

September 1996

VA HEALTH CARE

Travis Hospital Construction Project Is Not Justified



**Health, Education, and
Human Services Division**

B-274096

September 3, 1996

The Honorable Christopher S. (Kit) Bond
Chairman, Subcommittee on VA, HUD,
and Independent Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) has requested that the Congress fund a \$211 million hospital construction project at the David Grant Medical Center (DGMC) at Travis Air Force Base in Fairfield, California.¹ The proposed project would provide additional VA hospital beds to serve veterans who were previously served by the 235-bed VA hospital in Martinez, California, which closed in 1991 due to earthquake safety concerns.

In 1993, the Air Force and VA initiated a joint venture allowing VA to use space at DGMC to serve veterans on an interim basis pending completion of the proposed project. Currently, VA has access to 55 beds; the Air Force has committed to making a total of 73 beds available for VA use at the completion of the project. Thus, given the planned 170 new beds in two separate bed towers and 73 existing beds to be made available by the Air Force, the completed project would provide VA a total of 243 acute care hospital beds. The project would also include construction of a VA outpatient clinic expected to provide services for about 85,000 visits a year, as well as significant renovation of space in the existing hospital to provide ancillary services, such as radiation therapy and dietetics, to handle the increased workload expected to be generated by the additional hospital beds and outpatient clinic.

Given budgetary constraints and VA's ongoing efforts to realign its facilities into new Veterans Integrated Service Networks (VISN), you questioned whether the proposed Travis project represents the best way to meet the health care needs of the veterans expected to be served by the new facility. In responding to your request, we focused on

- the justification for the proposed construction project, including its potential effects on other medical facilities in northern California, and

¹DGMC was constructed as a 298-bed general medical and surgical facility. The hospital includes an additional 75 beds in an aeromedical staging facility.

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- potential alternatives to the proposed Travis project.

To address these issues, we reviewed VA's hospital and clinic planning methodologies, assumptions, and data pertaining to VA's Sierra Pacific Network. We visited the network's hospitals in San Francisco and Palo Alto and its Northern California Health Care System (NCHCS), including the VA/Air Force joint venture at Travis Air Force Base and clinics in Oakland, Sacramento, and Martinez. In addition, we visited the McClellan Hospital at the former Mather Air Force Base (hereafter referred to as the Mather hospital), which the Air Force is planning to close by 2001.

We interviewed federal officials, including VA's under secretary for health, the director of VA's Sierra Pacific Network, the Air Force's commander of the 60th Medical Group at Travis Air Force Base, and the administrator of the 77th Medical Group at the Mather hospital; the dean of the Medical School at the University of California at Davis; and the supervisor of the Hospital Financial Data Unit in the California Office of Statewide Health Planning and Development. These officials also provided us with studies, documents, and data, which we reviewed. In addition, we interviewed representatives of local veterans' service organizations to obtain their views on the accessibility of VA care in California as well as on the proposed Travis project and potential alternatives.

We presented our preliminary observations to your staff on August 16, 1996. This report presents the final results of our work. We did our work in July and August 1996 in accordance with generally accepted government auditing standards.

Results in Brief

Construction of additional hospital beds and an outpatient clinic as large as VA proposes at Travis Air Force Base is unnecessary. We found that significant changes have occurred in the health care marketplace and in the way VA delivers health care in the 4 years since the project was planned, but VA plans have not been revised accordingly. These changes alone have resulted in over 3,300 unused hospital beds in northern California hospitals, including beds in VA, Air Force, and community hospitals. In addition, the veteran population in the service area is expected to drop by about 25 percent between 1995 and 2010. We also found that VA has not considered the likely negative effects the additional beds could have on other hospitals in northern California, particularly those community hospitals in the Solano County area surrounding Travis Air Force Base that have occupancy rates of around 40 percent.

Data we obtained show that VA is currently meeting the health care needs of veterans served by NCHCS. With VA hospitals at Palo Alto, San Francisco, and Travis operating below capacity, VA clinics have no trouble placing patients needing hospital care. Also, while VA's four clinics in the area intended to be served by the Travis hospital are operating at close to full capacity, three have turned away no veterans needing hospital or outpatient care. In addition, the clinics have effectively used community hospitals for medical emergencies. VA officials pointed out, and our visits confirmed, that space constraints, such as the lack of sufficient numbers of examining rooms, prevent them from operating as efficiently as they could otherwise.

We identified several more efficient alternatives that are available to VA if increased demand for hospital care should materialize. For example, existing clinics' hospital referral patterns could be modified to manage excess capacity in existing VA and Department of Defense (DOD) hospitals. Similarly, VA clinics should be able to purchase care from community hospitals more conveniently and at a lower cost than would be incurred through the construction of additional beds. VA, however, currently has limited authority to purchase health care services from community hospitals other than in emergencies or in cases when scarce medical specialty services are required. Legislation to expand VA's contracting authority is pending in the Congress. Finally, with the planned closure of the Mather hospital, VA has an opportunity to obtain a fully functional facility for use as either a hospital or an outpatient clinic.

VA officials in the Sierra Pacific Network are currently studying the best way to meet veterans' future health care needs. Network officials are considering options to make better use of VA facilities and increase the use of private and other public facilities. The Congress' decision on whether to fund the construction of additional beds at Travis will significantly affect the current and future options to be addressed through the study.

Background

VA provides health care through a direct delivery system of 173 hospitals and over 200 free-standing clinics nationwide. VA facilities also purchase health care from other public and private providers under certain conditions, such as medical emergencies. VA served over 2.6 million veterans at a cost of about \$16.2 billion in fiscal year 1995.

In 1995, VA restructured its system into 22 VISNS. Each contains from 5 to 11 hospitals, as well as several clinics, covering a specified geographic area

that reflects patient referral patterns and the availability of medical services. The networks are responsible for consolidating and realigning services within their areas to provide an interlocking, interdependent system of care. VA expects to improve efficiency by trimming management layers, consolidating redundant medical services, and better using available private and public resources.

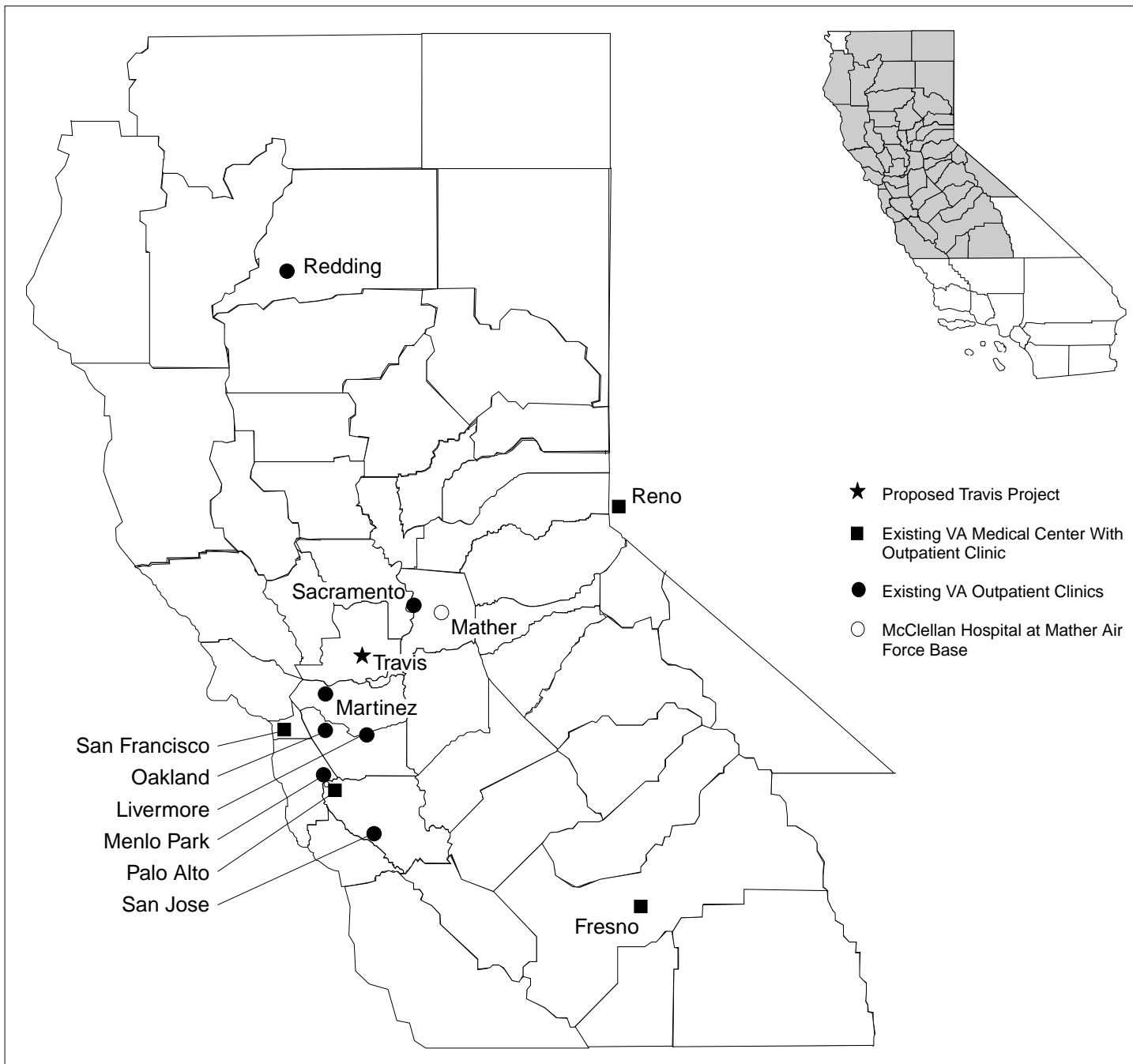
Another important change in the VA health care system is an enhanced focus on the provision of primary care and an increased emphasis on shifting care from inpatient to outpatient settings. VA is in the process of implementing a primary care approach in all of its clinics. Under primary care, veterans are expected to enroll in an outpatient clinic, where they are assigned to a primary care physician or physician group. When needed, VA primary care physicians refer veterans to VA or community hospitals. Because non-VA physicians do not have admitting rights to VA hospitals, the workload of VA hospitals is driven almost entirely through referrals from its outpatient clinics.

VA's Service Delivery in the Sierra Pacific Network

Northern California and parts of Nevada are served by the Sierra Pacific Network.² The network operates the hospital beds in the Travis joint venture project as well as hospitals in Reno, Nevada, and in Fresno, San Francisco, and Palo Alto (with divisions in Livermore, Palo Alto, and Menlo Park). It also operates outpatient clinics at each of these locations as well as satellite outpatient clinics in Martinez, Redding, Oakland, Sacramento, and San Jose. Although the Air Force operates an outpatient clinic at DGM, VA does not currently have an outpatient clinic at Travis. Figure 1 shows the location of the major VA facilities in the Sierra Pacific Network.

²The Sierra Pacific Network is also responsible for veterans' health care in Honolulu, Hawaii, and Manila, Republic of the Philippines.

Figure 1: VA Facilities in the Sierra Pacific Network

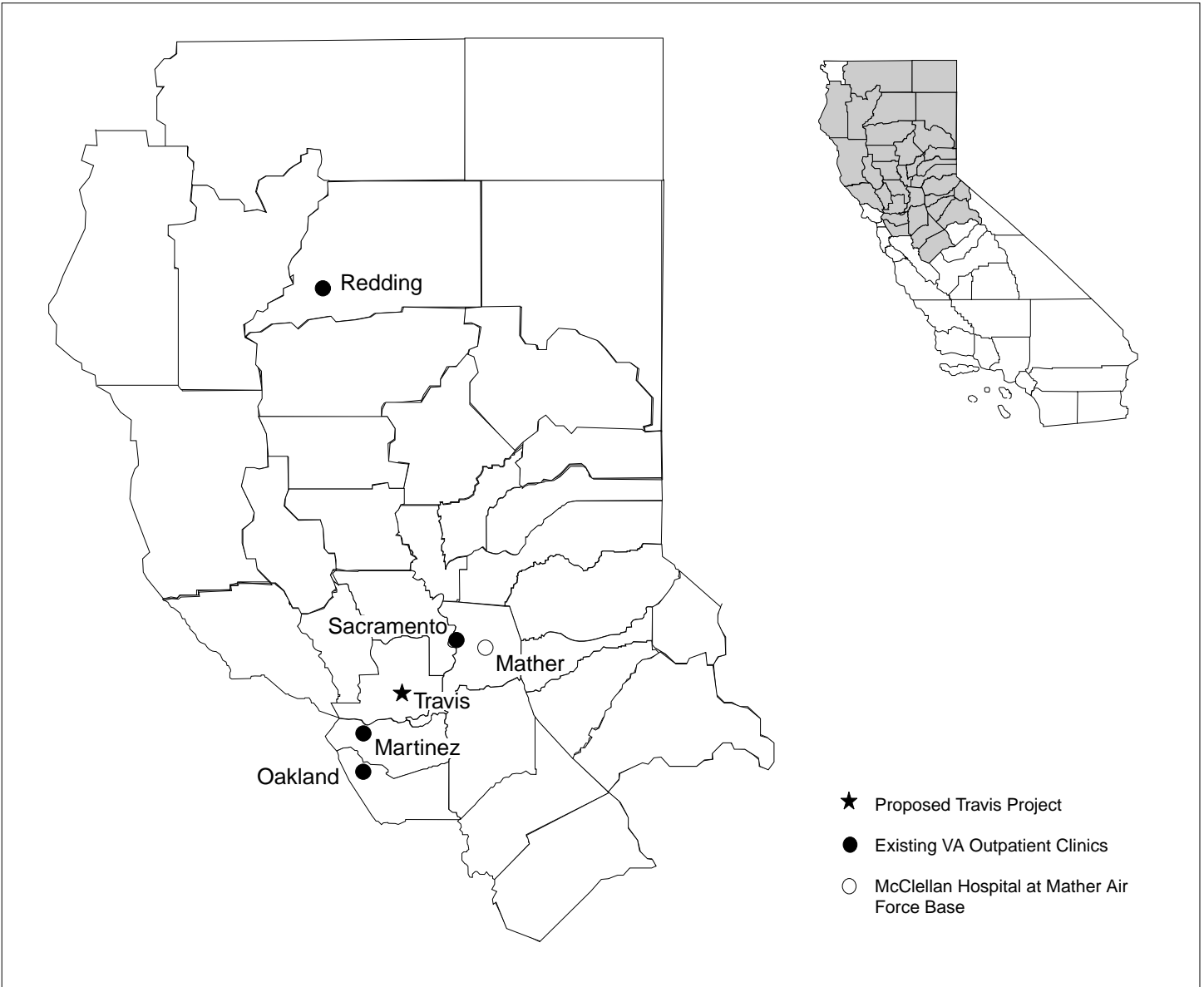


(Figure notes on next page)

Note: Does not include small community-based and outreach clinics; does not include Nevada counties in the Sierra Pacific Network.

The proposed Travis project is located in the Sierra Pacific Network's Northern California Health Care System. NCHCS includes the clinics in Martinez, Oakland, Redding, and Sacramento and the hospital beds at Travis Air Force Base. NCHCS primarily serves veterans east of the San Francisco Bay and in the northern part of the state. Currently, the only VA hospital beds operated in this area are the 55 beds in the joint venture at Travis. Travis Air Force Base is located about 50 miles northeast of San Francisco and about 77 miles northeast of Palo Alto. It is about 44 miles southwest of Sacramento, 34 miles northeast of Martinez, 41 miles northeast of Oakland, and 179 miles south of Redding. The proposed Travis project service area is shown in figure 2.

Figure 2: Proposed Travis Project Service Area



Note: Map shows the 33 counties included in the service area when the project was initially planned in 1992. NCHCS' service area now focuses primarily on 14 counties, but NCHCS facilities serve veterans from the other 19 counties as well as from other parts of the country.³

³The 14 counties are Alameda, Butte, Colusa, Contra Costa, Glenn, Sacramento, Shasta, Siskiyou, Solano, Sutter, Tehama, Trinity, Yolo, and Yuba.

The NCHCS service area continues to include the large veteran population in the East Bay (Oakland/Martinez) and Sacramento areas. Table 1 shows the number of veterans living in the four counties in the NCHCS service area with the largest veteran populations.

Table 1: NCHCS Counties With the Largest Number of Veterans, FY 1995

County	Number of veterans
Sacramento	123,498
Alameda (Oakland)	117,081
Contra Costa (Martinez)	91,422
Solano (Travis Air Force Base)	42,645

Source: Geographic Distribution of VA Expenditures; Fiscal Year 1995; State, County and Congressional District (National Center for Veteran Analysis and Statistics, VA)

VA's Construction Planning for NCHCS

Through its construction planning, VA expects to improve the geographic accessibility of VA hospital and outpatient care for veterans currently served by NCHCS, as well as for those who have not previously sought care from VA. When VA closed its hospital in Martinez, much of the area was left with limited access to VA hospital and outpatient care. In fiscal year 1991, the Martinez hospital had an average daily census of 235 patients. Although the Martinez hospital served veterans from much of northern California, most users came from the East Bay and Sacramento areas.⁴

In 1991, the Congress appropriated emergency funds to construct a replacement outpatient clinic and a nursing home on the grounds of the closed hospital. The replacement clinic—a prototype for the VA system—became operational in November 1992. It included modern ambulatory surgery capabilities, sophisticated imaging technology, and attractive surroundings. Construction of the nursing home was delayed pending demolition of the hospital building, but the nursing home is scheduled to open in the fall of 1996.

In 1992, VA planners conducted a study to determine where to build a replacement hospital. The options considered included partially renovating and seismically retrofitting the closed Martinez hospital, constructing a new hospital in Sacramento, constructing dual hospitals in Martinez and Sacramento, and constructing a joint venture hospital at Travis Air Force Base. Although the dual hospital option was judged to

⁴VA Health Care: Closure and Replacement of the Medical Center in Martinez, California (GAO/HRD-93-15, Dec. 1, 1992).

offer the greatest improvement in accessibility, the cost was considered prohibitive. After further negotiations with the affected parties, which resulted in the Air Force's offer to allow VA to establish some hospital beds at DGMC on an interim basis and reduce the number of beds to be included in the final construction project, VA decided on the 243-bed joint venture, including 170 new beds and 73 existing beds.

Although VA sought funding for the hospital project in its fiscal year 1996 budget submission, the Congress did not fund the hospital aspect of the project.⁵ Instead, the Congress provided \$25 million to construct only an outpatient clinic at Travis.⁶ Rather than going forward with construction of the clinic, however, VA, in its fiscal year 1997 budget submission, requested \$32 million toward construction of the entire original \$211 million project. Moreover, VA estimates that it will need about \$67 million more in one-time activation costs for the completed facility and about \$72 million a year to operate it.

Proposed Travis Project Not Adequately Justified

The proposed Travis project would probably add to existing excess hospital beds both in the VA system and in the community. Moreover, not enough low-income and service-connected veterans live near Travis Air Force Base to support a clinic of the size VA proposes. To support the clinic, VA would need to focus on attracting large numbers of higher-income veterans with no service-connected disabilities or attracting veterans from other NCHCS clinics.

Existing Hospital Beds Appear Adequate to Meet Future Demand

The 1992 decision to add 170 new hospital beds at Travis has essentially been overcome by events. Both VA and the private sector are increasingly shifting care to outpatient settings, decreasing demand for hospital care. Not only has VA been able to meet the demands for hospital care through use of existing VA and community beds, but there is also significant excess hospital capacity in VA, DOD, and community facilities.

To support the proposed number of beds planned for the Travis project, VA would need to more than triple the number of people it serves. Such an increase in market share appears unlikely because the veteran population in the service area is projected to decrease by about 25 percent between

⁵In our report, *VA Health Care: Effects of Facility Realignment on Construction Needs Are Unknown* (GAO/HEHS-96-19, Nov. 17, 1995), we suggested that the Congress consider delaying all major construction projects until VA developed and applied criteria for assessing alternatives.

⁶Proposed VA Hospital at Travis Air Base (GAO/HEHS-95-268R, Sept. 19, 1995).

Advances in Medical Practice and Technology Reduce Demand for Hospital Care

1995 and 2010. To the extent that VA is successful in increasing its market share by attracting veterans currently using community hospitals, the financial viability of community hospitals, particularly those in the vicinity of Travis Air Force Base, might be adversely affected.

VA's position that it needs to build 170 more hospital beds at Travis is based on the assumption that veterans will demand hospital care in 2005 at the same rate they did between 1989 and 1991. This assumption appears flawed given the changing health care delivery market.

Because the data used in VA's integrated planning model are several years old, the model does not fully reflect the decrease in hospital utilization occurring because of changes in medical practice and medical technology. For example, a few years ago, it was common practice for patients to remain in the hospital for 1 to 2 weeks following surgery. Now, however, it is common medical practice to get patients out of bed the day of or day after major surgery and to discharge them within a few days. In addition, new techniques, such as less invasive laparoscopic surgery, help shorten lengths of stay for those patients requiring hospital admission. Similarly, advances in medical technology and techniques, such as laser surgery, permit many procedures to be safely performed on an outpatient basis.

Moreover, in the past few years, VA has made major strides toward shifting care to outpatient settings. For example, the performance expectations that the under secretary for health set for VISN directors establish goals for increasing both the percentage of surgeries performed on an outpatient basis and the percentage of hospital admissions shifted to outpatient settings. The NCHCS clinics served more veterans in fiscal 1995 than they did in 1992, and fewer veterans were admitted to hospitals in 1995 than in 1990, the last full year that the Martinez hospital was open. This reduced usage seems consistent with VA's shifting of care from inpatient to outpatient settings.

With the establishment of the recently constructed Martinez outpatient clinic, NCHCS became a model for the rest of the VA system. The Martinez clinic offers modern ambulatory surgery and sophisticated imaging technology, permitting much care to be delivered on an outpatient basis. The bed days of care provided to veterans served by the Martinez clinic are among the lowest in the VA system, according to the VISN director. The ambulatory surgery and imaging capabilities at Martinez also help reduce hospital admissions from other VA clinics. For example, the Sacramento and Oakland clinics refer some patients to Martinez for ambulatory

surgery rather than admitting them to a hospital. As the Oakland, Sacramento, and Redding clinics' ability to perform outpatient surgery is expanded, further reductions in hospital admissions might well result.

VA is also moving towards nonhospital settings for patients who need subacute care. In 1991, VA provided a considerable amount of such care in its hospitals, and the 1992 plans for the proposed Travis project, for example, included 56 nonacute beds.

Existing Facilities Meet Current Users' Needs

The NCHCS clinics at Oakland, Martinez, and Sacramento—the primary clinics likely to generate admissions to the VA hospital at Travis—currently serve all veterans seeking outpatient care and place all veterans requiring hospital care in a VA or community bed. However, network and NCHCS officials told us, and we observed during our visits, that these clinics operate inefficiently, in part, because of space constraints, such as the lack of sufficient numbers of examining rooms. The fourth NCHCS clinic, in Redding, does not currently meet the needs of all veterans seeking care. The Redding clinic, which provides only primary care, evaluates all veterans seeking care but, according to the chief medical officer, does not serve higher-income veterans in the discretionary care category for hospital care or veterans who have no service-connected disabilities and do not receive a VA pension. According to the chief medical officer, the clinic was built to support 15,000 visits a year but provided 33,000 visits last year. A new, larger clinic is scheduled to open in November.

In 1995, the four NCHCS clinics served over 33,000 veterans, providing a total of 338,000 outpatient visits. Veterans served by the four clinics were admitted to hospitals about 2,800 times, primarily for general medicine services, but also for surgical, neurological, and psychiatric services. This admission rate, about 85 admissions per 1,000 veterans served, supported an average daily census of about 75 hospital beds, or about 2 beds per 1,000 veterans served.

VA Would Need to Triple Market Share to Support Additional Beds

VA's proposal to build 170 new beds at Travis and obtain 18 additional beds in the existing Air Force hospital would more than quadruple VA's current capacity of 55 beds. Because the hospital care needs of all current VA users are being met through use of existing VA and community beds, VA would need to attract significant numbers of new users to its health care system, or shift current hospital users to the Travis hospital, to justify the cost of the proposed additional beds. Given the limited potential to shift current hospital users from other VA hospitals and community hospitals to an

expanded Travis project, VA would need to more than triple its market share of veterans living in the NCHCS service area.

NCHCS clinics refer patients to any VA hospital in the Sierra Pacific Network but emphasize referrals to the Travis hospital. Clinic directors told us that referral decisions are based on where veterans live, the type of care they need, the urgency of their condition, the availability of beds, and where veterans would prefer to obtain care. NCHCS' summary admission statistics show that, in fiscal year 1995, 52 percent of the admissions were to VA's Travis hospital. Another 25 percent were sent to community hospitals. The remaining 23 percent went to other VA hospitals, primarily Palo Alto and San Francisco.

The potential to fill additional beds at Travis by reducing the use of community hospitals appears limited because admissions to community hospitals are generally for treatment of emergent conditions—conditions requiring emergency care. Because patients with emergent conditions are not stable and require immediate hospitalization, they are transported by ambulance to the nearest hospital capable of providing the needed services.⁷ Because of the distance from Sacramento, Oakland, Redding, and Martinez to Travis Air Force Base, patients needing emergency care generally would not be transported to Travis even if more beds were available there. Such patients would continue to obtain care in community hospitals.

If VA had additional beds at Travis Air Force Base, some of the veterans currently using the Palo Alto and San Francisco hospitals might be shifted to the Travis hospital. However, according to NCHCS clinic officials, many of the veterans referred to the Palo Alto and San Francisco hospitals were referred there because the veterans either lived closer to one of those facilities or needed specialized care not available at Travis.

To effectively use the additional beds it is seeking to construct and obtain through transfer from the Air Force, VA would need to more than triple—from 33,000 to over 112,000—the number of veterans in the service area who use VA health care services. In fiscal year 1995, the four existing clinics treated about 33,000 veterans, supporting about two hospital beds

⁷Patients not needing emergency care are considered either "urgent" or "nonurgent" depending on their medical condition. An urgent condition is one that requires immediate treatment but is not immediately life threatening. Urgent patients' admissions can be deferred for short periods of time. If their conditions can be stabilized, urgent care patients can be transported by ambulance to Travis or any other VA hospital. Care for patients with nonurgent conditions may be deferred for longer periods of time, and patients can be required to provide their own transportation to a VA hospital.

for every 1,000 veterans using VA services. Assuming an 85-percent occupancy rate in the proposed hospital, VA would need to attract about 72,250 new users to maintain an average daily census of 145 in the 170 additional beds it is seeking to construct and about 7,650 new users to maintain an average daily census of 15 in the additional 18 beds the Air Force plans to transfer to VA.

Utilization data from other VA medical centers support our estimate that VA would need to more than triple its market share of veterans living in the service area to support the proposed beds at Travis. The approximately 33,000 users in the service area were hospitalized a total of about 2,800 times during fiscal year 1995, maintaining an average daily census of 75 hospital patients. To maintain an average daily census of 145 (85-percent occupancy) in the new beds, VA would need to provide hospital care to about 6,500 additional patients each year, experience from existing medical centers suggests. For example, the Charleston, South Carolina, VA medical center, which had an average daily census of 145 in fiscal year 1995, treated about 5,923 patients. Similarly, the Iowa City, Iowa, VA medical center, with an average daily census of 142, treated 6,526 patients.

Existing Hospitals Have Hundreds of Unused Beds

Over 3,300 excess hospital beds exist in and near the areas that would be served by the proposed Travis project. First, veterans' use of VA acute care beds in Palo Alto and San Francisco has declined by about 180 beds over the past 3 years, adding to excess acute care capacity. The medical center director from San Francisco indicated that the facility could accommodate at least 80 additional acute care patients per day. Similarly, the Palo Alto medical center director estimated that the new acute care hospital nearing completion there will have about 100 unused beds when it opens. Although these hospitals are not convenient for veterans in Sacramento and other areas north of Travis, for veterans living in Oakland and some other parts of the East Bay, the hospitals are closer than Travis.

Second, the Air Force has unused beds at Travis that could potentially be used for VA inpatient care. For example, over 40 beds have been converted to office space.

Third, significant excess hospital capacity exists in community hospitals in northern California, including the Sacramento, Martinez, Oakland, Redding, and Fairfield areas. For example, community hospitals in the counties where the VA facilities are located had average occupancy rates in 1995 ranging from about 40 percent (Solano County) to about 68 percent

(Sacramento County). Overall, an average of 3,158 unused community hospital beds existed in the five counties on any given day (see table 2).

Table 2: Availability of Community Hospital Beds in Selected Northern California Counties, 1995

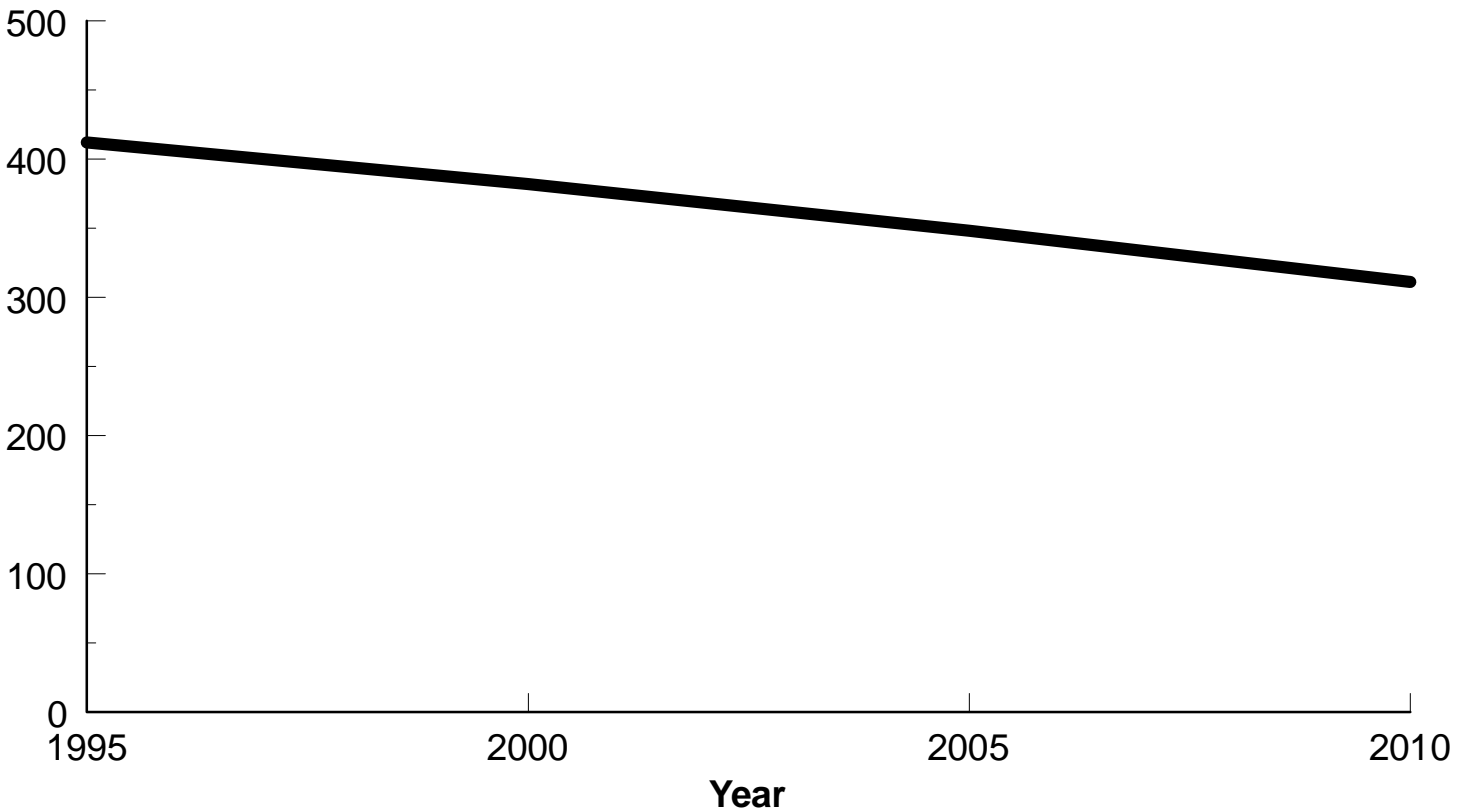
County	Available beds	Average occupancy rate	Average unused beds
Alameda (Oakland)	2,938	61.6	1,122
Sacramento	2,572	67.6	833
Contra Costa (Martinez)	1,637	54.9	738
Shasta (Redding)	627	59.3	255
Solano (Travis)	352	40.4	210
Total	8,126	61.1	3,158

Demand for Hospital Care Likely to Continue Declining

Declining numbers of veterans are likely to lead to continuing declines in demand for VA hospital care. In fiscal year 1995, an estimated 412,000 veterans lived in the area that would be served by the proposed Travis project. By 2010, VA estimates that the veteran population will have decreased by 25 percent. Figure 3 shows the expected decrease in veterans' population in the Travis service area.

Figure 3: Estimated Decrease in Veteran Population in Northern California Counties That Would Be Served by the Travis Project, 1995-2010

Veteran Population (in Thousands)



Source: VA's 1995 Integrated Planning Model

Veterans' use of other VA hospitals in northern California is also expected to continue declining, due in large part to the decreasing veteran population. VA's 1994 Integrated Planning Model⁸ estimates that veterans will use a total of 294 fewer beds at the Palo Alto and San Francisco hospitals between 1995 and 2010.

VA's Travis Project Would Affect Other Hospitals

The proposed Travis project would likely have a significant economic effect on other hospitals, particularly those in the Travis and Sacramento areas. As previously discussed, VA would need to generate about 6,500

⁸VA's Integrated Planning Model takes into consideration the expected increase in inpatient use of its aging veteran population.

additional hospital admissions in order to fill the new beds planned at Travis. The additional admissions would most likely come primarily from the Fairfield and Sacramento areas, because Oakland and Martinez are closer to VA hospitals in Palo Alto and San Francisco. As discussed above, community hospitals in the Fairfield area have occupancy rates of around 40 percent and those in the Sacramento area, about 68 percent.

Similarly, to the extent referral patterns for the Oakland and Martinez clinics would be changed to encourage shifting patients from Palo Alto and San Francisco to newly expanded beds at Travis Air Force Base, excess capacity would be increased at Palo Alto and San Francisco.

Veteran Population Near Travis May Not Be Large Enough to Support Proposed Clinic

The number of veterans traditionally targeted by VA—primarily veterans with low incomes or service-connected disabilities—living near the Travis Air Force Base does not appear to be large enough to support an outpatient clinic as large as the one planned. The Travis area is less densely populated than areas where other VA clinics are located. Thus, to meet workload projections, the clinic would have to serve large numbers of higher-income veterans with no service-connected disabilities or attract veterans away from existing VA clinics.

New Market Would Be Needed to Support Travis Clinic

Existing VA clinics in Sacramento, Martinez, and Oakland generally draw veterans from one of two distinct markets: the Sacramento and East Bay areas. The proposed Travis outpatient clinic, which would be as large as VA’s Sacramento clinic and larger than the Oakland clinic, would serve primarily the area around Solano County. Solano County has fewer veterans than the counties where the existing clinics are located (see table 3).

Table 3: Comparison of Estimated Workload of Travis Clinic With Fiscal Year 1995 Workload of Existing NCHCS Clinics

Clinic/County	County veteran population	Veterans served	Visits
Martinez (Contra Costa)	91,422	16,781	101,425
Sacramento (Sacramento)	123,498	11,672	83,151
Oakland (Alameda)	117,081	6,457	67,830
Travis (Solano)	42,645	(GAO estimate) 12,000	(Planned) 84,955

Although the Sacramento, Martinez, and Oakland clinics are crowded, they turn away no veterans seeking care, including higher-income veterans with

no service-connected disabilities. The clinics reported that most of the veterans they serve are in the mandatory care category and have service-connected disabilities or low incomes. Moreover, with more clinic space, it would be possible to serve even more veterans.

In effect, VA is planning to develop a new outpatient market in the area surrounding the Travis clinic. This market would comprise veterans residing in the northeastern part of the East Bay area and the southwestern part of the Sacramento area.

Convenience Would Be Important in Attracting Veterans to Travis Clinic

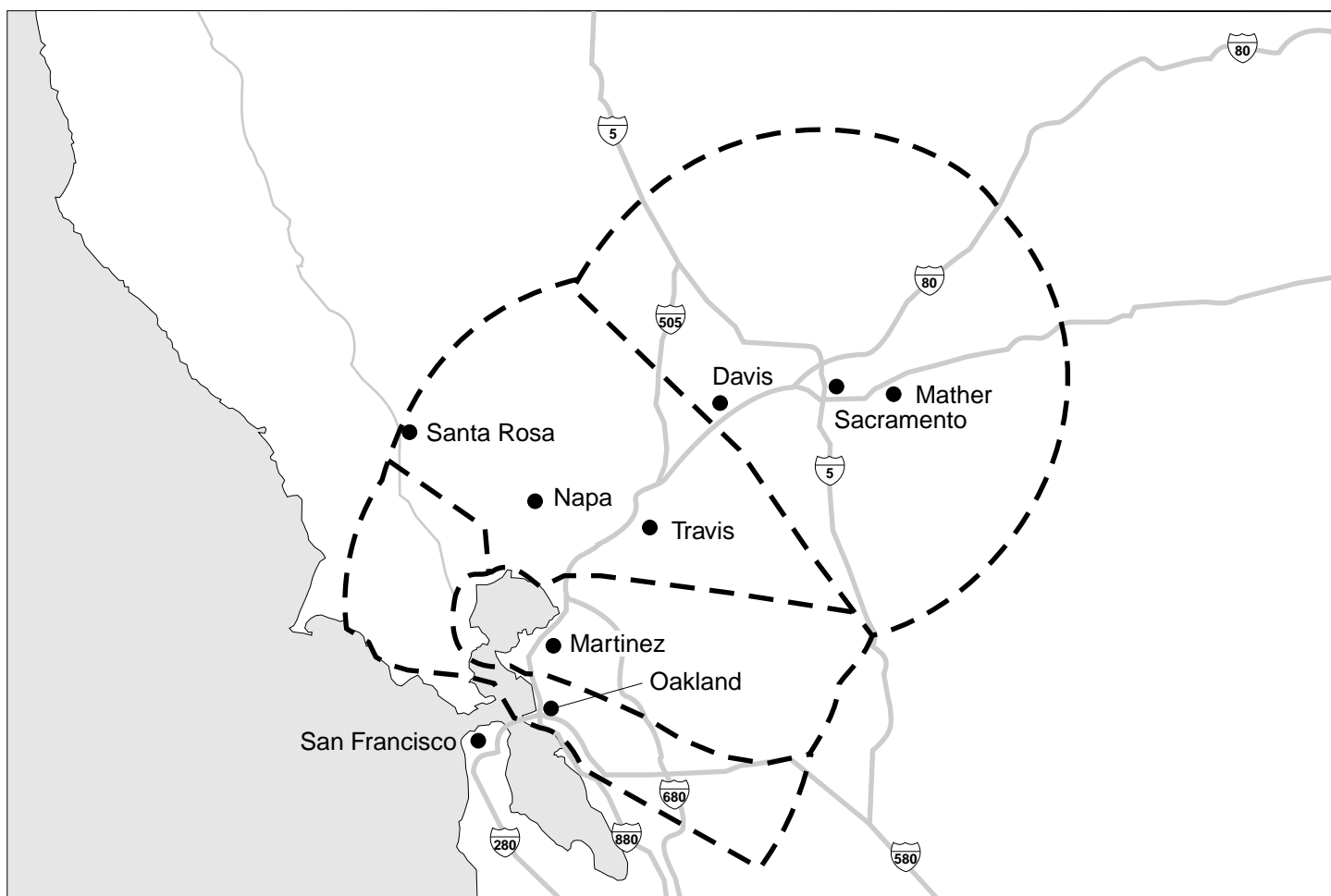
VA's facilities operate in a competitive market in northern California. According to public and private health care experts, convenience is an important factor in California residents' choices of health care providers. Several NCHCS officials said that veterans could not reasonably be expected to travel more than 25 to 35 miles for care.

Similarly, our review of VA patients using outpatient services in fiscal year 1993 showed that most VA clinic users live close to the clinic. Living within 5 miles of a VA clinic significantly increases the likelihood that a veteran will use VA health care services; nationwide, about 26 percent of veterans using VA outpatient services lived within 5 miles of a VA clinic, although only about 17 percent of veterans lived within 5 miles of a VA clinic. Moreover, about 68 percent of VA outpatient users lived within 25 miles of a VA clinic, and almost all lived within 100 miles.⁹

Accordingly, the proposed Travis outpatient clinic should draw users primarily from veterans living close to Fairfield. Because Travis is within 44 miles of the existing clinics at Martinez, Oakland, and Sacramento, however, the primary service area for the Travis clinic would actually be smaller. Veterans who live within 44 miles of both Travis and either Martinez, Oakland, or Sacramento would likely use the closest facility. Figure 4 shows the service area from which the proposed Travis clinic and existing Martinez, Oakland, and Sacramento clinics could expect to attract most of their users.

⁹VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995).

Figure 4: Projected Primary Service Area for Travis Outpatient Clinic



The primary Travis service area does not appear to have enough veterans to support about 85,000 outpatient visits a year. The clinic would have to attract about 19 percent of all veterans living in the primary service area, compared with an average market share of 13 percent for other clinics.

During fiscal year 1995, about 1,900 veterans living in the Travis primary service area used VA outpatient clinics. Many such veterans would probably begin using the Travis clinic because of added convenience. But

even if all VA users who reside in the Travis primary service area shifted to the Travis clinic, the number would be too small to efficiently support the Travis project.

Travis Clinic Would Need to Attract Large Numbers of Veterans With High Income and Without Service-Connected Disabilities

Establishing a clinic at Travis could attract a number of veterans who had not previously used VA health care services. To support 85,000 visits, however, the clinic would need to attract about 12,000 users (based on 11,672 users who generated 83,151 visits at the Sacramento clinic). The veterans most likely to use VA health care services are those with low incomes or service-connected disabilities. Although the Travis clinic is being designed to provide roughly the same number of visits as the Sacramento clinic and more than the Oakland clinic, the number of veterans with low incomes in the proposed Travis service area is smaller. Over 37,800 veterans with incomes of less than \$25,000 live in Sacramento County, 11,672 of whom used the Sacramento clinic in fiscal year 1995. Similarly, almost 31,800 veterans with incomes of less than \$25,000 live in Alameda County, 6,457 of whom used the Oakland clinic that same year. The Travis clinic area has only about 10,300 veterans with incomes under \$25,000 from whom to attract the estimated 12,000 users.

Veterans with service-connected disabilities are the other main category of VA users. Because the overall veteran population in Solano County is roughly one-third of the veteran population in either Oakland or Sacramento, the Travis clinic will likely have fewer service-connected veterans from whom to attract its users. We could not readily obtain data on the number of veterans in each county who have service-connected disabilities. Nationwide, however, about 2.2 million of the 26.2 million veterans (8.4 percent) have compensable service-connected disabilities. If Solano County is representative of the distribution of veterans with service-connected disabilities nationwide, then about 3,600 of the approximately 43,000 veterans living in Solano County have service-connected disabilities. In contrast, an estimated 10,400 veterans with service-connected disabilities live in Sacramento County.

Alternatives to Travis Should Be More Fully Explored

If demand for VA hospital care increases, several alternatives are available that do not entail constructing additional beds at Travis. These options include

- converting the Air Force's Mather hospital to VA use,
- expanding VA use of space at Travis Air Force Base,
- making greater use of excess capacity in existing VA hospitals, and

-
- expanding use of community hospitals.

The Sierra Pacific Network is currently assessing the best way to deliver health care to veterans. The Congress' decision on whether to fund the Travis hospital has significant implications for this planning effort.

Mather Hospital Available to VA at Lower Cost

Between 1988 and 1995, the Defense Base Closure and Realignment Commission recommended closing several DOD hospitals in northern California, including Letterman Army Medical Center in San Francisco, the Naval Hospital in Oakland, and the Air Force's Mather hospital near Sacramento. The Air Force currently operates a 105-bed hospital on the grounds of the former Mather Air Force Base, which is about 11 miles southeast of Sacramento. While physically located at Mather, the hospital is currently part of McClellan Air Force Base. DOD plans to close the Mather hospital by 2001.

The planned closure provides VA the opportunity to acquire a fully functional hospital and outpatient clinic at a fraction of the cost of new construction at Travis. In addition, the facility is closer to the larger Sacramento-area veteran population and would alleviate the crowding at the existing Sacramento outpatient clinic. Because Mather is a small hospital, however, operating costs per patient treated may be high.

VA has developed two primary options for potential use of the Mather hospital building:

- convert the building into an outpatient clinic and 91-bed hospital and
- convert the building into an outpatient clinic and use the second floor as an ambulatory surgery center.

VA's existing Sacramento outpatient clinic is overcrowded, and plans have been developed to build a larger facility. Building a replacement outpatient clinic in Sacramento that would provide 87,000 outpatient visits per year is estimated to cost about \$32 million (excluding the cost of land). VA officials believe that using the existing Mather clinic may be a cost-effective alternative to new construction.

NCHCS studied the Mather hospital to determine how to renovate the facility for use as a 91-bed VA hospital, outpatient clinic, and outpatient surgery center. Renovation would be required primarily to improve patient privacy, improve accessibility for the handicapped, and make safety and

seismic improvements. VA officials said that the inpatient wards at the Mather hospital could be reconfigured into a 91-bed hospital that meets the handicapped-access needs of the veteran population. VA officials, working with an architectural design firm, estimate that the total cost of converting the Mather hospital into a fully functional hospital and outpatient clinic would be about \$28 million. In addition, there would be start-up costs of about \$11 million and increased annual operating costs of about \$14 million.

In addition to the hospital building, VA has developed plans for using several of the adjacent buildings. For example, one building would be used to house a mental health clinic—the current clinic is located in a strip mall across the street from the existing Sacramento clinic. In addition, VA officials indicated that they might be able to use a new warehouse at the Mather site to serve all VA hospitals and clinics in the Sierra Pacific Network.

A potential drawback to using the Mather hospital as an inpatient facility is the cost of operating a small hospital. With small hospitals, the number of staff frequently exceeds the number of patients. A 91-bed hospital could be expected to have an average daily census of no more than 78 patients. The VISN director told us that, in the private sector, 150 beds is generally considered the break-even point for operating a hospital. Another VA official said that it is difficult to attract physicians to a small hospital because of the limited range of patients and services provided. The dean of the University of California at Davis medical school, however, did not see the size of the facility as a problem. Because of its proximity to UC-Davis, a hospital at Mather would, he said, be able to draw physicians and residents from the medical school. He said that Mather could be used for more routine hospitalizations and that specialized care could be provided at the University of California at Davis Hospital.

NCHCS' facility planner said that converting the Mather facility to only an outpatient clinic and ambulatory surgery center would cost about the same as converting the facility into a VA hospital, but annual operating costs would be less. Using the Mather hospital as a clinic would relieve crowding at the existing Sacramento clinic.

In November 1995, VA sent a letter to the Air Force Base Conversion Agency expressing an interest in acquiring, at no cost, the Mather facility and a separate dental clinic located at McClellan Air Force Base. The proposal was endorsed by the Sacramento County Board of Supervisors

and, on May 30, 1996, VA notified the Secretary of the Air Force of its intention to acquire the hospital. VA had concluded that acquiring the hospital, including required modifications, would be the most cost-effective alternative to building a new VA outpatient clinic in Sacramento.

The Air Force has already received an appropriation of \$10 million for fire, safety, and seismic improvements to the building. The Air Force informed VA that it will proceed with the improvements if it gets assurance from VA that the facility will be used as a hospital. As of August 1996, VA had not provided the Air Force assurance that the facility would be used as a hospital.

Opportunities Exist to Expand VA Use of Existing Beds at DGMC

The Air Force appears to have additional beds that could potentially be made available for VA use if the need arises. About 40 beds have been converted to office and other space. Moreover, further integration of Air Force and VA patient care services could provide VA access to additional beds.

According to VA officials, one significant drawback to VA's use of DGMC is the lack of office space for VA physicians. Typically, physicians spend only a portion of their day with hospitalized patients, using the rest of their day to see patients on an outpatient basis, complete paperwork, or conduct research. Because VA does not have an outpatient clinic at Travis and no physicians' offices are available to VA, physicians' options are limited.

Both VA and Air Force officials agreed that it is less costly to build office space than hospital space. While VA has no immediate need for additional beds, if either VA or DOD demand for inpatient care increases in the future, additional office space could be built, and some or all of the space currently used for administrative purposes could be returned to patient care. Similarly, additional inpatient beds might be made available if some of the 75 beds in the aeromedical staging facility could be used to support the ambulatory surgery program.

Excess Capacity at Existing VA Hospitals Could Be Used to Meet Hospital Care Needs of East Bay Veterans

Both the Palo Alto and San Francisco VA medical centers have significant excess capacity that could be used to serve veterans, especially those from the East Bay. Some of these veterans live closer to Palo Alto or San Francisco than they do to Travis Air Force Base. The chief medical officer

from the Oakland clinic said that the Palo Alto and San Francisco hospitals had approached him about referring more patients.

The main hospital at Palo Alto was severely damaged in an earthquake, and a replacement acute care facility is under construction¹⁰ The replacement hospital, scheduled to open in 1997, will be virtually a bed-for-bed replacement for the bed tower damaged in the earthquake. It will include 228 medical/surgical beds, including 24 intensive care unit beds. Because of changes in medical practice, the medical center director estimates that the hospital will have about 100 excess medical and surgical beds when it opens.¹¹

Moreover, the Menlo Park division of Palo Alto also has a number of empty beds. The division, which includes 118 psychiatric beds and a 100-bed drug and alcohol abuse unit, plans to reduce its operating beds by 50 percent. As a result, Palo Alto and its Menlo Park division will have sufficient excess capacity to accommodate the additional 60 psychiatric beds planned at Travis.

The VA medical center at San Francisco also has excess capacity. The San Francisco medical center is authorized 240 beds and is currently staffed to operate 190 beds, with an average daily census of about 160 patients, including many who may require only subacute hospital or extended care. The medical center director said that the hospital has about 80 excess beds now and will likely have more in the future because the hospital's workload has been steadily declining; the base closures in the Bay area have slowed the rate of decline, however, as military retirees with dual eligibility have sought care from VA after closure of DOD hospitals. Further, the San Francisco hospital is more convenient for some East Bay veterans because it is closer than the Travis Air Force Base, served by public transportation, or both.

¹⁰In addition to the main hospital at Palo Alto, the medical center includes facilities at Menlo Park and Livermore. Facilities at Menlo Park include inpatient units for long-term psychiatric care, posttraumatic stress disorder, and drug and alcohol treatment and outpatient care. Facilities at Livermore provide long-term care and outpatient care; acute care beds have been closed.

¹¹The hospital director plans to use a portion of the excess capacity to accommodate a 34-bed extended care unit currently housed in space that is less than satisfactory.

Opportunities Exist to Expand Use of Community Hospitals Close to Veterans' Homes

Thousands of unused beds are available in community hospitals in northern California. In the approximately 4 years since VA's decision to build a replacement hospital at Travis Air Force Base was made, significant changes in the availability of beds in community hospitals have occurred. For example, a major hospital in the Martinez area—Merrithew—expressed interest in selling its excess capacity to VA. Another hospital in Martinez—Kaiser Permanente—plans to close.¹² Similarly, four hospital systems based in Sacramento—Catholic, UC-Davis, Kaiser Permanente, and Sutter—have alliances with hospitals covering a wide geographic area in northern California. An alliance with one of these hospital systems might bring hospital care closer to veterans' homes than would construction of a VA hospital at Travis. The potential for such an alliance is one of the alternatives being explored by the network.

Although VA currently makes extensive use of contract hospitals to provide emergency services, it lacks authority to contract for routine hospital care for most veterans. VA has specific statutory authority (38 U.S.C. 1703) to contract for medical care when its facilities cannot provide necessary services because they are geographically inaccessible. VA also has authority (38 U.S.C. 8153) to enter into agreements “for the mutual use, or exchange of use, of specialized medical resources when such an agreement will obviate the need for a similar resource to be provided” in a VA facility. Specialized medical resources are equipment, space, or personnel that—because of their cost, limited availability, or unusual nature—are unique in the medical community. Neither statute authorizes VA to routinely provide hospital care through contracts with community facilities. As a result, VA cannot currently rely exclusively on contracting to meet any unexpected growth in the needs of veterans in the service area.

VA is seeking to expand its legislative authority to contract for hospital and other health care services. Language that would expand its contracting authority was included in veterans' health care eligibility reform legislation (H.R. 3118) passed by the House of Representatives on July 30, 1996. If enacted, contracting reforms would give VA considerable flexibility to contract with community hospitals.

A number of basic contracting approaches could be used to obtain beds from community hospitals. First, VA could lease excess space in a community hospital and staff and operate its own beds, sharing certain services with the hospital. Second, VA could contract with a hospital to

¹²The director of the Sierra Pacific VISN, formerly the director of the Kaiser Permanente hospital, said that the hospital has major structural deficiencies and would not be suitable for VA use.

operate a set number of beds for veterans. Such contracts, however, involve certain risks because of the unknown demand for care. In other words, if VA overestimates demand, then its costs of providing care through contracting would increase. The third method of providing care through contracting would be to purchase care “on the margin,” paying for each hospital episode separately, as VA does now for emergency services.

In May 1993, we testified before the Senate Committee on Veterans’ Affairs on the effects of changes in the health care system on VA’s major construction program. At that time, we suggested that VA consider seeking authority to use demonstration projects to test the feasibility of and best methods for contracting with community hospitals as an alternative to building VA hospitals that might never be used. One of the areas proposed for consideration as a demonstration site was the northern California area served by the former Martinez hospital.¹³

VA Study of Options for Serving Veterans in Sierra Pacific Network Will Be Affected by Travis Decision

VA is developing plans for restructuring the way health care services are provided in the Sierra Pacific Network. The Congress’ decision on whether to fund the proposed Travis project has significant implications for the study.

In 1995, VA provided its network directors proposed criteria to help identify opportunities for efficiencies. For example, the criteria suggest that directors use community providers (subject to current restrictions under the VA law) if the same kind of services of equal or higher quality are available at either lower cost or equal cost but in more convenient locations for patients. The criteria also encourage directors to use nearby VA facilities and to integrate or consolidate services if doing so would yield significant administrative or staff efficiencies.

In addition, the Sierra Pacific Network director has established a task team consisting of facility directors to study the best way to deliver care in the network. The goal is to develop a short-term strategic plan (1 to 2 years) and a longer term strategic plan (3 to 5 years). These plans are to be completed in the fall of 1996, although the Sierra Pacific Network director said that final plans on how to best deliver care will not be complete until spring of 1997.

¹³Veterans’ Health Care: Potential Effects of Health Care Reforms on VA’s Major Construction Program (GAO/T-HRD-93-19, May 6, 1993).

The task team is studying current use rates for each facility in the network, the types of services available at each facility, where the patients live, and the cost and availability of services in the community. This study will likely address such potential service delivery alternatives as integrating hospitals; establishing new clinics; purchasing care through community providers; using the soon-to-be-closed Mather hospital for inpatient care, outpatient care, or both; and expanding the joint venture at Travis Air Force Base.

It will be difficult for the network to recommend changes in facility missions, contracting with community providers, and hospital referral patterns until the Congress completes its deliberations on (1) funding the Travis project and (2) reforming VA health care contracting.

Conclusions

VA's plans to establish a 243-bed medical center at Travis Air Force Base—which include construction of 170 new hospital beds, renovation and expansion of existing Air Force support areas, and construction of an 85,000-visit outpatient clinic—are not justified on the basis of the current and expected workload and the availability of lower-cost alternatives.

First, VA is meeting veterans' needs with existing facilities. NCHCS clinics in Sacramento, Oakland, and Martinez, while crowded and operating at less than full efficiency, are meeting inpatient and outpatient needs and turning away no veterans.

Second, the decision to build at Travis was driven by VA's 1992 assessment of veterans' health care needs in northern California, which relied on assumptions concerning the future availability and use of hospital beds that are no longer valid. To support the number of beds VA plans to build at Travis, VA would need to more than triple the number of veterans now served there under the joint venture with the Air Force. VA's ability to attract such a large supply of new users is questionable, however, given the large supply of unused hospital beds in VA, Air Force, and private hospitals; the decreasing veteran population; and the shifting of medical care from inpatient to outpatient settings. Such uncertainties subject VA to the risk of spending federal dollars to build a hospital that will have a large supply of beds that may never be used.

Third, alternatives to the construction project could meet any increase in demand for hospital care without incurring the risk of spending hundreds of millions of dollars to build and operate hospital beds that are unlikely to

ever be used. VA has many more efficient alternatives to serve northern California veterans. For example, it might be able to obtain use of additional beds from the Air Force at DGMC or to obtain the Mather hospital from the Air Force when McClellan Air Force Base is closed. Similarly, it could change hospital referral patterns for its existing clinics, especially the Oakland and Martinez clinics, to send more hospital patients to Palo Alto and San Francisco to take advantage of existing excess capacity. Finally, if VA had the legislative authority, it could expand contracting with community hospitals in order to provide veterans access to hospital care closer to their homes and at the same time strengthen the financial viability of community hospitals, especially those operating at less than 50-percent occupancy.

Pursuing such alternatives before spending hundreds of millions of dollars to build and operate a new VA hospital appears consistent with VA's new network planning strategy in that it would help maintain the viability of existing VA hospitals. Without such planning, the existing VA hospitals' viability may be jeopardized by declining workloads associated with shifting veterans to the new Travis hospital.

Although construction of outpatient facilities at Travis Air Force Base appears justified to support the existing VA beds, there do not appear to be enough veterans in the primary area to be served by the clinic to support a clinic of the size that VA plans. In addition, if VA obtains and converts the Mather hospital into a clinic and ambulatory surgery center, or constructs a new outpatient clinic in Sacramento, the ability of the Travis clinic to attract veterans from the Sacramento area would likely be diminished. The clinic needs of veterans in the Travis area could be met with less clinic space than VA included in the proposed Travis project, and VA could build the smaller clinic with the flexibility to expand if necessary.

Recommendation to the Congress

We recommend that the Congress deny VA's request for funds to construct additional hospital beds at Travis Air Force Base, given the availability of cost-effective alternatives to meet the health care needs of veterans in the NCHCS.

Matters for Consideration by the Congress

The Congress may also wish to consider directing VA to spend only part of existing appropriated funds to construct a smaller outpatient clinic designed to provide considerably fewer than 85,000 visits a year. Moreover, the Congress could direct VA to delay expenditure of the

remaining appropriated funds for the Travis facility until VA's ongoing network study is completed. VA's study provides the opportunity to identify lower-cost alternatives to meet veterans' needs, including

- outpatient clinic improvements for veterans living in Oakland or Sacramento and
- acquisition and renovation of the Mather hospital for VA use as an inpatient or outpatient facility.

VA's study could also determine the highest-priority needs and, if necessary, justify congressional approval to spend all or a portion of the existing appropriations to meet any higher-priority needs identified through the study.

Because VA does not currently have legislative authority to contract for routine hospital care, it cannot take full advantage of the excess hospital capacity in Northern California to meet the hospital care needs of veterans closer to where they live. Therefore, if proposed legislation to expand VA's contracting authority is not enacted, the Congress may want to consider authorizing VA to conduct a demonstration project in northern California to assess the benefits and costs of VA's purchasing care for veterans with urgent and nonemergent conditions from community providers.

Agency Comments

We requested comments on a draft of this report from the Department of Veterans Affairs, but none were received in time to be included in the report.

We are sending copies of this report to the Speaker of the House; the President of the Senate; the Ranking Minority Member of the Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations; the Chairman and Ranking Minority Member of the Subcommittee on VA, HUD, and Independent Agencies, House Committee on Appropriations; the Chairmen and Ranking Minority Members of the Senate and House Committees on Appropriations; and the Chairmen and Ranking Minority Members of the Senate and House Committees on Veterans' Affairs. Copies of the report are also being provided to Members of congressional delegations from the affected portions of northern California. We are also sending copies to the Secretaries of Veterans Affairs, Defense, and the Air Force; the Director, Office of Management

and Budget; and other interested parties. Copies will be made available to others upon request.

This report was prepared under the direction of David P. Baine, Director, Veterans' Affairs and Military Health Care Issues, who can be reached at (202) 512-7101. You may also call Mr. Paul Reynolds at (202) 512-7109 or Mr. James Linz at (202) 512-7110 if you or your staff have questions concerning this report. Other evaluators who made contributions to this report include Byron Galloway, Deena El-Attar, Joan Vogel, John Borrelli, John Kirstein, Paul Wright, and Ann McDermott.

Sincerely yours,



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