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Health, Education and Human Services Division

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September 19, 1995

The Honorable Christopher S. 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 appropriate $211.1 million for a major construction project at the David Grant Medical Center at Travis Air Force Base in Fairfield, California. The proposed project is to provide space to serve veterans who had used the VA medical center in Martinez, California, which closed in 1991 due to earthquake safety concerns.[1] VA's current cost estimate for the Travis project is $47.3 million, or about 29 percent, higher than the estimate previously provided to the Congress.

This letter responds to a request from your office for information about the proposed Travis project. As agreed, we obtained VA's reasons for the higher project cost estimate and its assessment of where veterans living in the proposed Travis facility target area currently receive hospital care. In doing this, we visited the David Grant Medical Center, VA's Western Region and headquarters offices, and VA's Northern California Health Care System (NCHCS) office.[2] During the visits, we interviewed VA and Air Force officials and reviewed such documents as VA's fiscal year 1995 and 1996 budget submissions, project cost estimates, and selected studies.

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[1]In VA Health Care: Closure and Replacement of the Medical Center in Martinez, California (GAO/HRD-93-15, Dec. 1, 1992), we discussed factors that we believed VA should have considered in selecting a replacement facility for the Martinez medical center.

[2]NCHCS is the network of VA medical facilities that serves the former Martinez medical center catchment area.

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In summary, VA officials provided us with documents showing that the Travis project cost estimate increased primarily because VA believes it needs to construct and renovate more space than originally anticipated. (See enclosure 1.) In addition, a VA study of the impact of the Martinez closure indicated that many veterans in the target area currently receive hospital care in VA medical centers in the northern California/northern Nevada area. This and another study also showed that veterans' use of these VA medical centers was lower in fiscal years 1992 and 1993 than in fiscal year 1991, the year that Martinez closed. Both studies recognized that many factors may affect VA hospital utilization. Neither, however, had evidence to indicate the extent to which the decrease was attributable to a lack of access to hospital care after the Martinez closure, a switch from inpatient to outpatient care, use of non-VA hospitals, or other factors. (See enclosure 2.)

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We are sending copies of this letter to the Ranking Minority Member, Subcommittee on VA, HUD, and Independent Agencies; Chairmen and Ranking Minority Members, House and Senate Veterans' Affairs Committees; Chairman and Ranking Minority Member, House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care; and the Secretary of Veterans Affairs. Copies will be made available to others on request.

If you have any questions about VA's Travis project or need additional assistance, please call me or Paul Reynolds, Assistant Director, at (202) 512-7101.

Sincerely yours,

David P Baine

David P. Baine
Director, Health Care Delivery and Quality

Enclosures

VA'S REASONS FOR INCREASED COST ESTIMATE FOR THE TRAVIS PROJECT

On August 9, 1991, VA announced the emergency closure of its medical center in Martinez, California, because of concerns about the facility's safety in the event of a major earthquake. Rather than repair the Martinez facility, VA decided to build a replacement facility.[3] On November 10, 1992, VA announced that the replacement facility would be built at the David Grant Medical Center at Travis Air Force Base in Fairfield, California.

The VA replacement facility is a joint venture with the Air Force. It will be a major addition/alteration to the David Grant Medical Center, which is a 298-bed general medical and surgical facility opened in 1989. As currently designed, the project will provide VA with 243 beds, including 170 new beds for VA use and 73 existing beds that the Air Force will make available for VA use--40 directly and 33 on a shared basis. The project will also renovate existing support space for the new beds. When the VA project is complete, the joint medical facility will have 468 beds--210 for VA use, 225 for Air Force use, and 33 for joint use.

The VA project will construct or renovate almost 686,000 gross square feet of space. This includes 560,502 gross square footage of new construction, including two four-story bed towers, a three-story medical research and development building, and a warehouse. It also includes 125,450 gross square footage of renovated space to expand and upgrade areas housing such support services as dietetics and radiology. The total project is scheduled for completion in the year 2000.

VA's cost estimate for the Travis project has increased about 29 percent--VA's fiscal year 1995 budget submission estimated that the project would cost $163.8 million, and its fiscal year 1996 budget submission estimated that the project would cost $211.1 million, an increase of $47.3 million.

VA attributes the increase primarily to the need to construct and renovate more space than originally anticipated. The current design calls for about one-quarter of a million more gross square footage than originally anticipated. This reflects an increase from 441,000 to 560,502 in gross square footage for new construction and an increase from 17,000 to 125,450 in gross square footage for renovated space. Most of this space is for VA, although slightly over 20 percent is for the Air Force to house support services

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[3]In VA Health Care: Closure and Replacement of the Medical Center in Martinez, California (GAO/HRD-93-15, Dec. 1, 1992), we discussed factors that we believed VA should have considered in selecting a replacement facility for the Martinez medical center.

displaced by the VA project.

VA provided two primary reasons for the increased space needs. First, the Air Force's workload projections increased due to base closures and mission changes. This reduced the Air Force's sharing capacity and increased the need for more renovation to provide integrated services. The Air Force's Associate Administrator of the Joint Venture told us that space for 36 beds is being used to house administrative functions resulting from mission changes, reducing the number of available beds from 298 to 262. The Air Force also needs 34 more beds than originally anticipated to handle the increased workload associated with closure of such facilities as the Letterman Hospital in San Francisco (20 beds) and to provide neurology and other new specialty services that the Air Force plans to offer (14 beds).

Second, VA's workload projections increased. For example, the projected number of outpatient visits increased from 81,500 in the fiscal year 1995 estimate to 84,955 in the fiscal year 1996 estimate. VA officials told us that the fiscal year 1995 estimate was based on 1980 Census data and the fiscal year 1996 estimate is based on 1990 Census data. The 1990 Census data show that the number of veterans in northern California is higher than previously projected. Moreover, VA's planning model for projecting the outpatient workload for the fiscal year 1995 estimate used outpatient visits, while the model for projecting the fiscal year 1996 estimate used outpatient clinic stops. Officials said that the number of outpatient clinic stops increased even more dramatically than the number of outpatient visits because outpatient visits usually involve more than one clinic stop.

VA officials cited three other reasons for the increased estimate. First, the fiscal year 1995 estimate did not include all construction costs because project design had just begun when this estimate was developed. The fiscal year 1996 estimate includes costs to relocate underground electrical utilities over which the bed towers will be located; to expand the energy plant so the Air Force has sufficient excess capacity to carry out its defense readiness mission; and to expand tunnel space to handle steam, hot water, and other support systems needed to meet facility needs when the VA project is complete. Second, an increase occurred in the index that accounts for changes in the cost of material, labor, architect/engineer fees, and contractor overhead and profit for construction in specific geographic locations. For the Travis Air Force Base area, the index increased about 3 percent between the time VA developed its fiscal years 1995 and 1996 estimates, adding about $5 million. Third, the VA's space criteria changed. For example, a VA official said that its criteria for computer support space increased between the time VA developed its fiscal years 1995 and 1996 estimates. VA officials said that changed criteria

affected other areas, such as ambulatory care and radiology. In addition, VA erroneously omitted space for endoscopy in its original estimate.[4]

[4]A medical procedure involving inspection of body organs or cavities using a tube and optical system.

ENCLOSURE 2

VA'S ASSESSMENT OF WHERE VETERANS LIVING IN THE PROPOSED TRAVIS FACILITY TARGET AREA CURRENTLY RECEIVE MEDICAL CARE

VA's proposed Travis project would serve veterans in the former Martinez catchment area, which includes about 447,000 veterans in northern California. About half live in the Martinez and Sacramento areas, which are about 30 miles from Travis and about 60 miles from each other. This area is currently served by the Northern California Health Care System (NCHCS)[5], which includes clinics in Martinez and Sacramento, as well as Berkeley, Redding, and Oakland, and a day treatment facility in Martinez. In addition, the Air Force has dedicated 55 interim beds at the David Grant Medical Center for VA's use.

VA made arrangements for the displaced inpatient workload when it closed the Martinez hospital, which had an average daily census of 235 patients at the time. VA opened 20 psychiatric beds in Palo Alto; 18 neurology beds in Livermore; 30 medical/surgical beds in San Francisco; and 16 beds in Reno, Nevada. VA also redistributed Martinez's inpatient funds to these four facilities and the Fresno medical center to cover anticipated operating cost increases associated with care for veterans in the former Martinez catchment area.

VA established a task force to review the impact of the Martinez closure on the workload of the remaining VA medical centers in the northern California/northern Nevada area. The task force reported on January 31, 1994, that closing inpatient beds at Martinez increased the workload of the other VA medical centers in the area.[6] Using bed-days of care as the unit of measure,[7] the task force analyzed fiscal years 1991 and 1993 patient treatment files for the San Francisco, Palo Alto, Fresno, and Reno medical centers.[8] Of the

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[5]NCHCS was formerly called the Northern California System of Clinics.

[6]Regional Special Purpose Site Visit Report Of the Bay Area Task Force, VA Western Region.

[7]The task force developed its methodology, which used changes in bed-days of care to assess the impact of the Martinez closure, after attempts to monitor actual workload changes were discontinued because they were extremely time consuming.

[8]VA excluded the Livermore, California, VA Medical Center from its analysis because Martinez's neurology service was transferred in its entirety, with all resources, to Livermore and was to be returned in its entirety, with the original funding, to the NCHCS. In July 1993, VA began transferring the neurology unit to the David Grant

more than 455,000 total bed-days of care provided at the four locations in fiscal year 1993, the task force attributed almost 150,000 to patients from counties in the target area. This reflected an increase from fiscal year 1991 of over 23,000 bed-days of care attributable to patients from the target area.

Although each of the four VA medical centers had an increase in bed-days of care attributable to patients from the target area, total VA inpatient utilization decreased in the northern California/northern Nevada area after the Martinez closure. The task force report showed that total bed-days of care for the four medical centers decreased by over 21,000. In addition, in responding to the task force report, the Director of the then Northern California System of Clinics informed the task force chair that between fiscal years 1990 and 1993 the average daily census in the area declined by 322, or 21 percent, and the number of patients treated declined by 6,815, or 19 percent. The Director also said that the 23,000 bed-days of care increase attributable to patients in counties in the target area represented only a fraction of the 84,000 bed-days of care provided in the Martinez hospital in fiscal year 1990, the year before closure.

Similarly, a May 1993 VA report[9] also indicated a decrease in VA hospital utilization in the northern California/northern Nevada area. The report showed that between fiscal years 1991 and 1992, the total episodes of patients treated in VA hospitals in the area declined by 13.8 percent. It also showed that the number of unique veterans receiving inpatient services in the area declined by 19.7 percent for the combined San Francisco, Martinez, Livermore, and Palo Alto areas, by .49 percent for Fresno, and by 2.7 percent for Reno.[10]

Both studies recognized that many factors may have affected VA hospital utilization. For example, the task force report stated that no attempt was made to modify the study results to meet changing philosophies in health care, such as the desire to increase outpatient care and decrease inpatient care. The May 1993 report noted that a shift from inpatient to outpatient care and an increased use of non-VA hospitalization was implemented at the same time that utilization was declining. Neither report, however, had

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Medical Center.

[9]Northern California Network Utilization Rate Comparisons and Patient Origin Data, VA Western Region.

[10]A veteran was counted as a unique inpatient at each VA medical center that provided the veteran with one or more episodes of hospitalization during the year.

evidence to indicate the extent to which the decrease was attributable to a lack of access to hospital care after the Martinez closure, a switch from inpatient to outpatient care, use of non-VA hospitals, or other factors.

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