewed applicable VA regulations, policies, and procedures. Further, we interviewed Center employees and representatives of veterans' groups to obtain their views on various aspects of the mission change. We also contacted officials responsible for VA medical planning at the district, regional, and central offices

To assess whether the local community hospital had the capability and additional capacity to handle the Center's emergency surgeries, we contacted that hospital's director and obtained documents showing the hospital's services and workload. To determine the other VA hospitals' capabilities and additional capacities to perform the Center's nonemergency surgical workload, we contacted officials of the three VA hospitals (in Denver, Salt Lake City, and Fort Harrison) that would assume the workload. We obtained relevant documents from those officials and discussed their hospitals' capabilities, workloads, and travel procedures and budgets for patient transfers between hospitals

To determine the Center's authority for establishing the Billings and Wolf Point outreach clinics and whether these clinics' establishment was part of the mission change, we obtained information on VA criteria, policies, and procedures for establishing clinics and determined funding sources for the two clinics.

We discussed the matters in this report with officials of VA's Region 5 (in which the Center is located), the central office's Department of Medicine and Surgery, and VA's Inspector General. We have incorporated their comments in the report as appropriate

We did our review from July through September 1986 in accordance with generally accepted government auditing standards.

Unresolved Issues Relating to the Elimination of Inpatient Surgical Services

VA has not resolved a number of important issues in its plans to close the inpatient surgical service at its Miles City medical center. As part of a proposed mission change at the Center, VA plans to close the inpatient surgical service because of excessive costs and a declining workload. In reviewing its mission change proposal, we found that

- high costs cited for the Center's inpatient surgical service were not accurate;
- three VA units developed significantly different cost-saving estimates from closing the inpatient surgical service, and not all offsetting costs associated with the closure were recognized;
- in proposing to close the inpatient surgical service, VA did not address why its planning figures showed an increase in the need for surgical beds and why it was closing surgical beds when it had a goal of providing care as near to a patient's home as possible; and
- VA's proposal did not compare the advantages of meeting veterans' long-term care needs against the disadvantages of eliminating inpatient surgery.

Because VA has not adequately addressed these issues in its justification for the mission change, we do not believe it has demonstrated that the mission change is in the overall best interest of area veterans. We believe VA should resolve these issues before the VA Administrator makes a final decision on closure of the inpatient surgical service.

High Costs Cited for Inpatient Surgery Are Not Accurate

VA's MEDIPP proposal and Center and district officials cited cost-effectiveness considerations as a primary reason to close the inpatient surgery service. Although time constraints prevented our thorough review of the Center's cost-allocation reports, we identified several inaccuracies and inconsistencies that caused us to question the reliability of the per diem rates cited in the proposal which were calculated from the cost allocations.

The Center's allocations of the direct costs of dietetic salaries to the inpatient surgical ward were incorrect. In fiscal years 1984 and 1985, the Center allocated the salaries of 2.0 dietetic positions to the ward. In fiscal year 1986, the Center allocated the salary of only 0.8 positions to

the ward. According to the Center director's staff assistant,¹ the 2.0-position allocation was incorrect; the 0.8 figure was more accurate.

Also inconsistent were the nursing cost allocations among the three inpatient surgical units: the ward, the intensive care unit, and the operating room. In fiscal year 1984, \$463,381 (for all 17.8 surgical nursing positions) was allocated to the surgical ward, but no nursing costs were allocated to either the surgical intensive care unit or the operating room. The Center director's staff assistant said that this allocation was incorrect. The following year, the surgical nursing costs (and positions) were distributed among all three surgical units.

Had the 1984 surgical nursing costs been allocated among all three units as they were the next year, the per diem rates (calculated from the cost allocations) for the three units would have been considerably different than the rates reported. Table 2.1 shows the actual fiscal year 1984 surgical bed section per diem rates and the corrected per diem rates after adjustment for the dietetic and nursing salaries.

**Table 2.1: Miles City VA Medical Center
Surgical Per Diem Rates**

Hospital unit	Actual	Corrected
Surgical ward	\$181.85	\$138.05
Intensive care unit	12.80	1,220.10
Operating room	189.87	307.90

The mission change proposal reported the fiscal year 1984 surgical ward's per diem rate of \$181.85 as being the highest among eight analogous hospitals' rates, and used it as partial justification for the proposed closure of the Center's inpatient surgical service. Had the lower rate of \$138.05 been used, however, the Center's surgical ward per diem rate would have been the fourth lowest among the eight hospitals' rates. Similarly, the mission change proposal used the low per diem rates of the intensive care unit and the operating room as indicators that the Center had the least costly surgery (i.e., that minor procedures made up the bulk of the inpatient surgical workload). Again, however, had the 1984 per diem rates of the intensive care unit and the operating room been calculated based on an allocation ratio similar to that used in 1985, they would have been more comparable to those of the analogous hospitals.

¹At the time of our review, the Center did not have a director. Both the chief of staff (the acting director) and the director's staff assistant were familiar with the Center's mission change proposal initially developed by the former director.

The errors and inconsistencies we identified in the Center's cost allocations are similar to the findings contained in a recent GAO report² assessing VA's financial management processes. The report said that VA's cost allocation methods do not provide reliable information that is timely, useful for financial management, comparable between VA hospitals, or consistent over time.

Differences in Cost Estimates Have Not Been Reconciled, and Not All Costs Have Been Recognized

Three different estimates, ranging from \$412,000 to \$1.7 million annually, have been made of the cost savings that will result from closure of the Center's inpatient surgical service. These three estimates were not reconciled by VA. Other costs of the proposed change have not been recognized, and these costs must be offset from the estimated savings to determine the actual cost of the mission change. Until these costs are considered, VA will not know what, if any, savings will result from closing of the inpatient surgical service.

The first savings estimate of \$412,000, contained in the Center's mission change proposal, was based on potential staff reductions that would eventually (through attrition) save about \$412,000 annually. A second estimate, contained in a January 1986 VA Inspector General report, showed a net savings of \$1.4 million annually from closure of the inpatient surgical service. The third estimate, cited in a district 1985 MEDIPP planning document, indicated a savings of \$1.7 million from closure, with the savings being planned to fund other elements of the mission change. The three savings estimates differed because certain costs either were not considered or were based on different assumptions. Among these were the costs of outpatient surgery, patient transfers, emergency surgery, increased costs at other hospitals, and remodeling costs.

The Center's \$412,000 savings estimate was based on a projection that 15 positions could be eliminated through attrition if the mission change were implemented. The new configuration, according to the proposal, would require 187.5 positions, or 15 fewer than the 202.5 positions currently on the payroll. The Center claimed other unidentified savings would also result from closure of the surgical service.

Our discussions with Center staff and our review of pertinent documents led us to question the reliability of the 15-position savings estimate. Not only were Center officials unable to specify which positions

²Volume 1 of 2, Financial Management: An Assessment of the Veterans Administration's Major Processes (GAO/AFMD-86-7, June 27, 1986)

would be eliminated upon implementation of the mission change, but Center staff and personnel documents questioned the reliability of the estimate. According to the staff assistant to the director, the mission change would result in the elimination of only 6 positions, at most. A 1985 document prepared by the Center's personnel officer indicated that no positions would be saved. The personnel officer told us that based on staffing requirements for the outpatient surgical department subsequently received from VA's central office, the mission change would require, rather than a decrease, an increase of at least 2 positions.

The Inspector General's \$1.4 million savings estimate from closing the inpatient surgical service resulted from subtracting certain offsetting costs (of emergency surgery, patient transfers, and outpatient surgery) from the inpatient surgical service's \$1.7 million fiscal year 1984 operating cost. However, this estimate included about \$739,000 in indirect costs that possibly could be reduced but would not likely be totally eliminated through closure of the inpatient surgical service. Rather, these indirect costs would more likely be redistributed among other Center services. Among these indirect costs were allocations for administration, building management support, and engineering.

The district's \$1.7 million savings estimate would be the total cost of operating the surgical service. Unlike the Inspector General, however, the district did not subtract any offsetting corollary costs from its estimate.

Differences in the three estimates occurred primarily because certain costs relating to several elements of the proposed closure either were not considered or were based on different assumptions. Among these were the costs of outpatient surgery, patient transfers, emergency surgery, increased costs at other VA hospitals, and remodeling costs.

Outpatient Surgery Costs

The Center estimated that after the mission change, it would be able to handle about 40 percent of its present surgical workload on an outpatient basis. However, neither the Center's nor the district's estimate included the cost to operate the outpatient service. We were told by the Center's chief of staff that five to seven positions would be used to provide the needed outpatient surgical capability. Because these persons would also perform other work, this equates to about 2.5 to 3 full-time

positions. The Inspector General's staffing estimate for outpatient surgery was similar: one full-time surgeon, one full-time nurse, and one part-time nurse, with an estimated cost of about \$161,000.³

Maintaining an outpatient surgical service without a corollary inpatient surgical service may not be cost effective. Without the inpatient surgical workload after the mission change, only limited use of the two operating rooms, for outpatient surgery, will be obtained. The discrepancy is large between the minimum caseload that VA recommends for establishment of a cost-effective outpatient surgical service and the smaller caseload that the Center expects. VA's suggested minimum caseload for an outpatient surgical service is 1,000 procedures per year and two operating rooms, which the Center already has. Similarly, the 1985 State Health Plan for Montana cites that a minimum of 780 procedures should be performed to maintain cost-efficient operation of an independent outpatient surgery program. The Center anticipates performing about 40 percent of its surgical procedures on an outpatient basis.⁴ Based on fiscal year 1985 surgical statistics, that would equate to 284 (of 712) surgical procedures being done on an outpatient basis. Thus, with the physical capacity to perform 1,000 outpatient surgical procedures annually, but with a patient caseload of fewer than 300, the Center's surgical service would be underutilized. The Center's acting director told us he realizes the Center cannot support the 1,000-procedure requirement. He said he will attempt to obtain a waiver of this requirement.

Cost of Patient Transfers

Neither the Center's proposal nor the MEDIPP plan's estimated cost savings contained a provision for the cost to transfer patients to other hospitals for inpatient surgery. The Inspector General's report, based on estimates obtained from the Center's chief of staff, estimated VA's annual patient transfer costs to be about \$100,000.

Using the Center's estimate in the proposal of transferring about 60 percent of its current inpatient surgical caseload⁵ (with the Center handling the other 40 percent on an outpatient basis), we estimate that about 400

³This cost was based on an estimated 458 procedures per year, multiplied by the procedure cost shown in VA's September 1984 Summary of Medical Programs

⁴VA advised us in its comments that 70 percent of the Center's procedures will likely be done on an outpatient basis rather than the 40 percent initially estimated. However, VA's new estimate is based on changed conditions with less inpatient surgical capability, as discussed on page 20.

⁵In responding to our draft report, VA advised us that recent data show the workload that will be transferred to other VA hospitals may be closer to 30 percent.

patients would be transferred annually to other VA hospitals (based on the fiscal year 1985 surgical caseload). For this many patients, at an average round-trip transfer cost of \$664 per patient,⁶ the projected annual transfer cost to the district would be about \$265,000.

The average round-trip transfer cost of \$664 includes the cost of air charter service.⁷ A precise estimate of the number of transfers requiring air charter service that would occur upon closure of the Center's inpatient surgical service is difficult to make. However, as the veteran population ages, their overall medical condition likely will worsen, which we believe will require some air charter service

Emergency Surgery Costs

Neither the Center's proposal nor the District's MEDIPP plan accounted for the contract cost of emergency surgeries (which after the mission change would be performed by Holy Rosary, a private hospital located near the Center). The Inspector General, in consultation with the Center's chief of staff, initially estimated the emergency surgery contract cost to be about \$105,000. In developing a draft contract for emergency surgery, the chief of staff subsequently revised his estimate to a total of \$150,000 for both hospital costs and physician charges. To estimate hospital costs, he analyzed the operating room log, which showed an average of 16 emergency surgeries per year over a 7-year period (1979-85). Using Medicare reimbursement data, the chief of staff arrived at an average cost per case of about \$4,000, for an annual total hospital cost of approximately \$64,000. To make allowances for exceptions, he then increased that estimate to \$100,000.

To estimate physician charges for the same average annual number of emergencies, the chief of staff used an average charge of \$630 per procedure and multiplied it by 16 procedures per year to arrive at an average annual physician charge of \$10,000. He then increased that estimate, again to account for exceptions (e.g., if all emergencies performed were high-cost procedures), and arrived at a total physician cost of \$50,000.

⁶We calculated the average per-patient cost from VA's records of costs incurred to transfer 151 patients to other VA hospitals within the district over the 18-month period from October 1984 through March 1986.

⁷In responding to the draft report, VA said it was inappropriate to include air charter service costs since the additional patients transported if inpatient surgery were closed would be the least ill and could all be transferred by scheduled air or bus transportation. Without inclusion of the air charter costs, VA said the round-trip cost of transferred patients was \$370. Transferring 400 patients using VA's round-trip cost of \$370 would total \$148,000.

The former Center director estimated that the number of emergencies that would be transferred could be between 14 and 34 cases per year. Our analysis showed the number of annual inpatient emergencies for calendar years 1984 and 1985 to be 24. These emergencies were identified for us, at the direction of the chief surgeon, by the head operating room nurse. Using the Medicare-derived figure of \$4,000 per hospital case and multiplying it by 24 emergencies per year, we arrived at \$96,000 for hospital costs alone, as compared to the \$64,000 base cost that the chief of staff calculated using the lower average of 16 emergencies per year.

Costs at Other Hospitals

None of the cost-saving estimates included the costs that the receiving VA hospitals would incur in handling the Center's inpatient surgical caseload. The Fort Harrison hospital, for example, estimated that it would incur an increased annual cost of about \$175,000 if it were to handle the Center's total nonemergency inpatient surgical workload. Although neither the Denver nor the Salt Lake City VA hospital estimated its increased costs, a VA study dealing with cost effectiveness showed that surgical costs are usually higher at teaching hospitals, such as Denver and Salt Lake City, than at nonteaching hospitals, such as Fort Harrison.

Remodeling Costs

Upon closure of the inpatient surgical service, the Center plans extensive remodeling, in part to accommodate the other elements of the mission change. This remodeling is estimated to total about \$5.25 million and would include converting space to accommodate the entire nursing home unit and the outpatient surgical service. The mission change proposal, however, while noting that remodeling projects were planned, did not mention the costs involved or offset the costs against any cost savings expected to result from closing the inpatient surgical service.

If funding for these remodeling projects is not obtained, the 60-bed nursing care unit would be split between two floors. Such a split, according to the Center director's staff assistant, would require additional nurses to adequately staff both floors. The chief of nursing service estimated that splitting the 60-bed unit would require eight additional nurses at an annual cost of about \$192,000.

Elimination of Inpatient Surgical Services Is Inconsistent With Prior Planning Projections

In recommending closure of the inpatient surgical service, the Center cited statistics in its 1985 proposal showing a declining number of surgical procedures and a low average daily census for the inpatient surgical service. The proposal did not, however, address the fact that only 1 year earlier, the district's fiscal year 1984 MEDIPP plan had forecast the need for an increase in acute surgical beds for both the Center and the district. Nor did the proposal address the district's recognition, cited in the fiscal year 1984 MEDIPP plan, of the importance of providing care as near to a patient's home as possible.

The number of surgical procedures at the Center fluctuated from 367 in 1980 to 712 in 1985. The highest number of procedures performed during those years was 722 in fiscal year 1982. During those same years, the average daily census ranged from 14 in 1980 to 9 in 1985. The peak of 14, reached in fiscal year 1980, was repeated in fiscal years 1982 and 1984.

Data through the third quarter of fiscal year 1986 show that 479 procedures were performed at the Center and that the average daily census was 4. This decline from prior years' levels is partially attributable to the following events:

- Because one of the two surgeons was on extended sick leave, the inpatient surgical service was essentially shut down for about 4 months.
- Both the orthopedic and ophthalmology consultants resigned in fiscal year 1985. The latter was not replaced, and the new orthopedic consultant provided only outpatient examination and referral services.
- Contract specifications for the urological consultant were changed in 1986 to specify that the contract urologist would perform outpatient procedures only.

The district's fiscal year 1984 MEDIPP plan projected a need for 23, 25, and 26 acute surgery beds for the Center in 1990, 1995, and 2000, respectively. Further, district planning documents indicated that, because of great distances between the eight medical centers in the district, each facility must offer as many health care options as possible to veterans. In apparent adherence to this policy, the district's fiscal year 1984 MEDIPP plan did not provide for any surgical bed closures. Among the stated reasons were that "travel distances are long and provision for surgical care as near to the patient's home is ideal" and "a 34 percent increase in surgical procedures is expected by 1990, primarily due to the aging of the veteran population."

Notwithstanding these factors, the fiscal year 1985 MEDIPP plan showed that closing the Center's inpatient surgical service was the district's "number one" priority. The mission change proposal did not explain the reversal in priorities; that is, (1) why the increase in acute surgery beds projected just a few months earlier was no longer valid or (2) why the earlier cited goal of providing care as near as possible to the patient's home was no longer applicable. Officials in the district, regional, and central office explained that this change in priorities was brought about because of budgetary constraints on the VA medical system and the district.

Giving top priority in fiscal year 1985 to closing the Center's inpatient surgical service may also be inconsistent with the Center's extension of service through outreach clinics established in Billings and Wolf Point, Montana. The Center expects that the Billings clinic may eventually experience about 15,000 visits annually, growing from an initial start of about 4,500 visits. With 15,000 visits to the Billings clinic, the Center's total outpatient visits would be about 10,500 more than the number of outpatient visits to the Center alone. It seems likely that as the total number of outpatient visits increases, the number of medical conditions diagnosed as requiring inpatient surgery would also increase. Thus, one would anticipate an overall increase, rather than a decrease, in the Center's future inpatient surgical workload. However, the Center did not recognize this possibility in its proposal to eliminate the inpatient surgical service.

VA Did Not Compare the Trade-Offs Between the Center's Inpatient Surgical and Extended Care Capabilities

According to the proposal, the Center is facing an increasing need for extended care services. VA's proposal to establish nursing home and intermediate beds will benefit veterans needing this type of care. On the other hand, the area veteran population will continue to need inpatient surgical services, which are to be eliminated at the Center under the mission change. While the Center made provisions for providing these surgical services, certain costs and hardships are involved.

Neither VA's proposal, the documentation supporting it, nor VA officials indicated that VA attempted to compare the benefits of enhancing the Center's long-term care capabilities against the disadvantages associated with eliminating the inpatient surgical capability.

One benefit of enhancing the long-term care capability, according to the 1985 MEDIPP plan, is that it will allow the Center to play a prominent role in long-term care in the district. According to the proposal, the existing

26-bed nursing home care unit will be expanded to 60 beds. The proposal states that the Miles City service area can support a unit this size, and the Center had a patient demand of 59, including 25 in its nursing home care unit, 20 in contract nursing homes, and 14 on a waiting list ⁸

One disadvantage of closing the inpatient surgical bed section is the need to transfer elderly veterans for surgery. Because the Center's primary service area is very large with a low population density, some veterans will have to travel long distances to get to the Center. Without an inpatient surgical service at the Center, these veterans may have to travel again to either Fort Harrison, Salt Lake City, or Denver for inpatient surgery. From the Center, travel to Fort Harrison would usually involve a bus or automobile trip of about 350 miles, travel to Salt Lake City or Denver would usually involve a van ride of about 3 hours from the Center to Billings, Montana, followed by an airplane flight and a taxi ride.

Physicians we interviewed at the Center expressed concern about transferring elderly patients to the other district hospitals. One doctor mentioned a "sundowning" effect, whereby an elderly patient who is placed into unfamiliar surroundings (such as a different hospital) becomes disoriented. Another doctor said that additional travel would impose unnecessary hardships on many veterans who have multiple pathologies and poor overall medical conditions. This same concern was expressed by consultants involved with another VA hospital's proposed mission change. The consultants believed that the hospital's maintenance of sufficient surgical services was essential, especially considering such factors as the hazards of transporting acutely ill elderly patients to remote facilities.

Because VA's proposal did not compare the advantages of meeting veterans' long-term care needs against the disadvantages of eliminating inpatient surgery, we could not evaluate whether the mission change will be in the overall best interest of the area veterans.

⁸In December 1986, a medical center official informed us that there were 19 individuals on a waiting list for extended care services.

Comments of Regional and Central Office Officials

On October 8, 1986, we met with VA regional and central office officials to discuss a draft of this report. In this meeting, VA officials, while acknowledging that regional and central office staff concurrence with the mission change proposal was based on factors discussed in this report, said that additional undocumented and previously undisclosed factors were also considered. These factors related to the future quality of surgical care that may be provided at the Miles City medical center and the minimum number of procedures (critical mass) needed to maintain a surgeon's proficiencies.

In a paper dated October 9, 1986, the director of VA's central office Surgical Service provided us with the service's position on closure of the inpatient surgical service. This paper stated, in part, that

“ VA Central Office Surgical Service believes that the surgical work load and case mix at the Miles City VA Medical Center is inadequate to maintain the competency of a surgeon and therefore is a potential threat to the quality of patient care. VA Central Office Surgical Service responded to the proposal of closing the Surgical Service in the affirmative when asked to comment on the results of the Inspector General's Audit and MEDIPP submission. Our concurrence was based on the small work load and the assurance of availability of alternative surgical care for veterans in the Miles City area. Maintenance of a surgeon on the staff for the purpose of consultations, care of post-operative patients whose surgery was performed elsewhere, and for performing minor ambulatory surgery under local anesthesia has also been recommended by VA Central Office Surgical Service.”

These factors had previously not been disclosed to us, although we had made numerous inquiries concerning possible quality-of-care issues involved in the mission change proposal. In discussing the closure with the chief surgeons at Fort Harrison, Denver, and Salt Lake City and with other VA officials, we were told that they knew of no standards on the minimum number of procedures needed to maintain proficiency except in the area of cardiac surgery. These surgeons offered varying opinions on whether surgical proficiency might be affected by the types and numbers of procedures performed at the Miles City medical center. Also, reviews involving evaluations of surgical quality by VA and by an external organization did not identify any concerns about the quality of surgical care at the Center.

Conclusion

Our analysis indicates that a number of issues remain unresolved and, while we recognize that the Center would be able to provide a different mix of services, we do not believe that VA has demonstrated that overall VA service to the veterans in the Center's service area will be improved.

Recommendation

GAO recommends that the Administrator of Veterans Affairs address the cost, planning, and trade-off issues raised in this report, as well as the potential quality-of-care issue, before making a final decision on the proposed mission change.

Agency Comments and Our Evaluation

In a letter dated December 19, 1986, the Administrator of Veterans Affairs stated that since VA received our draft report for comment, a VA central office task force visited Miles City to review factors affecting the proposed mission change and that additional reviews were made at several levels within the central office. The Administrator stated both the original data and subsequent data trends indicate the mission change proposal was proper at the time it was made, continues to be so, and warrants prompt implementation. The Administrator said that the VA actions taken since receiving the draft report thoroughly address the issues raised and implement the recommendation in the draft report. He attached a detailed enclosure to his letter discussing VA's views regarding the issues raised in our draft report.

We do not agree with the Administrator's overall assessment. Our analysis of VA's detailed response showed that the following important issues still need to be addressed and resolved:

- VA's 1985 mission change proposal, on which we focused our review, remains largely unsupported in terms of the cost and savings justifications.
- In its comments, VA reasserted its view that as the number of aging veterans continues to rise, the need for extended care beds will inevitably rise. However, VA provided little additional information to indicate that it has assessed whether it is in the best interest of area veterans to meet the need by providing less acute care at the Miles City medical center.
- Although not covered in the proposal, VA central office officials told us in October 1986 that factors relating to concern over the potential future quality of surgical care at the Miles City medical center were also important in their support of the mission change proposal (see p. 22). These factors related to a diminishing inpatient surgical workload and number of complex cases. In its December 1986 reply to our draft report, VA did not explain how or to what extent these factors entered into its impending decision to close the Center's inpatient surgical service. We, therefore, cannot ascertain from VA's comments the relative importance of this issue.

Chapter 2
Unresolved Issues Relating to the Elimination
of Inpatient Surgical Services

Our detailed analysis of VA's comments on our draft report appears in appendix I. We believe that our recommendation remains appropriate and that VA should more fully address the issues raised in this report before the Administrator makes a decision regarding the proposed mission change at the Miles City medical center.

GAO's Responses to the Requester's Questions About the Mission Change Proposal

Congressman Marlenee raised six specific questions about the implementation of the proposed mission change, including the ability of VA and community hospitals to absorb increased workloads, and the status of the change at the Center. He also asked us to comment on whether the mission change is in the best interest of area veterans, an issue we discussed in the previous chapter. Following is our response to these questions.

Question 1

Given the number of emergency surgery patients normally treated at the Center, does Holy Rosary have the additional available capacity to accommodate the increased load of emergency surgery patients that would come from the Center under the proposed contractual agreement? Do you foresee any problems that may arise resulting from this arrangement?

GAO Response

Holy Rosary should be able to accommodate the Center's emergency surgery referrals—about 24 per year, or 2 per month (see p. 17). From January 1984 through mid-August 1986, the Center performed an average of two emergency surgeries per month. The peak on any given day was two emergencies, but this occurred only twice during the 32-month period. According to its director, Holy Rosary has the necessary equipment and staff to perform as many as 12 surgical procedures per day—more than twice as many as it currently performs (about 5 per day, based on 1985 data). The director said that Holy Rosary has five fully equipped operating rooms, two of which are regularly used; the other three are “on standby”—ready to go whenever needed. He said the necessary staff (surgeons, anesthesiologists, etc.) are also available—either in the hospital or on call—to perform emergency surgeries.

Additionally, the low occupancy rate of Holy Rosary's medical/surgical beds indicates that the hospital could readily accommodate the Center's emergency surgery patients. Of Holy Rosary's 75 medical/surgical beds, about one-third were occupied in fiscal year 1985.

Because Holy Rosary's surgical capacity and bed availability far exceed the Center's projected emergency surgery referrals, we do not foresee any problems with the proposed contractual agreement between the two hospitals.

Question 2

Given the present and projected patient load at the VA hospitals in Fort Harrison, Salt Lake City, and Denver, will these facilities have the additional available capacity needed to accommodate the increased nonemergency surgical patient load that would come from the Center? Are these transfers likely to result in any time delays in scheduling veterans for surgery? Do you see any problems that may arise resulting from this arrangement?

GAO Response

The medical center facilities at Denver, Salt Lake City, and Fort Harrison have the additional available capability and capacity to accommodate the increased patient load that would come from the Center. The Center would most likely send its patients to Fort Harrison rather than the other two facilities, because Fort Harrison has the only other surgical service in Montana.

Fort Harrison officials anticipate no problems in accommodating the Center's inpatient surgical transfers (about 425 patients per year, based on the Center's estimate that 40 percent of its inpatient surgeries could be done on an outpatient basis). The Fort Harrison facility has a surgical bed occupancy rate of about 65 percent. It offers a broader range of surgical services than the Center does, but a narrower range than the Denver and Salt Lake City facilities do. The latter two, for example, perform specialty inpatient surgical procedures in neurology, ophthalmology, dermatology, and otolaryngology. As in the past, Miles City Center patients would still have to travel to one of these facilities for specialty surgeries not offered by Fort Harrison. Officials at the Denver facility were also confident that, upon its October 1986 completion of a construction project that increased its surgical beds by about 30 percent (from 112 to 144), it would have no difficulty in accommodating transfers from the Center. The Salt Lake City facility, however, according to the chief of staff, would be "hard pressed" to take any more cases—not because of a lack of surgical beds, but because of staffing constraints (primarily nursing staff shortages). Despite these constraints, the Salt Lake City facility will accept transfers from the Center on a space-available basis.

Anticipated delays in scheduling vary by facility and by surgical procedure. Scheduling delays at the Center, as of August 1986, ranged from 7 to 14 days. For the same types of procedures that the Center performed, similar scheduling delays existed at the Fort Harrison and Salt Lake City facilities. At the Denver facility, delays for these typical procedures ranged from 60 to 90 days. However, delays of 6 months at the Salt

Lake City and Denver facilities were not uncommon for ophthalmology and orthopedic surgeries. Officials at the three facilities said it is not planned that Center patients will receive "priority" in scheduling inpatient surgery (as cited in the proposal). Rather, they and other patients needing nonemergency surgery at the facilities will be scheduled chronologically, according to when their physicians order surgery for them.

Because the types of surgical procedures now done at the Center will either continue to be done there on an outpatient basis or be referred to one of the other three VA facilities, we do not see any problems that may arise from this arrangement, with one exception. Increased travel may inflict undue hardship on elderly area veterans, as discussed on page 21.

Question 3

What procedures does the Center have in place to insure efficient, hassle-free, and unimpeded travel for veterans who must travel? Do you see any problems that may arise from this arrangement?

GAO Response

The Center has newly developed procedures to assist patients referred to other facilities for care. We believe that some problems will inevitably occur because of the many transfers anticipated and the nature of travel itself. That is, travel poses many uncertainties that cannot be anticipated or mitigated, such as weather conditions, airline schedules, the patient's health, and family arrangements. Additionally, although expected according to the mission change proposal, it may be impractical to implement procedures to return patients to the Center for post-operative care, thus reducing the time they are separated from their families.

The Center has new policies and procedures governing the travel of patients it refers to other VA facilities. Issued by the District in June 1986, these policies and procedures

- designated Fort Harrison as the preferred facility for receipt of patient transfers and suggested that if the care required is beyond the capacity or capability of the Fort Harrison facility, the patient be referred to one of the other VA medical facilities in District 23, if possible,
- designated a physician in each of the three receiving facilities (Fort Harrison, Salt Lake City, and Denver) as the contact point for discussing and scheduling the care of patients referred by the Center; and
- required each receiving facility and the Center to appoint a "transfer coordinator," who would work with the physician contacts and each

other to coordinate the scheduling of surgery and travel arrangements of patient referrals.

Although the Center has transferred many patients over the past several years (e.g , 106 in fiscal year 1985 and 182 during the first 9 months of fiscal year 1986), we identified few problems resulting from patients' transfers, and those problems that we did identify occurred before the new policies and procedures were developed. None of the nine veterans' service organizations (e.g , Veterans of Foreign Wars and the American Legion) we contacted in Miles City told us of any recent problems related to patient transfers.

Among the past problems that we identified were two that involved inadequate travel arrangements for patients discharged from the Denver facility. In one case, the Denver facility did not contact the Center upon discharging the patient, who was to fly to Billings and then take a connecting flight to Miles City. When the flight from Denver to Billings was delayed, the patient missed the connecting flight to Miles City. Had it not been for a Center employee who happened to be in Billings and gave the veteran a ride back to Miles City, the veteran would have had to wait 9 hours for a bus. In the other case, a wheelchair-bound veteran had to wait at the Billings airport for 4 hours because word of his arrival was late in reaching a relative.

Although the new procedures should minimize logistical travel problems, one element of the proposal, designed to minimize patients' separation from their families, may not be practical to implement as designed. The mission change proposal states that patient stays at the three receiving hospitals will be held to a minimum because patients will be returned to the Center for postoperative care. Our discussions with physicians at the three receiving facilities, however, indicated that in many cases it may be impractical to minimize surgical inpatient stays at the receiving hospitals. For example, the chief of staff at Fort Harrison said that for relatively simple procedures requiring 2 to 3 days of postoperative care, little likelihood exists that the length of stay could be reduced at the receiving hospital. Because the additional cases to be transferred upon closure of the Center's inpatient surgical service would be relatively simple surgeries, there would be limited opportunities to reduce stays at the receiving hospital. Further, according to the Denver facility's chief of surgery, to return a patient to the Center for postoperative care would often be inappropriate because the surgeon who performed the procedure would not be available if complications arose.

Question 4

How will the proposed reduction in VA travel funds affect the travel benefits that would otherwise accrue to veterans who will have to travel to Fort Harrison, Salt Lake City, or Denver because of the mission change?

GAO Response

VA funds two types of travel: (1) the transportation expenses of certain veterans who travel between their residences and VA medical facilities to receive treatment and (2) the travel costs of veterans transferred as patients from one medical facility to another. A recently enacted major reduction in VA's beneficiary travel funds could adversely affect both kinds of travel

Payment of transportation expenses between veterans' residences and VA medical facilities is authorized for certain eligible veterans under 38 U.S.C. 111. VA defines eligible veterans as those who either (1) have a service-connected disability, (2) are receiving a VA pension, or (3) have an annual income equal to or less than the maximum established VA pension rates. The veterans' reimbursement for such travel is limited to the lesser expense of public transportation or privately owned vehicle at 11 cents per mile.

The reimbursement eligibility criteria do not apply, however, to inpatient transfers between VA medical facilities. Once a veteran is admitted as an inpatient, VA pays all costs associated with the patient's transfer between that facility and another.

VA's fiscal year 1987 appropriations reduced VA's beneficiary travel funds from last year's \$100 million to about \$10 million. The House Appropriations Committee indicated that use of the funds should be limited to "emergency travel" reimbursements, such as those for ambulances and wheelchair vans

To deal with the reduction, VA plans to stop paying for veterans' transportation expenses between their residences and VA medical facilities. Additionally, VA officials told us they will no longer finance non-emergency patient transfers out of beneficiary travel funds. Instead, according to these officials, facilities must fund such transfers from other budget accounts. As of mid-January, VA was revising its beneficiary travel regulations to reflect these changes.

Should the Center be unable to provide sufficient funds to cover inpatient transfer costs, with the additional number of transfers that will probably result from closing the inpatient surgical service, veterans will

be adversely affected either financially or medically. That is, veterans will have to either pay for their travel to another VA facility or receive care at a non-VA facility. Some veterans may postpone or forgo receiving medical attention.

Question 5

Did the Center have the authority to set up the Billings and Wolf Point clinics? Where is the funding for these ventures coming from, and how is it related to the money that would be saved from the mission change? Will the clinics remain open if the mission change is not approved?

GAO Response

According to VA central office and district officials, the Center had the authority to set up the Billings and Wolf Point clinics as long as it was able to fund them out of its existing budget, which it did. The Center plans to expand the Billings clinic, partially based on the savings anticipated from the mission change. According to Center officials, the clinics will remain open whether or not the mission change is approved. The regional office plans to provide some funding for the Billings clinic in fiscal year 1987.

According to VA policies and procedures, a medical center director has the authority to "organize and operate the medical center programs; to change internal procedure, workflow, and sequence of operations as dictated by local conditions or when such changes will produce improved service at no additional cost or equal service at reduced cost." Also, VA criteria for establishing an outreach clinic state that the new clinic must be at least 50 miles from an existing or planned VA health care facility, with demonstrated difficulty of access to the base facility. It was under these provisions and criteria that the Center director established the Billings and Wolf Point outreach clinics.

The Billings outreach clinic was opened in July 1985 in leased space. Part of the justification for the Billings clinic was the long distance from Billings to the Center (300 miles round trip). Center officials believed that this distance discouraged veterans from using the Center's services. The Billings clinic was initially staffed with three people (physician, nurse, and office coordinator), and three more (physician's assistant and two clerks) have since been hired. The director's staff assistant told us that the clinic's fiscal year 1986 costs totaled about \$150,000, mostly for salaries, and about \$100,000 of that total was taken from the Center director's reserve fund. According to the staff assistant, the clinic's planned budget for fiscal year 1987 is about \$350,000. We were told by

regional office officials that the region will provide about \$150,000 of that funding

Although the Billings clinic is currently an outreach clinic, center and district officials want it to be a larger "satellite clinic," as they anticipate a need to accommodate about 15,000 annual visits by 1990. However, establishing a satellite clinic constitutes a mission change and thus requires central office approval, which has not yet been granted.

The Wolf Point outreach clinic was opened in July 1986 in space donated by a local medical group. The clinic was established to assess the need for permanent medical service to veterans in that area. Also, the local bus service between Wolf Point and Miles City had been discontinued, thus reducing veterans' access to the Center from the Wolf Point area. The clinic is staffed by one Center surgeon, who travels to Wolf Point one day per month.

Question 6

Has the Center gone ahead with any actions to implement the mission change even though final approval has not been received? Is there any evidence to suggest that statistics were manipulated to justify the mission change?

GAO Response

Technically, according to VA criteria, a medical center mission change involves adding or deleting a bed service; it does not involve increasing or decreasing a service. Mission changes require VA central office approval.

VA central office approval has not been given to close the Center's inpatient surgical service, and the service is still open. But the Center has taken the following actions closely related to its closing:

- Initiated actions in March 1986 to contract with the Miles City community hospital (Holy Rosary) for provision of emergency surgical services
- Established outpatient surgical services in August 1985 at the Center
- Implemented patient referral procedures in June 1986, "due to the anticipated] surgical service closure . . ." according to a District policy memorandum
- Operated, from May through mid-July 1986, a service under which Fort Harrison physicians were flown to the Center's Billings clinic to diagnose patients, seven patients requiring inpatient surgery were flown or referred to Fort Harrison

During fiscal year 1986, inpatient surgeries at the Center significantly declined compared to prior years. This decline appears to be partially attributable to several events related to the availability of physicians. One of the Center's two surgeons was on sick leave for 4 months, the contract for ophthalmological services was not renewed, and urological and orthopedic services were limited to outpatient treatment.

The Center's acting director provided the following explanations for these events: no attempt was made to obtain back-up support for the physician who was on extended sick leave because the duration of the leave was not known in advance. As for the ophthalmological contract, the Center attempted to renew it upon the contract ophthalmologist's resignation, but could not find a replacement. The reason that urological and orthopedic surgical procedures are performed only on an outpatient basis is that the respective specialists commute to the Center from Billings. The acting director said it is too risky to perform major inpatient surgical procedures without the specialist being available full time in Miles City to deal with any complications that might arise. He said the Center could not find an orthopedic surgeon in Miles City to replace the one who resigned in 1985. He also told us that the Center formerly had a urologist under contract who performed inpatient procedures, but his contract was not renewed because he and the Center could not agree on the terms. (The urologist told us that he had heard of the mission change and for professional reasons did not desire to do only outpatient surgery and consultations.)

The acting director also said that the demand for inpatient surgery has decreased because (1) fewer people nationwide are being hospitalized, (2) elderly patients need more complicated surgeries than the Center can perform, and (3) the Center has been able to perform on an outpatient basis 50 to 75 percent of the procedures it previously performed on an inpatient basis.

Other changes, not directly related to closing the inpatient surgical service and not requiring VA central office approval, have been implemented. For example, the Center

- reduced the number of medical beds from 62 to 52;
- increased the number of intermediate beds from 10 to 20;
- designated 10 beds as alcohol treatment beds; and
- established two Montana outreach clinics, one in Billings and one in Wolf Point.

VA regional and central office officials informed us that the above items, while included as part of the mission change, were well supported and could stand on their own merits.

As discussed in chapter 2, the Center's mission change proposal and supporting documents, in our opinion, contained inaccurate and inconsistent cost data and saving estimates. Also, we found inaccurate statistics in the proposal. These inaccurate and inconsistent data were used to support the need for the mission change or the cost savings estimated to result from it. However, we did not find any evidence that VA officials intentionally overestimated savings or manipulated any statistics to justify closing the inpatient surgical service.

Question 7

Is it your professional judgment, based on all of the data you have gathered, that the mission change is in the best interests of area veterans?

GAO Response

Neither VA's proposal nor the documentation supporting it weighed the advantages of enhancing the Center's long-term care capabilities against the disadvantages associated with the elimination of inpatient surgery capability. Therefore, VA has not demonstrated that, and we could not determine whether, the proposed change is in the best interests of area veterans.

Comments From the Veterans Administration

Note GAO comments supplementing those in the report text appear at the end of this appendix

Office of the
Administrator
of Veterans Affairs

Washington DC 20420



.DEC 19 1986

Mr. Richard L. Fogel
Assistant Comptroller General
Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

This responds to your request that the Veterans Administration (VA) review and comment on the General Accounting Office (GAO) October 18, 1986 draft report VA HEALTH CARE: Lack of Support for Change at Miles City, Montana Medical Center. The GAO reviewed the plans to change the mission of the VA Medical Center (VAMC) at Miles City to a predominantly extended care facility, closing the inpatient surgery service, decreasing the number of medical beds, and increasing the number of long-term care beds.

Your report concluded that the proposed mission change would offer increased access to veterans needing extended care services, but GAO was unable to judge whether or not the proposed change was in the overall best interest of area veterans. The GAO recommended that I address the issues raised in the report, as well as potential quality of care issues, before making a final decision on the proposed mission change.

A VA Central Office task force made a site visit to Miles City to review factors impacting on the proposed change, and additional reviews were made at several levels within Central Office. The original data and subsequent data trends indicate the mission change proposal was proper at the time it was made and continues to be so, and warrants prompt implementation.

I believe the actions taken since receiving your draft report thoroughly address all the issues raised and implement the recommendation. The enclosure contains a discussion of the issues.

Sincerely,

A handwritten signature in black ink, appearing to read 'Thomas K. Turnage', written in a cursive style.

THOMAS K. TURNAGE
Administrator

Enclosure

Appendix I
Comments From the Veterans Administration

DISCUSSION OF ISSUES CONTAINED IN THE OCTOBER 18, 1986
 GAO DRAFT REPORT VA HEALTH CARE LACK OF SUPPORT FOR CHANGE
AT MILES CITY, MONTANA MEDICAL CENTER

See comment 1

HIGH COSTS CITED FOR INPATIENT SURGERY ARE NOT ACCURATE

The report cites inaccuracies and inconsistencies that caused GAO to question the reliability of the per diem rates calculated from direct cost allocations to subaccounts. In particular, the areas of dietetics, nursing, and surgical workload are challenged in the report.

Expendable costs decline as the patient load or average daily census (ADC) drops. The ADC in the surgical bed section dropped from 11 in fiscal year (FY) 1984 and 9 in FY 1985 down to 4 in FY 1986. This lower ADC is translated, correctly, into less time spent by dietetics in the surgical bed section. The resulting drop in full-time employee equivalents (FTEs) shown by dietetics on the RCS 10-0141 "Department of Medicine and Surgery (DM&S) Medical Cost Distribution Report" was a reflection of the low ADC on the surgical ward.

For Nursing Service, the error on the FY 1984 RCS 10-0141 in costing nursing personnel did impact on the per diem costs of the individual units (surgical ward, surgical intensive care unit, and other operating room) but did not impact on the overall per diem cost of the bed section. Using FY 1985 staffing distribution percentages, the FY 1984 RCS 10-0141 per diem rate was recomputed. As shown below, the total cost of the surgical bed section was unchanged under the recomputation. However, the individual unit costs changed as costs were shifted from one unit to the other.

Data from FY 1984 RCS 10-0141
DM&S Medical Cost Distribution Report

	<u>Costs</u> <u>(Direct only)</u>		<u>Days of Care</u>
<u>Based on 1984 staffing guidelines</u>			
Surgical ward	\$ 879,987	divided by	4,839 = \$181.85
Surgical intensive care unit	883	divided by	69 = 12.80
Other operating room	150,753	divided by	794 = 189.87
	<u>\$1,031,623</u>	divided by	<u>5,702 = \$180.92</u>
<u>Recomputation, using 1985 staffing guidelines</u>			
Surgical ward	\$ 731,863	divided by	4,839 = \$151.24
Surgical intensive care unit	61,060	divided by	69 = 884.93
Other operating room	238,700	divided by	794 = 300.63
	<u>\$1,031,623</u>	divided by	<u>5,702 = \$180.92</u>

**Appendix I
Comments From the Veterans Administration**

2.

In addition, the RCS 10-0141 and Summary of Medical Programs reports for fiscal years 1983 through 1986 reflect the following cost and workload data for the surgical bed section:

	Fiscal Year			
	1983	1984	1985	1986
Surgical procedures	478	598	712	625
Patients treated	678	736	513	227
Days of care	4,790	5,702	3,697	1,259
FTEE (direct)	27.5	28.1	23.6	15.9*
Per diem (direct)	205.32	180.92	225.85	347.19*
Average daily census	13	13	9	4
Occupancy rate	72.2	72.2	47.4	21.1
Applications for hospital care	2,316	1,833	1,560	1,129

*Through June

The above data reflect a continuing decline in utilization and an increase in the cost of the inpatient surgical ward.

Evidence concerning the types of surgical procedures performed can be determined by reviewing clinical records such as surgical logs and surgical procedures reports. During the Inspector General (IG) 1985 audit, these records were reviewed for the period April 1984 through March 1985 and conclusively showed the workload consisted largely of minor procedures and diagnostic and therapeutic procedures. During that period, 548 procedures were performed. Only 46, or 8.4 percent, were recorded as major in the surgical log. The remaining 502, 91.6 percent, were minor or diagnostic and therapeutic.

Rather than stressing cost allocations to subaccounts, we believe the comparison of per diem inpatient surgery costs is more pertinent. The GAO report implies that per diem costs at Miles City were not significantly higher than at the seven comparable VAMC's studied by

Appendix I
Comments From the Veterans Administration

3.

Medical District #23 planners. The June 30, 1986 DM&S Summary of Medical Programs shows the surgical per diem cost at Miles City was significantly higher than at the comparable facilities.

<u>VAMC</u>	<u>Surgical Per Diem Cost</u>
Miles City	\$703.35
Prescott	510.81
Livermore	406.52
Grand Junction	361.90
Lincoln	341.73
Cheyenne	333.64
Boise	296.70
Fort Harrison	245.68

ADDITIONAL COSTS FROM THE PROPOSED CHANGE HAVE NOT BEEN RECOGNIZED

The GAO questioned the reliability of the estimates of staff required after the mission change and cited three factors. After reviewing the available data, it is clear these factors are based on misunderstandings of the data and, therefore, do not undermine the reliability of the proposed FTEE data contained in the recommended mission change.

-- The staff assistant to the director stated the mission change would result in the elimination of only six positions, at most.

This comment was made in the context of renovations needed to consolidate the proposed 60 nursing home care beds into an efficient and integrated operation. If the renovations are not made, the VAMC would need an additional six FTEE to accommodate the inefficiencies inherent in providing staff coverage to two separated ward areas. However, planning for the mission change includes renovations to correct fire and safety deficiencies and to consolidate nursing home care ward areas. These renovations will permit maximum utilization of FTEE and obviate the potential problem the staff assistant cited.

-- A 1985 document prepared by the VAMC personnel officer indicated that no positions would be saved.

The personnel officer prepared this handwritten analysis "Possible Staffing with Change of Mission" at the request of the former VAMC director in early 1985. It is a comprehensive listing of perceived FTEE needs and incorporates obsolescent staffing guidelines, the views of the former director, and the views of the personnel officer. It is not based on approved, objective criteria. The document shows a proposed need for 202.5 FTEE, the number of staff on duty at the time the analysis was made, and represents an internal VAMC assessment. It was not included in the original mission change proposal submitted to VA Medical District #23 and should not be perceived as an official statement of proposed FTEE needed after the mission change. The FTEE level of 187.5 recommended in the mission change proposal was based on an objective analysis prepared by Medical District #23 staff. This level was derived by applying national average FTEE factors to the

see comment 2

4.

VAMC's projected workload. These factors were developed in VA Central Office in order to insure nationwide uniformity and consistency in the planning process. The proposed level of 187.5 has been sustained in subsequent district and region reviews of the planning process.

The director's staff assistant was a member of the District Planning Board, participated in the review process, and would have been aware of any discrepancies between the 187.5 FTEE level and the personnel officer's perception of staffing needs. There is no evidence in the review process that such a discrepancy arose, so we must assume the difference between the proposed level of 187.5 and the 202.5 cited in the internal workpaper was overtaken by events.

-- Based on information subsequently received from VA's Central Office, the mission change would require an increase of at least two positions.

This statement, attributed to the personnel officer, is based on an unrelated proposal to consolidate the administrative management of the Fort Harrison and Miles City VAMC's. Such a proposal has not surfaced in the formal planning process and should not be linked to the FTEE levels proposed for the mission change.

See comment 3

In this section of the draft report, GAO also addresses the estimated savings of \$1.4 million per year resulting from eliminating inpatient surgery as mentioned in the January 1, 1986 IG report on VAMC Miles City. The GAO concluded that approximately \$739,000 in indirect costs would not likely be eliminated, but would need to be redistributed among other VAMC activities. We disagree because if inpatient surgery were eliminated, the space could be vacated and most of the staff positions used to support this space could be eliminated. The indirect costs of supporting vacant space are minimal.

However, the IG did not recommend eliminating resources now used for Surgical Service. Instead, it was recommended that the resources be used to enhance the VA's capability of providing nursing home care. This would result in a savings to the VA because underutilized resources would be used productively in caring for nursing home patients. In addition, underutilized surgical resources at other VAMC's could be more productively used to meet the surgical needs of VAMC Miles City.

See comment 4

Outpatient Surgery Costs

The report discusses the IG audit report suggestion to retain the ambulatory surgery capability, staffed with 2.5 FTEE. GAO states this staffing pattern is contrary to the 1986 VA guidelines for 10.25 positions. Actually, the guidelines encourage all VA medical centers to establish an ambulatory surgery capability and use existing resources to the extent feasible. If the workload cannot be met with existing resources, then it may be feasible to construct a dedicated ambulatory surgical suite. If such a dedicated suite is constructed, the suggested staffing should be 10.25 FTEE to meet a suggested

Appendix I
Comments From the Veterans Administration

5.

workload of 4 procedures a day or 1,000 per year. These staffing criteria do not apply to VAMC Miles City because existing space and staff can be used to meet the small outpatient workload of about 1.7 procedures per day or 430 per year. The 1,000-procedure standard is not a requirement; it applies only to the proposed construction of new, dedicated ambulatory surgical suites, and then only when it can be demonstrated that the projected workload could not be met with existing resources.

The report also states that the VAMC Chief of Staff said five to seven employees would be needed to operate the outpatient surgery clinic. We discussed this with the Chief of Staff and were told the five to seven employees would work part-time in the surgery clinic and part-time in other activities. The clinic will only operate 2 days a week. The staff time currently devoted to the clinic equates to 2.5 to 3 FTEE, which is the staffing level recommended in the IG report.

See comment 5

Cost of Patient Transfers

The GAO-projected annual cost of transferring patients, about \$265,000, is based on the actual cost of transferring 151 surgical patients during the October 1984 through March 1986 period. These patients required complex surgery or specialized procedures that could not be performed by the existing Miles City inpatient surgery service. This type of patient would always have to be transferred. Eighteen of the patients had to be transferred by air charter at an average cost of about \$2,811. The remaining 133 were transferred as regular air or bus passengers at an average round trip cost of about \$370. GAO arrived at an average round trip cost of \$664 by averaging the air charter costs and the regular passenger fare costs. This calculation does not accurately portray the costs of transfers required if inpatient surgical services were eliminated.

The patients requiring transfer if inpatient surgery were eliminated would be the least ill, those requiring only routine elective surgery, and could all be transferred by scheduled air or bus transportation. In FY 1984, 28 percent of the beneficiary travel budget was used to transfer 297 patients, a cost of \$221 per patient. For FY 1985, it was \$200 per patient and for FY 1986, \$280 per patient. These figures are less than half the amount cited by GAO, \$664 per patient.

The chartered jet that transports professional staff from VAMC Salt Lake City for the fly-in clinics at Miles City is also used to transport patients at no cost. In addition, there is the possibility of establishing a contract with a charter service, further reducing transfer costs.

On June 6, 1986, a Medical District 23 referral policy, specific to the Miles City mission change, was adopted. It provides mechanisms for Miles City area patients in need of surgery to obtain that surgery in other District facilities. Physicians and administrative personnel have been designated at each facility to coordinate the transfers.

**Appendix I
Comments From the Veterans Administration**

6.

Initially, it was estimated that about 60 percent of the Miles City surgical workload would be transferred to other VA facilities. Recent data show it will be closer to 30 percent. Fiscal Year 1986 experience with similar procedures indicates that 74 percent of the FY 1984 and FY 1985 surgeries could have been done on an ambulatory basis.

See comment 6

Emergency Surgery Costs (Referrals to Holy Rosary Hospital)

The GAO draft report states the dollar amount estimated for the annual cost of emergency surgery may be underestimated and that 24 and 30 procedures per year may be more realistic. We believe GAO did not distinguish between outpatient and inpatient emergencies when reviewing data and thus included emergencies that could be treated by VAMC staff in an outpatient setting. The cited average of 16 referrals per year, FY 1979 through FY 1985, is correct, but we believe this figure will decline. In FY 1986, only four cases were referred to Holy Rosary Hospital, the back-up for VAMC Miles City. Of these, only one was admitted. Surgery can be handled in various ways, many through ambulatory surgery. VAMC Miles City is developing an ambulatory surgery program and will be able to handle more of these cases.

See comment 7

Costs at Other Hospitals

The report cites a \$175,000 increased annual cost of absorbing Miles City patients at VAMC Ft. Harrison as a result of the mission change. It also suggests that costs may be higher at VAMC's Salt Lake City and Denver since costs for surgery are normally higher at teaching hospitals. We believe the \$175,000 figure refers to a study performed by the chief of Surgical Service at Fort Harrison. This study assumes that Fort Harrison would handle the entire Miles City surgery workload.

About \$68,000 of the \$175,000 would be for nursing staff needed to meet that workload. However, it has never been intended that Fort Harrison would take the entire workload. Many of the general surgical procedures and all of the specialized surgical procedures would go to VAMC's Salt Lake City and Denver.

The study also proposes expanding the VAMC Fort Harrison surgical capability to add specialized surgery such as orthopedic, ophthalmology, and urological procedures. This proposed expansion of services accounts for a large portion of the \$175,000. Another part of the cited additional cost relates to direct care expenses for an increased number of patients such as meals, drugs, surgical supplies, orthopedic supplies, x-rays, and laboratory tests. However, these costs would be incurred whether the surgical procedures were performed at Fort Harrison or at Miles City. To the extent that these direct costs increase at VAMC Fort Harrison, they will decrease at VAMC Miles City, and will be more than accounted for by reimbursement through the Diagnostic Related Group process by which the VA is now funding its medical centers.

Appendix I
Comments From the Veterans Administration

7.

See comment 8

Remodeling Costs

The \$5.25 million GAO describes as "extensive remodeling to accommodate the other elements of the mission change" actually includes numerous deficiencies that were scheduled for correction regardless of the mission change. In fact, a Joint Commission on the Accreditation of Hospitals review conducted during our recent site visit cited the facility for some of the same problems.

See comment 9

ELIMINATION OF INPATIENT SURGICAL SERVICE IS INCONSISTENT WITH PRIOR PLANNING PROJECTIONS

The FY 1984 bed sizing model projected an increase to 24 surgical beds for 1990. The report cites this projection as an indication that surgery beds should be maintained. However, the bed sizing model is merely a projection tool based on historical data. The FY 1984 bed model used four years of data, 1980 through 1983. The historical base of these years showed a moderate decrease in surgical activity. This historical base produced a surgical bed level about equal to the existing level. The mission change was proposed because the number of surgical procedures is declining rapidly and would best be done, in large measure, in an outpatient setting. These facts are not properly taken into account in the projection model which is designed to project beds based largely on a stable and continuing workload.

The Billings outreach effort has been very successful in attracting veterans who, in the past, have not accessed the VA health care system. However, it would be a burden on these veterans to send them back to Miles City for major inpatient surgical services when there is a major airport in Billings. Adequate plans have been made to transfer these veterans directly to a VA referral facility in order to expedite care. Furthermore, if the Billings clinic is expanded into a full outpatient operation, consideration will be given to performing various minor outpatient surgical procedures on site.

See comment 10

VA DID NOT COMPARE THE TRADEOFFS BETWEEN THE CENTER'S INPATIENT SURGICAL AND EXTENDED CARE CAPABILITIES

The draft report states GAO was unable to determine if the mission change was in the best interest of area veterans because VA's proposal did not compare the advantages of meeting long-term care needs against the disadvantages of eliminating inpatient surgery. Cited as disadvantages were the increased travel burden imposed by closing inpatient surgery and "the hazards of transporting acutely ill elderly patients to remote facilities."

As the number of aging veterans continues to rise, demand for extended care beds will inevitably rise. Converting acute care beds to extended care will better enable VAMC Miles City to meet this need. Not having beds available would impose substantial travel hardships on veterans and their families. In addition, older persons are more likely to suffer multiple medical problems and surgical interventions become more

Appendix I
Comments From the Veterans Administration

8.

complex. These surgical cases are routinely transferred to tertiary care centers now, and this trend could be expected to increase even if inpatient surgery were maintained at Miles City.

There has been a marked decline in the number of surgical procedures performed at Miles City and many, formerly done on an inpatient basis, can be performed in an ambulatory setting. VAMC professional staff currently estimate that, at most, two surgical patients per week would have to be transferred to tertiary care centers. Sound medical judgment, of course, would determine whether or not a transfer would place a patient in jeopardy and in those instances, emergency care would be available at Holy Rosary Hospital.

A part of the mission change proposal is the establishment of outpatient care at Billings. Converting the current outreach effort to a satellite outpatient clinic would recognize the fact that most veterans served by VAMC Miles City come from this geographic area and enhance their ability to gain access to VA health care.

The mission change is the best way for the VA to use the vacant beds and underutilized resources at VAMC Miles City and it is clearly in the best interest of Eastern Montana veterans to implement it as soon as possible.

The following are GAO's comments on VA's letter dated December 19, 1986.

GAO Comments

1 VA agreed that the fiscal year 1984 cost allocations to the individual surgical units were in error. It pointed out, however, that rather than stressing cost allocations to subaccounts, it believes the comparison of the total per diem inpatient surgical costs among comparable hospitals is more pertinent

We examined the subaccount allocations because those costs were cited by VA in its proposal when it stated that the Center's surgical ward per diem costs were the highest and that the Center had the least costly and simplest surgical caseload among comparable hospitals.

Comparing the total fiscal year 1984 surgical per diem costs among comparable hospitals, which VA now asserts is more pertinent, does not support VA's position that the Center's costs were out of line. The direct total per diem cost of the Miles City surgical bed section in fiscal year 1984 was not the highest of VA's eight comparable hospitals, but instead was the third lowest. In fiscal year 1985, the Center's total surgical per diem cost of \$408.92 was higher than the VA national average of \$345.37, but lower than 23 other VA hospitals

In its comments, VA also cited inpatient surgical per diem costs, as of June 30, 1986, to show that the Center's surgical costs were the highest among comparable medical centers. We did not examine costs as of that date. We question, however, the relevancy of the current comparisons considering that, for various reasons, as discussed on page 19, the Center's inpatient surgical service has been reduced and may no longer be comparable to the other hospitals.

2. Regarding the number of full-time equivalent employees (FTEEs) that would be saved because of the mission change, VA asserted that the Center's personnel officer based his assessment on obsolescent staffing guidelines. This may be the case, but we believe it is important to note that when we discussed the possible personnel savings with the personnel officer and staff assistant to the director, neither person was able to pinpoint the positions that would be eventually eliminated. Also, based on current staffing guidelines, the Center, since at least fiscal year 1984, has employed 35 persons more than the staffing guidelines dictate. This indicates that VA officials exercise judgment in applying staffing guidelines and do not manage personnel allocations solely on

the basis of standard guidelines. In commenting on the section of the report pertaining to staffing an outpatient surgical unit, VA stated that this was the case. Accordingly, we believe saving estimates should be based on the elimination of actual positions.

In commenting on the staff assistant's estimates that only six positions would be eliminated because of the mission change, VA stated we misunderstood the data provided to us. Contrary to VA's contention that the six positions we referred to were additional staff needed if renovations were not made, these six positions had no connection to the renovation project. The context for our information is correct. We asked the staff assistant to identify the 15 FTEES that the Center's proposal showed as a savings, and he told us the positions had not been identified. In that same context, he stated that at best only six positions would likely be eliminated through attrition. We also asked the staff assistant about staffing as it related to proposed renovation work. He said that if the second and third floors were not remodeled, the nursing home service would have to be split between two floors, and this would require an additional eight FTEES. This was corroborated by the Center's chief of nursing service.

VA also is incorrect in stating that our reference to the Center needing two additional personnel was linked to consolidating administrative management of Fort Harrison and Miles City. The statement, made by the personnel officer, was associated with staffing the new outpatient surgical service. In its mission change proposal, VA did not reduce its estimated 15-FTEE savings by the staffing requirements of the outpatient surgical service.

3. VA's comments indicate that indirect costs supporting the surgical bed section could be saved if the space were vacated. We continue to believe that many of the indirect costs would still be incurred and would have to be redistributed among other Center services. For example, about 36 percent (\$101,296) of the total cost of the office of the director and chief of staff are charged to the surgical bed section. Vacating the 19-bed surgical unit would likely require that the costs be charged against other hospital sections. In slightly different terms, 19 of the office's 52 positions are charged against the surgical bed section. We believe it unlikely that the 19 positions would be eliminated if the surgical bed section were vacated.

We agree that savings would result through utilizing the space that would be vacated by closing the surgical service if the Center would

have otherwise avoided incurring expense to provide this nursing care elsewhere. However, VA did not tell us about any plans or budget commitments for the Center to provide nursing home care outside the Center. In the absence of such planning, we believe it inappropriate to claim a savings.

4. We have modified the report to recognize VA's planned staffing levels for the Center's outpatient surgical service. However, we continue to question the potential cost-effectiveness of the planned outpatient surgical service. VA intends to eliminate the existing two operating rooms and construct them on a different floor. VA's guidelines suggest that a minimum of 1,000 outpatient surgical procedures be performed per year using two operating rooms. Because the Center plans to perform fewer procedures, the planned outpatient surgical unit would appear to be too large and potentially inefficient.

5. We clarified the language in our report to show that the \$664 cost included some air charter service which we continue to believe may be required. We also added a footnote to the report to recognize a possible lower total patient transfer cost based on VA's updated lower estimate of the number of patient transfers and VA's lower average transfer cost.

6. VA states that our estimate of the approximate number of emergencies to be handled by Holy Rosary was too high because we did not distinguish between outpatient and inpatient emergencies. We revised our estimate to make the distinction. The number of inpatient emergencies for calendar years 1984 and 1985 is 24. Emergency cases were identified for us, at the direction of the chief surgeon, by the head operating room nurse, who took into account the overall medical condition of the patients in addition to the type of procedure performed.

7. While the Center's proposal, the MEDIPP plan, and the Inspector General's audit report all recognized savings from the closure of the Center's inpatient surgical service, none recognized the costs at other VA hospitals from absorbing the Center's workload. The estimated \$175,000 cost was developed by Fort Harrison officials based on the assumption of absorbing the entire Miles City workload. Whether the patients go to Fort Harrison or other VA hospitals, these hospitals will incur some additional direct costs for patient care. Further, the extent of unused capacity at these other hospitals will determine whether there also will be other costs. For example, Salt Lake City VA hospital officials told us they could not accommodate any more patients without additional nursing staff.

The estimated \$175,000 at Fort Harrison did not include any of the costs associated with adding specialized surgery, such as orthopedics and ophthalmology, as VA states. It did include potential costs associated with performing more urological procedures because of the increased workload of former Miles City patients

VA states that additional costs incurred at hospitals that absorb the Miles City workload would be offset by eliminating costs at Miles City. This is true. However, in estimating savings, VA considered only the Miles City reductions and not the increase at other hospitals. Therefore, the savings are overstated.

8. The \$5.25 million remodeling cost is applicable to three of six planned construction projects that the director's staff assistant identified as being directly related to the mission change. The same three projects were also identified by a VA central office site visit team in September 1985 as being applicable to the mission change. We have revised the report to show that the planned remodeling is, in part, directed to accommodate elements of the mission change.

9. VA's response does not adequately address information we presented in our draft report which showed a projected stable and continuing inpatient surgical workload for the Center. VA dismisses the usefulness of its 1984 bed projections done through its MEDIPP process. These projections were based on historical data from 1980 to 1984. VA states that these years showed only a moderate decrease in surgical activity and that the mission change was proposed in 1985 because the number of surgical procedures was declining rapidly and would best be done, in large measure, in an outpatient setting. However, the fiscal year 1986 MEDIPP bed projections continued to show surgical requirements of about 25 beds through the year 2005.

VA's response to our draft report also does not address the likely increase in the Center's future inpatient surgical workload resulting from an aging veteran population. The response does not reconcile the District's fiscal year 1984 MEDIPP plan determination for no surgical bed closures to its 1985 plan, which placed the Miles City surgical bed closure as its "number one" priority. VA also does not address the fact that the fiscal year 1984 MEDIPP plan predicted a 34-percent increase in surgical procedures by 1990, primarily due to the aging of the veteran population.

Regarding the Billings area veterans, VA asserts that it is better to serve them at locations other than Miles City without any explanation of why it would be a burden to transport them to Miles City for inpatient surgical services. Nor does VA comment on its earlier position that among the stated reasons for not closing surgical bed sections was that travel distances between district hospitals are long and provision for surgical care as near as possible to the patient's home is ideal.

10 In responding to the issue that comparisons of trade-offs between inpatient surgical and extended care capabilities were not made, VA addressed a number of points that we made, but still has not made its own assessment of the trade-offs. VA seems to imply that, in addressing the factors we commented on, it has now fully assessed the trade-offs. By introducing several factors we considered important, we did not intend them to be construed as all inclusive. We believe to properly assess trade-offs, a more comprehensive analysis is needed. This could include, for example, demand for acute and extended care over time, medical considerations in providing care, eligibility, cost of providing care, and effects on veterans and family members on where care is provided.

In commenting on the items we mentioned in our report, VA did not fully examine matters pertinent to a thorough comparison. For example, VA said that as the number of aging veterans continues to rise, demand for extended care beds will rise, and converting acute care beds to extended care beds will help meet this need. However, VA did not address the population of veterans needing extended care versus acute care, or whether those entitled to priority rights because of service-connected disabilities are in greater numbers for one type of care than the other. The following further illustrates the importance of these considerations.

- Closing the inpatient surgical bed service will provide resources for an additional 34 nursing care patients who currently stay just under 3 years each, at the expense of about 460 veterans who may be transferred for inpatient surgery during the approximate 3-year period.
- While the Center knows that 2 of the 19 veterans on its extended care waiting list have service-connected disabilities, it has not estimated how many area veterans with service-connected disabilities may need inpatient surgical care in the future.

Another example of matters not considered is the potential ultimate cost (estimated in excess of \$1 million) of establishing the Billings outpatient clinic as part of the mission change and the extent to which these costs

will offset savings from the closing of the Center's inpatient surgical services. Moreover, no consideration was given to the impact of the increased inpatient surgical workload that the clinic will generate.

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