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Report to Max Cleland, Administrator, Veterans Administration; by Gregory J. Ahart, Director, Human Resources Div.

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A review of outpatient surgery and preadmission testing programs being used in the Veterans Administration (VA) hospital system disclosed that opportunities exist, through increased use of these programs, to eliminate the need to hospitalize some veterans and to reduce the length of hospitalization for others. A review of a random sample of 233 surgical procedures from a universe of 6,382 procedures performed at three hospitals during 1975 indicated that from 744 to 1,338 of the 6,382 procedures could have been performed on an outpatient basis, saving from 2,177 to 5,657 hospital days. Projecting the results of the sample to a preadmission testing program indicated that a range of 402 to 998 cases could have had preoperative workups on an outpatient basis, resulting in additional savings of hospital days. In response to the recommendations of a National Academy of Science study, the VA has stated that studies will be conducted to determine the medical feasibility of performing more outpatient surgical procedures and to reduce the length of stay for surgery patients. A systemwide policy for outpatient surgery and preadmission testing should be developed, based on the results of the VA studies, and the policy should be implemented in all general medical and surgical hospitals in the VA system. (SC)

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-133044

April 4, 1978

The Honorable Max Cleland
Administrator of Veterans Affairs

Dear Mr. Cleland:

We completed our review of outpatient surgery and preadmission testing programs being used in the Veterans Administration (VA) hospital system. Our review disclosed that opportunities exist, through increased use of these programs, to eliminate the need to hospitalize some veterans and reduce the length of hospitalization for others. Although some problems exist which currently impede increased use of these programs, we believe the reduction in hospital days and attendant costs that can be achieved make it essential that the programs be more fully implemented.

BACKGROUND

Veterans who have medical disabilities incurred or aggravated in the line of military duty are entitled to all reasonable medical service, including outpatient care, necessary to treat the service-connected disabilities. Public Law 93-82, enacted in August 1973, authorized ambulatory care for nonservice-connected conditions if the veterans were unable to defray the expense of necessary care and if such care would obviate the need for hospital admission. Before this legislation outpatient care could not be provided to such a veteran unless the care was (1) reasonably necessary in preparation for a scheduled hospital admission or (2) an extension of treatment received while hospitalized.

The concept of outpatient surgery is not new, having been performed for many years in hospitals, generally as a part of emergency services. Outpatient surgery has been developed for patients who need minor surgery using either local or general anesthesia and who are able to go home the same day. Preadmission testing, screening, and presurgical workup prior to hospitalization is used to reduce preoperative hospital stays for elective surgery cases that cannot be handled as outpatient surgery. This concept can be used for diagnostic procedures as well as routine laboratory and X-ray examination required prior to surgery.

Generally the costs of providing outpatient care are less than the cost of providing inpatient or hospitalized care. Therefore, any services VA provides on an outpatient rather than on an inpatient basis should result in a reduction of service costs. The resulting savings, whether in terms of money, staff time, or space could then be used to treat more veterans with existing resources or to reduce the total costs of veterans care.

In 1973, 1/ we reported that length of stay, in six VA hospitals reviewed could have been reduced--832 days for 144 patients--if preadmission testing had been performed on an outpatient basis.

During our current review, we visited VA hospitals in Denver, Colorado; Salt Lake City, Utah; and Cheyenne, Wyoming; to determine the potential workload for outpatient surgery and preadmission testing. We made a random selection of surgical cases for calendar year 1975 at these hospitals and discussed each case with appropriate hospital officials to determine whether outpatient surgery and preadmission testing would have been feasible. We also visited 12 other VA hospitals in 6 medical districts to determine why comparable hospitals did not report similar outpatient surgery workload in response to a VA questionnaire on the subject. Additionally, discussions were held with VA central office officials concerning the potential for outpatient surgery and preadmission testing programs throughout the VA hospital system.

We also contacted a private freestanding outpatient surgery center and three community hospitals that had implemented outpatient surgery programs to obtain data on the type of procedures performed and to gain a better understanding of the type of facilities required for such programs.

Two of the three community hospitals visited in the Denver, Colorado, area were using inpatient operating rooms to perform outpatient surgery while one had a self-contained suite of operating rooms devoted solely to outpatient surgery.

1/"Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans," (B-167656, Apr. 11, 1973.)

We learned that outpatient surgery services can be performed in one of several types of health care settings, such as a

--hospital inpatient facility,

--hospital outpatient facility,

--hospital affiliated outpatient surgical facility, and

--freestanding outpatient surgical facility.

In June 1976, VA central office conducted a detailed survey of the methods of delivery of ambulatory surgery in health care facilities throughout the country. Of the methods identified in the study, the one deemed best suited for the VA hospital system involved the use of well-equipped ambulatory surgery units established as an integral part of the outpatient clinic. The Surgicenter concept for the VA hospital system was not deemed satisfactory. As a result of this study by VA central office, the criteria for all new ambulatory clinic construction have included provisions for a well-equipped minor operating room for performance of procedures under local anesthesia on an in-and-out basis.

STATUS OF OUTPATIENT SURGERY AND PREADMISSION TESTING PROGRAMS IN VA HOSPITALS

To determine the potential for reducing hospital days through outpatient surgery and preadmission testing programs, we selected a random sample of 233 surgical procedures from a universe of 6,382 procedures performed at 3 hospitals during 1975. We asked hospital officials to review the patient's medical records and to make a determination as to the appropriateness of outpatient surgery or preadmission testing. Consideration was given to such impediments as distance traveled, age, health, and social and economic problems. The procedures these hospital officials determined as appropriate for outpatient delivery included cystoscopy, bronchoscopy, excision of lipoma, tonsilectomy, tendon repairs in fingers and hands, and certain hernia repairs. We estimated that procedures, ranging from 744 to 1,338 of the 6,382 procedures, could have been performed on an outpatient basis, thereby saving a range of 2,177 to 5,657 hospital days. By projecting the results of the sample to a preadmission testing program, we estimated that a range of 482 to 998 cases could

have had preoperative workups on an outpatient basis. This would have resulted in additional savings of hospital days.

After discussing the results of our current review with VA central office officials, they decided to conduct a survey of all VA general medical and surgical hospitals to determine the extent of outpatient surgery being performed. In VA's survey conducted in March 1977, 123 of 132 VA hospitals responded to a VA questionnaire. These 123 VA hospitals performed an estimated 7,626 outpatient surgery procedures per month. Of these 123 VA hospitals, there were 45 (34 percent) which performed 5,877 (77 percent) of the estimated 7,626 outpatient surgery procedures per month. Comparable hospitals reported different outpatient workloads. For example, the Long Beach, California, VA Hospital reported 7 outpatient surgery procedures while the Los Angeles (Wadsworth), California, VA Hospital reported 400; the Brooklyn, New York, VA Hospital reported 14 procedures while the Bronx, New York, VA Hospital reported 111.

We visited 12 of the 123 VA hospitals to determine why comparable hospitals did not report similar outpatient surgery workloads. The types of procedures performed on an outpatient basis varied by hospital. Some hospitals were performing procedures on an outpatient basis for which other hospitals admitted patients. This occurred for patients who appeared to have received reasonably comparable procedures. For example, cystoscopies, a common procedure in VA hospitals, were performed on an outpatient basis at some hospitals, while other hospitals admitted all patients for the procedure. The effect of such practice is unnecessary hospitalization expense.

The organization, staffing, and facilities for providing outpatient surgery also varied by hospital. In one hospital a minor surgery room was located in the ambulatory care area, staffed by ambulatory care physicians and nurses, and supervised by the chief of ambulatory care. In other hospitals, a minor surgery room was located in the ambulatory care area, but staffed and supervised by surgery service. In others, minor surgery and diagnostic procedure rooms were located in or adjacent to the major operating suite and in hospital ward areas.

Based on the results of our review, VA's March 1977 survey, and our discussions with hospital officials, we believe VA needs to more fully implement outpatient surgery and preadmission testing programs throughout the VA hospital system. However, there are several problems which could impede the development of the programs.

POSSIBLE IMPEDIMENTS TO THE DEVELOPMENT OF THE PROGRAMS

At the time of our review VA did not have a generally accepted listing of procedures that could be appropriately handled on an outpatient basis. In responding to VA's March 1977 survey, some hospitals included both diagnostic and incisional procedures in their reported outpatient surgery workload while others reported only incisional procedures. Some hospitals were performing outpatient procedures under general anesthesia in the major operating suite while others were not. VA's policy forbids using general anesthesia in an outpatient area. Some VA physicians stated that procedures requiring general anesthesia would not be appropriate to include in outpatient surgery. Other physicians said they believed certain procedures, such as a simple hernia, that are generally done under general anesthetic could be done with a local anesthetic. Additionally, as noted earlier, hospital practices were not consistent as to the appropriateness of performing certain diagnostic procedures, such as cystoscopies on an outpatient basis. The effect of not having a generally accepted listing of procedures appropriate for outpatient delivery is that no one knows what the workload for the program might be, what facilities and staffing would be needed, or how the program should be organized.

VA officials stated that because of the nature of their patient population, the needs for ambulatory surgery programs within VA may be far less than in private facilities. These officials said their patients are older, in poorer health, and have greater social and economic problems than the general population. They said many have not been seen by a physician before going to the hospital, and frequently travel long distances to obtain care. The characteristics of the patients in our sample of 233 surgery cases supported this observation. We agree that the needs within VA hospitals may be less than community hospitals; however, the results of our work suggest that a sizable workload for the program exists and a significant number of hospital days could be saved.

Additional problems cited by hospital officials were how the programs would be funded and what impact they might have on other hospital services. During fiscal year 1977, hospitals were funded $35 per outpatient visit for a predetermined number of visits. Hospital officials said that $35 per visit would probably not cover the expenses involved in providing outpatient surgery programs.

VA officials indicated that outpatient surgery and preadmission testing programs might have an impact on other hospital services in a manner similar to that experienced in implementing Public Law 93-82. In implementing this law for outpatient medical conditions, VA found a pattern in that the increased use of outpatient visits was followed by an increase in hospitalization. The additional hospitalizations and outpatient visits increased the workload of the support services. However, we see the programs as meeting existing needs on an outpatient basis that are currently being met through hospitalization, not as an expansion of the number of the veterans being served.

FINDINGS OF THE NATIONAL ACADEMY OF SCIENCE

The National Academy of Science (NAS) found 1/ that the VA hospital system is organized, and its resources are allocated, primarily to supply inpatient hospital services. Outpatient care services in many VA hospitals do not have adequate staff or facilities, are not well organized, and are not managed effectively. NAS concluded that the ambulatory care programs in many VA facilities, as currently set up, cannot provide comprehensive, continuous care of high quality. NAS recommended that:

--Facilities for outpatient surgery be developed to reduce the use of inpatient care for minor procedures.

--More emphasis be placed on the workup of surgery patients on an outpatient basis to reduce preoperative hospitalization.

VA concurred with these recommendations and in response stated that studies would be conducted to determine the medical feasibility of performing more outpatient surgical procedures and to reduce the length of stay for surgery patients.

1/"Health Care for American Veterans," May 1977.

VA has already prepared a circular of instructions and guidelines for performance of ambulatory surgery as a first stage toward implementing the NAS recommendations.

CONCLUSIONS AND RECOMMENDATIONS

We believe VA could eliminate the need for some hospitalizations and realize a significant reduction in the length of hospital stays and attendant costs for others by implementing outpatient surgery and preadmission testing programs. We endorse VA's studies as a means of finding solutions to problems that impede development of the programs and as a means of determining what procedures are appropriate for outpatient delivery, what facilities and staffing are needed, and how the programs can be organized and managed successfully. We recommend that a systemwide policy for outpatient surgery and preadmission testing be developed by VA, based on the results of these studies, and that the policy be implemented in all general medical and surgical hospitals in the VA system.

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As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Chairmen, House Committees on Appropriations, Government Operations, and Veterans Affairs; the Chairmen, Senate Committees on Appropriations, Governmental Affairs, and Veterans Affairs; and to the Director, Office of Management and Budget.

We would appreciate being informed on any actions taken or planned on the matters discussed in this report.

Sincerely yours,

Gregory J. Ahart
Director