GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-247411

February 25, 1992

The Honorable Frank H. Murkowski
United States Senate

Dear Senator Murkowski:

This report discusses the Department of Veterans Affairs (VA's) current plans for increasing VA's presence in Hawaii by establishing a medical center there. We have prepared it in partial response to your broader request that we assess the effects of employee-mandated health insurance on the demand for VA services. We will be reporting separately on the results of that broader review. With respect to the planned Hawaii medical center, this report discusses whether

- VA could increase its presence in Hawaii and provide acute and long-term care services to the state's veterans sooner than currently planned,
- VA has accurately projected its acute care bed needs in light of the Hawaii health insurance mandates, and
- excess bed capacity exists at the Department of Defense's (DOD's) Tripler Army Medical Center that could be used to meet those needs.

Our scope and methodology are discussed in appendix I.

We presented our preliminary findings on these issues at an August 16, 1991, hearing held by the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. This report expands on those findings (see app. I), discusses concerns expressed at those hearings (see app. II), and presents a chronology of key events in the planning process for the Hawaii VA medical center (see app. III). The report also incorporates the results of our discussions with members of a Joint Venture Committee, which is developing plans for the proposed VA medical center. The committee is composed of officials from Tripler Army Medical Center, VA's outpatient clinic in Honolulu, and the University of Hawaii medical school, which will become affiliated with the VA medical center.

Background

Because Hawaii does not have a VA hospital, the acute care needs of veterans have traditionally been met through a VA sharing agreement with Tripler Army Medical Center and contracts with community hospitals. Similarly, because there is no VA nursing home in Hawaii, VA relies on contracts with community nursing homes to meet the long-term care needs of veterans. VA's presence in Hawaii consists of an outpatient clinic in

Honolulu's federal building and primary care clinics on three of the outer islands.

In a 1978 report we concluded that improved coordination among DOD, VA, and other federal agencies could improve the provision of health care services to all federal beneficiaries in Hawaii.[1] During the next several years, VA and DOD reached a series of agreements for increased interagency sharing at Tripler. The most significant was a 1979 agreement that the Army would provide acute care to veterans in its newly renovated hospital and turn Tripler's E-Wing over to VA for renovation into a nursing home and long-term psychiatric facility.

The agreement began to fall apart during 1987 Senate hearings. Veterans' groups complained about Tripler's responsiveness to veterans and the quality of care provided there. Most called for the establishment of a distinct VA "presence" in Hawaii in the form of a VA facility separate from Tripler.

After the hearing, VA established a task force to study health care for Hawaii veterans. Later in 1987, the task force recommended constructing a VA medical center to establish that presence. When limited progress had been made in developing plans for the center, the Senate Veterans' Affairs Committee held a hearing in August 1990 to encourage VA to expedite its construction. In response, VA officials made a commitment to expedite the project.

In March 1991, VA announced plans to build the medical center on the grounds of Tripler Army Medical Center rather than as a totally separate facility. The plans call for renovating Tripler's E-Wing to accommodate 105 acute care beds and surgical and intensive care capability. They also call for constructing a nursing home, outpatient clinic, and other facilities on the grounds of Tripler. Under VA's plans, all veterans, including those currently authorized to obtain care at community hospitals on Hawaii's outer islands, would be required to go to the planned medical center for all but emergency care. VA expects to complete the planned construction and renovation in 1997.

[1]Better Coordination Could Improve the Provision of Federal Health Care in Hawaii (HRD-78-99, May 22, 1978).

Construction of Additional Acute Care Beds Not Needed and Will Delay Project Completion

VA's plans to construct additional acute care capacity at Tripler will delay by several years the long-awaited creation of a distinct VA presence in Hawaii. In addition, the VA plan would result in duplicating rather than complementing most of the acute care capacity that already exists at Tripler and would increase costs without providing a commensurate increase in access to care for Hawaii veterans. VA has significantly overestimated its acute care needs—in terms of beds, operating rooms, and intensive care beds. For example, in developing its projected bed needs, VA has not considered the potential effects of the almost universal health insurance coverage available to Hawaiians.

Adequate capacity—including 69 acute care beds—was specifically included in the renovated Tripler Army Medical Center to meet the current and future acute care needs of Hawaii's veterans. Excess capacity also exists in operating rooms and intensive care units. By developing a joint venture agreement centered on the use of existing excess capacity at Tripler, VA and DOD could create the long-awaited VA presence much sooner—in months rather than years—than VA is now planning.

Such an approach would enable VA to promptly begin providing nursing home care—generally regarded as the most pressing health care need of Hawaii veterans—through the use of Tripler's E-Wing. It would also significantly reduce construction costs and give VA the flexibility to allow outer island veterans to continue to receive VA-sponsored services from community hospitals and nursing homes closer to their homes.

We discussed options for developing a joint venture agreement using existing excess acute care capacity at Tripler Army Medical Center with the Joint Venture Committee on November 26, 1991. In his role as a member of the committee, the director of VA's Medical and Regional Office Center in Honolulu told us that the Secretary of Veterans Affairs had been presented three options for the creation of a VA medical center on the grounds of the Tripler Army Medical Center. Two of the options involved the use of existing unused medical/surgical acute care wards at Tripler as an alternative to construction of additional medical/surgical beds in Tripler's E-Wing. The Secretary, the director told us, chose the option of building additional medical/surgical wards in E-Wing.

At the time the Secretary made the decision to construct additional acute care beds in E-Wing, he may not have been aware of the additional information developed in this report. For example, the options paper did not discuss (1) the deficiencies in the projections of VA acute care bed

needs, (2) the existence of 69 acute care beds specifically constructed for the care of veterans in the renovated Tripler Army Medical Center, and (3) the concerns of veterans living on the outer islands about VA's plans to make them use the planned VA medical center rather than community hospitals closer to home.

Recommendations

We recommend that the Secretary of Veterans Affairs reconsider his decision to build additional acute care beds in Tripler's E-Wing. We recommend that the Secretary, in cooperation with the Secretary of Defense, develop a joint venture agreement that will give VA greater influence over the care provided to veterans in already renovated acute care space at Tripler. This could be accomplished either by integrating VA and DOD staff or by transferring a mutually agreed upon number of acute card wards to VA. The agreement should also provide for meeting VA's inpatient surgery and intensive care unit needs through use of existing capacity at Tripler.

We also recommend that VA use Tripler's E-Wing to accommodate its planned nursing home and other portions of its proposed medical center project as appropriate.

Agency Comments

In commenting on a draft of this report, VA said that it would consider our recommendations, although it has several concerns about them. DOD officials concurred with our findings and recommendations. (For a complete discussion of the departments' comments, and our evaluation of them, see p. 24.)

We are sending copies of this report to the Secretaries of Veterans Affairs and Defense, the House and Senate Committees on Veterans' Affairs, the House and Senate Committees on Appropriations, the House Committee on Government Operations, the Senate Committee on Governmental Affairs, and other interested parties.

Please call me on (202) 512-7101 if you or your staff have any questions concerning this report. Other major contributors are listed in appendix VI.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

Contents

Tables

Abbreviations

DOD	Department of Defense
GAO	General Accounting Office
VA	Department of Veterans Affairs

VA Health Care in Hawaii: Construction of Additional Acute Care Beds Not Needed

Background

Hawaii is one of only two states that do not have a VA hospital.[1] Nor is there a VA nursing home or state veterans' home in Hawaii. VA's presence in Hawaii consists of an outpatient clinic in Honolulu's federal building and four primary care clinics on the outer islands.

In recognition of this situation, Hawaii veterans are provided greater access to care at military and community hospitals than are veterans on the mainland. Acute care is provided primarily through a sharing agreement between VA and Tripler Army Medical Center in Honolulu. Veterans with service-connected or non-service-connected disabilities can also be authorized to use private or state providers at VA expense. On the mainland, such fee basis care is generally limited to service-connected veterans who are geographically inaccessible to a VA facility.

As shown in table I.1, from fiscal year 1988 through fiscal year 1991, VA provided acute inpatient care to an average of 67 patients per day. This care was provided at Tripler and community hospitals on the island of Oahu and at community hospitals on the outer islands.

Table I.1: Hawaii VA Hospitalization Average Daily Census by Location
(Fiscal Years 1988-91)

	Fiscal year				
Location	**1988**	**1989**	**1990**	**1991[a]**	**FY88-91 average**
Oahu hospitals					
Tripler	34	32	40	40	37
Community	22	17	15	18	18
Total	**56**	**49**	**55**	**58**	**55**
Outer island hospitals					
Community	11	13	12	10	12
Total	**11**	**13**	**12**	**10**	**12**
Total all hospitals	**67**	**62**	**67**	**68**	**67**

[a]Fiscal year 1991 data cover from October 1990 through June 1991.

Because of the aging veteran population and the severe shortage of community nursing home beds in Hawaii, VA officials and others have long considered the construction of VA nursing home beds one of the most critical health care needs of Hawaii veterans. For example, a 1981 task force

[1]Alaska is the other.

concluded that the need for long-term care capacity for the state's veterans constituted the most urgent requirement for VA to address.

Because there is neither a VA nursing home nor a state veterans' home in Hawaii, VA relies on contracts with community nursing homes to provide veterans with nursing home care. In fiscal year 1990, VA paid for an average of 20 patients a day in community nursing homes. However, nursing home beds in the state are in short supply, and the state has one of the nation's lowest ratios of nursing home beds per 1,000 elderly residents. State health officials report that more than 200 residents are in acute care beds awaiting placement in nursing homes because of the shortage of beds.

Improving health care services for Hawaii's veterans has been a protracted process. In the mid-1970s, DOD began developing plans for major renovations and construction at Tripler. At the request of Senator Daniel Inouye, we evaluated those plans and concluded that better coordination between VA and DOD could improve the provision of health care services to all federal beneficiaries in Hawaii.[2]

During the next several years, VA and DOD reached a series of agreements for increased interagency sharing at Tripler. The most significant were agreements that the Army would (1) provide acute care to veterans in its renovated facility and (2) turn Tripler's E-Wing over to VA for renovation into a nursing home and long-term psychiatric facility upon the expected completion of Tripler's renovation in 1986. VA identified its primary acute care needs that were not being met by Tripler at that time as psychiatric care and hemodialysis. These needs were factored into the plans for Tripler's renovation, and 69 acute care beds for the care of veterans were included in the renovation project approved by the Congress. VA officials repeatedly expressed their commitment to this sharing arrangement over the next several years.

Delays in the renovations at Tripler and thus the availability of E-Wing, coupled with decreases in DOD funding for Tripler's operation, led to questions about the viability of using Tripler as a long-term solution to meeting the health care needs of Hawaii's veterans. At a 1987 Senate Committee on Veterans' Affairs hearing, veterans groups complained about (1) the way veterans were treated at Tripler, (2) the quality of care provided there, and (3) the delays in constructing VA facilities in Tripler's E-Wing. They called

[2]Better Coordination Could Improve the Provision of Federal Health Care in Hawaii (HRD-78-99, May 22, 1978).

for establishing a distinct VA presence in Hawaii. After that hearing, VA established a task force to study health care for Hawaii veterans.

The task force found that

- VA spends less on veterans' health care in Hawaii than in several states with smaller veteran populations,
- Hawaii veterans use inpatient hospital services less than their counterparts on the mainland, and
- veterans were generally dissatisfied both with the way they were treated and with the quality of the services available at Tripler.

The task force attributed the lower spending and utilization to "suppressed demand"—a lower than expected demand for VA services caused by barriers to access faced by Hawaii's veterans. The task force recommended constructing a 105-bed acute care hospital and a 60-bed nursing home.

Significant improvements have been made in the delivery of health services to Hawaii veterans since the 1987 task force report. Specifically,

- VA established primary care clinics on three of the state's outer islands to improve veterans' access to services,
- VA officials relaxed their formerly strict interpretations of VA's eligibility criteria, allowing easier access to VA-sponsored care in community health facilities,
- DOD completed the renovations at Tripler, and
- VA and DOD reached agreements for joint VA/DOD staffing of a psychiatric ward at Tripler.

Overall patient satisfaction with Tripler and with the quality of care it provides has greatly improved.

The conference report on the fiscal year 1989 VA appropriation directed VA to use $3 million in advance planning funds for initial planning of a new medical center in Hawaii. In June 1989, VA notified DOD that it no longer planned to use Tripler's E-Wing. This decision was reinforced by an April 1990 report by VA's Western Region, which found that E-Wing was not a viable option for meeting the inpatient health care needs of Hawaii's veterans.

The Secretary of Veterans Affairs, however, rejected the finding of the Western Region study that Tripler was not a viable option and directed that

the medical center be established at Tripler as a joint venture between VA and DOD. In June 1990, VA and DOD established a committee to develop plans for the joint venture. This team consists of Army and VA officials as well as officials from the University of Hawaii medical school, which will become affiliated with the VA medical center.

In August 1990, the Senate Committee on Veterans' Affairs held a hearing on veterans' health care in Hawaii. Veterans expressed considerable frustration with the delays in VA's efforts to establish a medical center in Hawaii. In response, VA officials made a commitment to expedite the project.

The Joint Venture Committee developed three options, two of which envisioned VA taking control of two recently renovated acute care wards and an existing 8-bed intensive care unit in the main Tripler building. The third option involved constructing acute care beds in Tripler's E-Wing. The Assistant Secretary of the Army notified VA that any of the options would be acceptable to DOD.

In March 1991, VA selected the third option. The plans call for renovating Tripler's E-Wing to accommodate 105 acute care beds and constructing a freestanding nursing home and outpatient clinic. Other components of the planned medical center include constructing office space for the VA district counsel and regional office, permanent and temporary housing for VA staff, and a day care center. VA expects to complete the planned construction and renovation in 1997.

Objectives, Scope, and Methodology

As part of a broader effort to assess the effects of state-mandated health insurance on the demand for VA services, Senator Frank Murkowski, in his former capacity as Ranking Minority Member of the Senate Committee on Veterans' Affairs, asked us to review VA's current plans for the Hawaii medical center. Specifically, he wanted to know whether (1) VA had accurately projected its acute care bed needs in light of the Hawaii health insurance mandates, (2) excess capacity existed at Tripler Army Medical Center that could be used to meet those needs, and (3) VA could increase its presence in Hawaii and provide medical services sooner than currently planned.

Our preliminary findings were presented at an August 16, 1991, hearing held by the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. We expanded our work to include additional issues concerning VA's plans and alternatives to construction of

additional acute care capacity raised at those hearings. These issues are discussed in appendix II.

To determine whether VA had accurately projected acute care bed needs, we reviewed VA planning documentation for the Hawaii medical center, VA facility planning guidance, VA workload estimates, historical workload data, and VA studies of health care for Hawaiian veterans. In addition, we interviewed VA regional planners, officials from the VA outpatient clinic in Honolulu, and VA central office officials. Finally, we interviewed officials from Tripler, the Healthcare Association of Hawaii, the Hawaii State Health Planning and Development Agency, the University of Hawaii Schools of Medicine and Public Health, and the State of Hawaii's Department of Health.

To determine whether Tripler Army Medical Center has excess capacity that could be used to meet VA's acute care needs, we (1) interviewed Tripler officials, (2) reviewed documents pertaining to the construction and renovation of Tripler to determine the extent to which veterans' health care needs were factored into the plans, (3) obtained and reviewed data on actual workload at Tripler, including constructed capacity, operating beds, and occupancy rates, and (4) compared the data obtained to VA's current and projected workload.

We used the information obtained from the work described above and interviews with VA, DOD, and University of Hawaii officials to determine whether there were options available that would enable VA to provide needed services more quickly and less expensively.

We focused primarily on the justification for the construction of additional acute care beds and did not review, in detail, the justification for the other parts of the medical center.

Our work was done between April and November 1991 in accordance with generally accepted government auditing standards.

VA Overestimated the Number of Acute Care Beds Needed

VA has significantly overestimated the number of acute care beds that would be needed in a VA medical center in Hawaii. Although VA has shifted its acute care bed plans from constructing a freestanding hospital to renovating Tripler's E-Wing, the 1987 task force's acute care bed need projection, updated in 1990, continues to be the primary justification for the planned medical center. The 1987 task force, and the VA Western Region in

its 1990 reevaluation, based their workload projections on questionable assumptions about how many veterans would continue to use other hospitals. They then inflated their workload projections to compensate for what they assumed was suppressed demand without adequately considering alternative explanations for Hawaii veterans' historically low demand for VA services.

Questionable Workload Assumptions

VA based the projected workload of the planned VA hospital on the assumption that all veterans who had been receiving VA-sponsored care at Tripler and community hospitals would obtain future care from the VA hospital. This, in our opinion, is not appropriate because some care to veterans will, of necessity, continue to be provided by these other hospitals. For example, emergency care will continue to be provided by the Army at Tripler or by the nearest community hospital because the proposed VA medical center does not include plans for emergency services. Similarly, the proposed VA hospital would be a secondary care facility too small to warrant the inclusion of many specialty services. Consequently, VA will have to continue sending patients needing these services to Tripler and the larger community hospitals.

VA officials could not provide data on how much of the care currently provided to veterans at Tripler and in community hospitals is for emergency and specialty care. A 1990 study by VA's Western Region estimated that about 6 percent of the care would continue to be provided by other hospitals after the VA hospital was completed. Although we believe the percentage of care that remains in other hospitals may be higher, neither the 1987 task force nor the Western Region in its 1990 study reduced their bed need projections to reflect the 6 percent of care that the region estimated would continue to be provided in other hospitals.[3]

VA also based its projections on the assumption that all veterans on the state's outer islands would use the planned hospital. As shown in table I.1 (see p. 8), an average of 12 VA patients per day were treated at municipal hospitals on the outer islands in fiscal year 1990, although these veterans currently have the option of traveling to Oahu to obtain care at Tripler.

After adjusting the bed requirements for an 85-percent occupancy factor and for suppressed demand (see p. 14), VA's plans included a requirement

[3]The region developed the 6-percent estimate by analyzing referrals from the Hampton, Virginia, VA Medical Center to the Salem, Virginia, VA Medical Center and the Richmond, Virginia, VA Medical Center. This analysis excluded, however, emergency admissions to community facilities and referrals to community facilities for specialty care.

for 16 beds for the care of outer island veterans. It is unreasonable, in our opinion, to expect outer island veterans to fly to Oahu for inpatient care when such care is readily available closer to home. Interisland travel may be stressful for patients who are already faced with the difficulty of needing hospital care and is inconvenient and costly ($80-$110 roundtrip) for friends and family who wish to visit the veteran in the hospital (see p. 19). Even if VA follows through on its plans to require outer island veterans to use the new VA hospital, representatives of veterans' groups with whom we spoke said that many outer island veterans will choose to use hospitals closer to home rather than travel to Oahu.

Alternative Explanations for Lower Utilization Not Fully Considered

Veterans' utilization of VA-sponsored hospital care is lower in Hawaii than on the mainland, but VA did not adequately consider possible explanations for such differences before adjusting bed needs for suppressed demand. In addition, construction of a VA medical center is not needed to address any suppressed demand that may exist.

In 1987, VA's task force concluded that there was suppressed demand for VA care in Hawaii. It did this by comparing utilization of VA inpatient hospital services by Hawaii veterans to that by mainland veterans. The task force found that Hawaii veterans are hospitalized under VA sponsorship at 43 percent of the national VA rate. The task force also noted that the general population in Hawaii uses inpatient hospital services at only 60 percent of the national rate. Based on this comparison, the task force concluded that the 17-percent difference represented suppressed demand for VA inpatient care. The task force then increased its estimated bed requirements by 13 to address suppressed demand, arriving at a total bed requirement of 105 beds. Although the Western Region planners lowered projected workload estimates in their 1990 study, rather than reducing the number of beds planned for the VA hospital, they increased the adjustment for suppressed demand to 27 beds.

VA did not fully evaluate other possible explanations for the lower than average utilization of VA health care services by Hawaii veterans. For example, VA did not consider the extent to which military retirees who are dually eligible for VA and DOD health care were using their DOD benefits. About 9 percent of the days of care provided by the Army at Tripler are for military retirees who are also eligible for VA care. Such care is included in DOD rather than VA utilization data.

Similarly, VA did not consider the extent to which veterans had other health insurance options and therefore did not seek care from VA. This is important because veterans who have private health insurance are less likely to seek care from VA. According to the 1987 VA survey of veterans, less than 1 percent of all insured veterans nationally had used a VA hospital in the past year compared to about 8 percent of uninsured veterans.

The relationship between health insurance coverage and the demand for VA-sponsored care is particularly important in Hawaii, which has one of the highest percentages of residents with health insurance in the nation. This is due, in part, to low unemployment and a state law that requires employers to provide health insurance to most workers. Beginning in 1974, the state required employers to provide health insurance to the vast majority of employees working 20 hours or more per week. The state health department estimates that since 1974, the percentage of Hawaiians without any health insurance has declined from about 17 percent to between 2 and 5 percent. The percentage of uninsured people in the United States overall is about 18 percent.

The insurance provided under the employer mandates includes comprehensive hospitalization benefits and therefore may have reduced the demand for VA inpatient care. We were unable to obtain veteran-specific data on health insurance coverage in Hawaii. Veterans, in general, however, are more likely to have health insurance than the general public, data from the Bureau of the Census Current Population Survey suggest. Given that the percentage of the uninsured population in Hawaii is now 5 percent or less compared to the national average of 18 percent, it is probable that Hawaii veterans are now insured at a higher rate than veterans on the mainland and as a result have sought fewer VA inpatient services. To illustrate the magnitude of this effect, a decline in the percentage of uninsured veterans from 18 to 5 percent could reduce the number of veterans using a VA hospital by about 41 percent.

Finally, the lower utilization may be caused by a lack of resources to pay for fee basis care. The director of VA's Honolulu outpatient clinic told us that the clinic denies fee basis authorization to many veterans because it has insufficient funds to pay for the care. The director said that his budget requests have been cut by both VA's Western Region and its central office. The director did not know how many veterans were denied care because of funding constraints.

Construction of a VA medical center is not a prerequisite to addressing any suppressed demand that may exist. The task force attributed suppressed demand to veterans' incomplete knowledge of benefits, their geographic distance from the Honolulu outpatient clinic, and VA's application of eligibility rules. VA does not, in our opinion, need to wait until the medical center is completed to address these problems. For example, VA could expand outreach efforts to make veterans more aware of their benefits. Similarly, VA could streamline its application process to make it easier for veterans to obtain authorization to use community providers or Tripler.

VA's current plans to require outer island veterans to use the planned VA medical center rather than community hospitals on their home islands will, in our opinion, likely increase rather than decrease suppressed demand by making VA-sponsored care more geographically inaccessible to such veterans.

Comments From Briefing of the Joint Venture Committee

At our November 26, 1991, briefing of the Joint Venture Committee, the director of VA's Medical and Regional Office Center in Honolulu disagreed with our assertion that VA had overestimated its acute care bed need. He said that the 105 acute care bed need was developed in 1987 using VA's hospital sizing model and is a conservative estimate of VA's acute care needs. He emphasized that the bed needs were revalidated through a 1990 study by VA's Western Region.

We believe VA did not correctly apply its hospital sizing model in arriving at its projected acute care bed needs in Hawaii. First, the model should have been based on projected workload for the services that will be offered in the planned facility; VA included workload data on emergency and specialty care that will not be available at the planned VA medical center. Second, the hospital sizing model does not contain provisions for increasing projected bed needs based on assumptions concerning suppressed demand; the 1990 Western Region revalidation of the 105 acute care beds added 27 beds for suppressed demand. Based solely on projected workload—even with emergency and specialty care included—the Western Region had projected, using the hospital sizing model, the need for 78 acute care beds.

Tripler Has Adequate Bed Capacity to Meet VA's Acute Care Needs

The renovated Tripler facility was constructed with adequate bed capacity to meet the current and future acute care needs of Hawaii's veterans. Tripler is currently meeting about two-thirds of the acute care needs of the state's veterans. Moreover, the commanding general told us that Tripler has adequate staffed bed capacity to absorb VA's total current workload. Tripler has enough additional beds in currently closed medical, surgical, and psychiatric wards to meet VA's projected workload even under VA's inflated bed need projections. Finally, Tripler appears to have adequate capacity in its operating rooms and intensive care units to meet VA's needs. As a result, construction of additional acute care beds would create additional excess capacity in an already underutilized hospital.

Tripler was not built strictly as an Army hospital. It was sized and built to serve as the federal hospital for the Pacific basin, serving all four military services, veterans, trust territory beneficiaries, and Public Health Service beneficiaries. Of the 538 beds included in the renovation project, 69 were added specifically to allow Tripler to meet the acute care needs of Hawaii's roughly 100,000 veterans. Another 12 beds were included for care of federal beneficiaries from the trust territories.

Demand for VA-sponsored care at Tripler has consistently been well below the 69-bed constructed capacity, averaging about 40 patients per day. Even if care currently provided at community hospitals were consolidated at Tripler, the average daily census of VA-sponsored care would be below the acute care capacity constructed for veterans at Tripler. The commanding general told us that Tripler could routinely serve 65 to 85 VA patients per day in the hospital's staffed and operating beds.

In addition, Tripler has 68 unused beds suitable for care of veterans located in renovated wards that are fully equipped but closed because of low demand or staff shortages.[4] When these unused beds are considered, it becomes clear that Tripler's available acute care bed capacity is also more than adequate to meet VA's inflated projected acute care needs of Hawaii's veterans.

In 1990, planners in VA's Western Region updated the acute care workload estimates for Hawaii. This 1990 update projected that in the year 2005, VA would have a workload of about 67 inpatients per day in Hawaii (excluding any increases for suppressed demand), which, as shown in table I.1 (see p. 8), is identical to its average workload over the past 4 years. This projected workload is well within Tripler's current staffed capacity to care

[4]We excluded obstetric and pediatric beds.

for veterans. Even with VA's questionable workload adjustments to bring the acute care bed needs up to 105, Tripler has the capacity to meet those needs.

If VA were to build 105 acute care beds, the beds now used by VA patients in Tripler would be left vacant, and the underutilization of Tripler facilities would be exacerbated. A target occupancy rate of 85 percent is usually used by VA to plan for the efficient use of hospital beds. If VA, as planned, moves all of the veterans treated at Tripler to newly built VA beds, the utilization of Tripler's staffed beds would drop from its current 80 percent to 68 percent, while the utilization of Tripler's physical capacity would fall from 66 percent to 56 percent.[5] Appendix IV provides detailed information on Tripler's current capacity and occupancy rates.

Tripler also appears to have adequate capacity in its operating rooms and intensive care units to meet VA's needs; one operating room and two 8-bed intensive care units are currently unused. Previous GAO studies have shown that one operating room should be adequate to support the 30 surgery beds VA plans to construct.[6] Tripler is already providing surgical care for about two-thirds of the VA beneficiaries in Hawaii. Thus, the increase in surgeries from the establishment of a VA hospital should be minimal.

Comments From Briefing of the Joint Venture Committee

At our November 26, 1991, briefing of the Joint Venture Committee, the director of VA's Medical and Regional Office Center in Honolulu said that Tripler cannot accommodate VA's requirements for 105 acute care beds in the existing acute care wards.

As discussed above (see p. 17), we believe Tripler has adequate capacity in its already renovated acute care wards to accommodate all VA patients, even under VA's inflated projections. Tripler officials told us that they could accommodate 65 to 85 veterans in their currently staffed and operating wards. In addition, there are 68 acute care beds suitable for use in caring for veterans in currently closed wards.

[5]We excluded from Tripler's capacity those beds not suitable for care of veterans, such as obstetric and pediatric beds.

[6]Better Guidelines Could Reduce Planned Construction of Costly Operating Rooms (HRD-81-54, Mar. 3, 1981); VA Health Care: Too Many Operating Rooms Being Planned and Built (GAO/HRD-86-78, Apr. 29, 1986).

Construction of More Acute Care Beds Would Increase Costs but Decrease Access

Compared to VA's possible use of the existing excess capacity in the renovated Tripler facility, VA's plans to construct an additional 105 acute care beds in Tripler's E-Wing will increase costs substantially. VA's plan, however, is likely to decrease, rather than increase, access to care for Hawaii veterans. VA has not developed cost estimates for the project as currently envisioned or its individual components. VA's 5-year facility development plan for fiscal years 1990-94, however, had earlier estimated costs for a more modest medical center project at $170 million. It appears to us, based on an analysis of a 1990 report by VA's Western Region, that construction of the acute care portion of the project would be at least $65 million.[7]

At our November 26, 1991, briefing of the Joint Venture Committee, the director of VA's Honolulu outpatient clinic and regional office said that VA Western Region officials had been in Honolulu the prior week to develop cost estimates for the medical center project. The renovation of E-Wing into 105 acute care beds is, he said, expected to be extremely expensive. He said that no estimates were developed of the cost to renovate E-Wing into a nursing home.

Operating costs are also likely to be higher in the planned VA hospital than through the sharing agreement with Tripler. In fiscal year 1990, VA's systemwide average per diem cost for hospital care was about $388; the per diem cost under the sharing agreement with Tripler was $347. The higher VA cost may be caused in part by higher VA salaries and benefits for nurses. The commanding general at Tripler said that this could create a problem for Tripler in recruiting and retaining nurses. He said that he is seeking authority to match VA salaries and benefits for nurses.

The higher construction and operating costs of the proposed hospital might be justified if the project could be expected to increase veterans' access to care. VA, however, plans to reduce veterans' access and options for VA-sponsored care once the medical center is completed. This is particularly true for the 22 percent of Hawaii's veterans living on the outer islands.

[7]The 1990 VA Western Region report estimated the costs of several proposed construction options. One involved continued use of Tripler and community hospitals for acute inpatient care, with VA construction limited to psychiatry and nursing home beds and an outpatient clinic. Another included construction of new acute care beds as part of a freestanding medical center. The estimated difference in cost between these options indicates that the costs of the 105 acute care beds may be about $65 million.

As discussed earlier, VA's justification for building 105 acute care beds assumed that all outer island veterans would use the new medical center for inpatient care. VA's Chief Medical Director explained at the 1990 Senate hearing that outer island veterans will be required to come to the new facility for treatment because VA cannot have the new medical center operating at 50-percent occupancy.

During the same hearing, veterans' groups from the outer islands expressed considerable concern about VA's plans to require outer island veterans to use the proposed hospital rather than community hospitals. Similar concerns were expressed in our recent conversations with veterans' groups on Maui and Hawaii. This is because plane travel from the outer islands costs $80 to $110 round-trip and hotel expenses are high due to the international tourist trade. These costs would hinder the ability of family and friends to visit patients.

Such concerns were expressed again at an August 16, 1991, hearing before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. At the hearing, VA officials confirmed their intention to require outer island veterans to use the planned hospital.

Comments From Briefing of the Joint Venture Committee

At our November 26, 1991, briefing of the Joint Venture Committee, the director of VA's Honolulu outpatient clinic and regional office again confirmed VA's intention to require outer island veterans to use the planned hospital. He questioned why we would advocate giving veterans on the outer islands what they want—continued use of community hospitals—but not advocate giving veterans on Oahu what they want—a VA hospital. In addition, he said that it would be much cheaper to treat outer island veterans at the planned VA hospital than to pay for their care in the community.

We believe the options presented in this report would provide both Oahu veterans and outer island veterans with appropriate access to VA care and at a significantly lower cost than VA currently plans. Oahu veterans would be provided access to a veterans' hospital without depriving veterans living on the outer islands of their ability to obtain routine care at community hospitals closer to home if they so desire. In addition, the costs of constructing 105 additional acute care beds in E-Wing, which the director said would be very expensive, would be avoided.

Joint Venture Using Existing Acute Care Capacity Could Create VA Presence Sooner

Although VA and DOD are planning a joint venture at Tripler, VA's current plans would result in VA duplicating rather than complementing most of the acute care capacity that already exists at Tripler. By developing a joint venture agreement centered on use of the existing excess acute care capacity at Tripler, VA and DOD could create the long-awaited VA presence sooner—in a matter of months rather than years—and at less cost. In addition, use of the existing acute care capacity could give VA added flexibility to allow outer island veterans to continue to use home-island hospitals and nursing homes. An ongoing joint venture between VA and the Air Force in Albuquerque, New Mexico, could provide a useful model in developing a DOD/VA joint venture in Hawaii. Alternatively, VA could develop a joint venture agreement under which acute care services for veterans would be more fully integrated with those for military beneficiaries through joint VA and DOD staffing of several wards at Tripler.

Use of Albuquerque Model

Although the Albuquerque model is not the only way to manage a partnership, the conditions that existed in Albuquerque before the joint venture closely parallel the current conditions in Hawaii:

- The Air Force needed to replace or renovate an aging hospital at Kirtland Air Force Base and wanted to maintain its separate identity. VA believes it needs its own acute care beds in Hawaii to establish such an identity.
- VA had excess capacity at its newly constructed/renovated medical center in Albuquerque. The Army has excess capacity at its recently renovated medical center in Hawaii.

In Albuquerque, a joint venture agreement was reached to use the excess VA acute care capacity as an alternative to new construction. In Hawaii, however, VA's current plans are to build additional acute care beds rather than to use the excess acute care capacity at Tripler.

Under the Albuquerque joint venture agreement, the Air Force was given three wards on the sixth floor of the VA hospital. The Air Force was also given a share of the operating suites on the third floor and space on the first floor for an urgent care clinic. Land was provided for the construction of Air Force outpatient and dental clinics. A fully integrated emergency room was created using both VA and DOD staff. In essence, the emergency room, which has an Air Force director and VA deputy director, became an Air Force entity providing contract services to VA. VA physicians working in the emergency room applied for and were awarded Air Force privileges.

Provisions were made for cross-training staff (for example, VA staff were familiarized with pediatric behavior).

Under the Albuquerque joint venture, both VA and the Air Force maintain a clearly identifiable presence. Each maintains control over its acute care beds (in other words, VA cannot reclaim the three sixth floor wards given to the Air Force), including the right to decide when to admit and discharge patients.

We believe that Tripler Army Medical Center has sufficient excess acute care capacity to allow a similar joint venture arrangement between VA and DOD without constructing additional acute care beds, inpatient operating suites, or intensive care beds. The Army could give VA medical, surgical, and psychiatric wards in the renovated portion of Tripler. A surgery suite and intensive care unit could also be turned over to VA, or such care could be fully integrated. The new VA outpatient clinic could be built adjacent to the DOD clinic as currently envisioned. Before the Secretary of Veterans Affairs decided to build additional acute care beds, DOD had expressed a willingness to turn renovated wards over to VA as part of the joint venture.

Increased Use of Staff Integration

Another option would be to develop a joint venture agreement that would more fully integrate acute care services by having VA and DOD jointly staff acute medical and surgical care wards in the already renovated Tripler facility. Such an approach is already being used in psychiatric wards at Tripler. This option could be implemented quickly, at minimal expense, and would increase VA's presence by allowing VA doctors and nurses to care directly for the VA patients who are treated at Tripler.

The dean of the University of Hawaii medical school told us that he believes VA, Tripler, and the university should work together to operate an integrated medical facility for all beneficiaries. He said that under such a system, there would be no division in the provision of care, and VA, DOD, and university physicians would work together throughout the hospital in all wards. Such an arrangement would, he said, strengthen and benefit the programs of all three organizations.

By using existing acute care beds at Tripler, VA's adoption of either joint venture approach would give VA the flexibility to operate fewer than 105 beds and allow outer island veterans to obtain care at home-island hospitals. Under either of the above options, Tripler's E-Wing would be available to VA as a possible site for administrative offices and its proposed nursing

home, as was originally planned by VA more than 10 years ago. E-Wing was used by Tripler for patient care as recently as 1989, and any renovation could be completed in less time and at less cost than VA's current plans to construct a freestanding nursing home. VA could perform some of the renovation work floor by floor as was done by the Army during the recent renovation of Tripler. This approach would enable VA to begin using part of E-Wing for nursing home patients on an interim basis as soon as staffing could be assembled while other floors are remodeled.

Comments From Briefing of the Joint Venture Committee

None of the members of the Joint Venture Committee commented on our conclusion that a joint venture agreement involving the use of existing acute care capacity at Tripler rather than the construction of additional acute care beds in E-Wing could significantly speed completion of the project.

Conclusions

VA's plans to construct additional acute care capacity at Tripler are not in the best interests of either the government or Hawaii's veterans. They are not in the best interests of the government because they will (1) create additional capacity in a hospital that already has significant excess capacity and (2) increase health care costs. They are not in the best interests of Hawaii's veterans because they will (1) delay by several years the long-awaited establishment of a VA presence in Hawaii, (2) reduce their freedom of choice in selecting health care providers, and (3) reduce the ability of family and friends to visit hospitalized outer island veterans.

VA should not further delay the establishment of a VA presence in Hawaii by focusing on the construction of additional acute care beds. The desire for a separate, visible VA presence in Hawaii should be met in ways that will complement rather than duplicate the acute care capability that already exists to meet veterans' health care needs. VA should work with DOD to develop a joint venture agreement that will allow VA to meet the acute care needs of Oahu veterans through the existing, renovated acute care capacity at Tripler. The needs of outer island veterans could continue to be met through contracts with community hospitals.

Construction and/or renovation should be limited to those portions of the planned VA medical center, such as the nursing home and outpatient clinic, that cannot be accommodated within the renovated Tripler facility. VA should reevaluate the location of and justification for other portions of the medical center in light of the adjustments made in plans for providing

acute care capacity. Finally, VA should promptly begin to address the nursing home care needs of Hawaii veterans. Nursing home care has been recognized as the most critical need of Hawaii veterans for more than a decade. VA's plans to use Tripler's E-Wing for acute care beds, however, could delay by several years the establishment of a nursing home care unit. Tripler's E-Wing has been available to VA since 1989 and could be used to provide nursing home care on an interim basis almost immediately while the facility is renovated on a floor-by-floor basis.

Recommendations

We recommend that the Secretary of Veterans Affairs reconsider his decision to build additional acute care beds in Tripler's E-Wing. We recommend that the Secretary, in cooperation with the Secretary of Defense, develop a joint venture agreement that will give VA greater autonomy over the care provided to veterans at Tripler Army Medical Center. This could be accomplished either by integrating VA and DOD staff or by transferring some mutually agreed upon number of Tripler Army Medical Center acute care wards to VA. The agreement should also provide for meeting VA's inpatient surgery and intensive care unit needs through use of existing capacity at Tripler.

We also recommend that VA use Tripler's E-Wing to accommodate its planned nursing home and other portions of its proposed medical center project as appropriate.

Agency Comments and Our Evaluation

VA did not specifically address the recommendations in our draft report, noting that any substantive change in plans would require full discussion with Hawaii's congressional delegation. In a letter dated January 9, 1992 (see app. V), the Secretary of Veterans Affairs said that the Department has for years acknowledged the need for an increased VA presence and more timely medical care for Hawaii's veterans. He said that because the need for action is long-standing, he is very concerned about any potential change that could result in delays, which are inherently costly. VA said that it will closely examine the likely effects of our suggestions in light of the above concerns.

We agree with the Secretary that substantive changes in the plans should be discussed with the Hawaii delegation. Before the August 16, 1991, hearing, we met separately with each member of the delegation, or their representatives, to make them aware of the options we planned to discuss at the hearing and in our report. We emphasized that these options would

enable VA to establish the long-awaited presence sooner than the plan VA had previously presented to them, at less cost, and without the negative impact on access to care for veterans from the outer islands.

Regarding our recommendation that Tripler's E-Wing be occupied almost immediately for activating nursing home care beds, VA said that there are many deficiencies in the present E-Wing that will delay immediate implementation of the recommendation.

We recognize that renovations are needed to bring E-Wing up to current building and privacy standards. Many of these are similar to those made by DOD as part of the recently completed renovation of the remainder of the Tripler facility. We are suggesting that a portion of the building could be used on an interim basis to meet the nursing home care needs of veterans while plans were being developed for the full renovation of the building. As noted on page 23, renovations to the main Tripler hospital were handled on a floor-by-floor basis, with patient care continuing on floors above and below the floor being renovated. The Army also used E-Wing for patient care during the renovation of the main hospital despite the deficiencies VA referred to. It was used for patient care as recently as 1989.

In a meeting on January 13, 1992, DOD officials concurred with our findings and recommendations, saying it is prepared to coordinate with VA to develop plans and programs that will maximize the cost-effective delivery of high-quality, accessible health care to beneficiaries of both departments in Hawaii.

Evaluation of Concerns Expressed During the August 1991 House Committee on Veterans' Affairs Hearing on VA Health Care in Hawaii and American Samoa

During the August 16, 1991, hearing before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, congressional members and other witnesses expressed a number of concerns about our involvement in this issue and our testimony at the hearing. These concerns and our evaluation of them are summarized in this appendix.

GAO Would Shift Burden of Veterans' Health Care to the State

Concern

GAO is attempting to shift the responsibility for veterans' health care from the federal government to the state of Hawaii.

GAO Evaluation

We are not suggesting that the government's obligation to care for veterans seeking care through VA be decreased because of the Hawaii health insurance mandates. However, the size of that obligation—in other words, the number of veterans likely to seek care from VA—will likely be lower in Hawaii because so many veterans have alternative sources of care. As a result, the number of acute care beds VA will need in order to provide care to veterans seeking care through VA will likely be smaller than in a state with more uninsured veterans.

Concern

The need for a veterans' hospital should not be affected by Hawaii's efforts to achieve universal health care for its citizens.

GAO Evaluation

While the government's obligation to meet the health care needs of veterans is not diminished because of Hawaii's efforts to achieve universal health care coverage, the way in which that obligation is met may be affected. Because the state mandates are likely to significantly reduce the demand for VA care, the number of acute care beds VA needs to operate is reduced. There are several options for meeting those acute care needs, including constructing a freestanding hospital, entering joint ventures with Tripler Army Medical Center, and continuing the current use of sharing agreements and contract care.

Our analysis shows that there are enough acute care beds at Tripler to meet VA's current and future needs and that VA could establish a hospital in Hawaii without constructing additional acute care beds.

Concern

Many veterans are in the "gap group," who are not eligible for medical insurance through employers or for welfare assistance because of their VA compensation. VA should not neglect its obligations to such veterans.

GAO Evaluation

We are not suggesting that VA neglect its obligation to such veterans. What we are suggesting is that the state health insurance mandates have resulted in a smaller "gap group" in Hawaii than in most other states. This equates to lower demand for VA care because veterans with alternative sources of care are less likely to seek care from VA.

Concern

GAO is questioning the need for a medical center because veterans with health insurance are less likely to use VA hospitals.

GAO Evaluation

We are questioning the size of, not the need for, a VA hospital because veterans with health insurance are less likely to use VA hospitals. Because most health insurance has limited coverage of nursing home care, the employer mandates do not alter the need for nursing home beds.

Concern

GAO is recommending that the health care needs of Hawaii veterans be provided by the state. Both prepaid health care (the employer mandates) and the State Health Insurance Program are financed by in-state resources.

GAO Evaluation

Private health insurance will be liable for the costs of covered services for most veterans regardless of whether the veteran obtains care under VA auspices. This is because VA has been required, since 1986, to recover from insurers a portion of the costs of VA medical services provided to privately insured veterans with no service-connected disabilities. In 1990, this requirement was expanded to include recoveries from private health insurance for non-service-connected care provided to service-connected veterans. These two groups account for almost 90 percent of the care VA provides.

Concern

Hawaii is being penalized because it has an advanced health care system.

GAO Evaluation

Hawaii would not be penalized because of its state health insurance mandates. VA should adjust its plans for the medical center, however, to complement rather than duplicate the coverage available to veterans because of those mandates. For example, the mandates provide only limited coverage of nursing home care, and Hawaii has among the lowest ratios of nursing home beds per 1,000 elderly residents in the country. In our opinion, it would be appropriate for VA to place a higher priority on meeting the nursing home care needs of veterans than on providing veterans another acute care option where excess capacity already exists in the community and at Tripler Army Medical Center.

Concern

Hawaii's health insurance program does not address the unique treatment and rehabilitation needs of veterans. GAO does not evaluate the incompleteness of the state coverage with respect to the length of a hospital stay and all other things that are guaranteed under VA medical coverage.

GAO Evaluation

The health insurance offered under the employer mandate portion of the Hawaii program provides fairly comprehensive coverage of basic acute care needs, including hospitalization. The State Health Insurance Program provides only limited benefits and has strict limits on hospitalization. Most of the insurance coverage in Hawaii is, however, a result of the employer mandates, not the state program. Only about 14,000 Hawaiians are covered under the state program, and over 40 percent of them are under 18 years of age.

We are not suggesting that none of those veterans with private health insurance would seek care from VA. We would expect, however, based on data from the 1987 survey of veterans, that the percentage of veterans seeking hospital care from VA would be significantly lower than in states with larger percentages of uninsured veterans. Similarly, insured veterans may still seek VA care for services not covered under their private health insurance.

Concern

Asking employed veterans and their employers to bear the cost of treatment for a service-related problem would mean that the individuals and private employers in Hawaii would fund services provided by VA in 48 other states.

GAO Evaluation

We are not suggesting that veterans or their employers be treated any differently in Hawaii than in any other state. Neither private employers nor service-connected veterans would be expected to bear the costs for treatment of a service-connected disability. VA would continue to be responsible for such care as it is in other states. Care for service-connected disabilities, however, generally accounts for only about 10 percent of the care provided by VA.

Veterans seeking care for non-service-connected disabilities would also be treated in the same way they are treated in other states—and the same way they are currently treated in Hawaii. Such veterans would be eligible for care under VA sponsorship if they meet the basic eligibility requirements. As discussed above, however, VA is required to recover a portion of the costs of non-service-connected care from privately insured veterans' health insurance.

Changing Plans for the Medical Center Now Would Result in Further Delays in Establishing VA Presence

Concern

GAO is reviewing the justification for the Hawaii medical center after it has undergone extensive reviews by the Congress and VA. The health care needs of Hawaii's veterans and the need for a VA medical center have been thoroughly documented, evaluated, and supported by VA.

GAO Evaluation

Although the justification for the Hawaii medical center has undergone extensive reviews by the Congress and VA, those reviews have been based on incomplete analyses conducted by VA's 1987 task force. As discussed on pages 12 to 16, the task force's justification for constructing additional acute care beds is flawed. Nowhere in its evaluation of the need for acute care beds does the task force acknowledge that Tripler Army Medical Center was built to include 69 beds for the treatment of Hawaiian veterans and 12 beds for the treatment of federal beneficiaries from the trust territories. Similarly, the task force did not adjust its bed needs to reflect the portion of VA-sponsored health care that will remain at Tripler or in the community. Finally, the task force did not adequately consider alternative explanations for the lower utilization of VA-sponsored care in Hawaii than in other states.

Concern

GAO's involvement is too late to play a constructive role. Changing course now would delay construction of the VA medical center.

GAO Evaluation

Our analysis could speed the establishment of a VA acute care presence in Hawaii, enable VA to address the nursing home care needs of Hawaiian veterans almost immediately, enable VA to establish the desired VA presence without penalizing veterans living on the outer islands as currently planned, and reduce overall project costs significantly.

GAO's involvement has already had a constructive role in refining plans for the medical center by focusing central office attention on plans developed at the local level to construct an excessive number of operating rooms. After we brought the plans to construct eight VA operating rooms to the attention of central office officials, those plans were significantly scaled back and plans were made to use existing Tripler operating rooms for inpatient surgery.

VA still plans, however, to construct eight ambulatory surgery suites, including four for Tripler. VA officials said that the four DOD suites are necessary to enable Tripler to give VA two inpatient suites. These modified plans do not, however, appear adequately justified. Based on VA's projected workload, there will be only two outpatient surgeries per room per day. In addition, the two operating rooms DOD is planning to make available to VA are currently unused.

A VA Presence Cannot Be Established Without a Separate Acute Care Hospital

Concern

VA needs to construct additional acute care beds in order to establish a VA medical center in Hawaii.

GAO Evaluation

At the August hearing, the director of VA's outpatient clinic stated that while it was technically feasible for VA to take over and operate a portion of Tripler's acute care capacity, such a solution would reduce the identity of the VA medical center. Several options are available that would enable VA to establish a medical center in Hawaii without constructing additional acute care beds. Because patients generally enter a VA hospital through the outpatient clinic, moving the VA outpatient clinic to the grounds of Tripler Army Medical Center is the most critical part of the medical center project. Although placing the acute care beds in the E-Wing would add to the identifiable presence for the center, the Air Force has been able to maintain a presence in Albuquerque by operating wards on one floor of the VA hospital and an Air Force outpatient clinic. Also, VA and the Air Force are planning a joint venture at the Nellis Air Force Base Hospital under which they will jointly staff a fully integrated hospital. We believe either approach, combined with the move of the VA outpatient clinic to the Tripler grounds, would give VA a clear presence in Hawaii without the construction of additional acute care beds.

Concern

GAO is talking about having veterans scattered throughout the Tripler hospital.

GAO Evaluation

We believe VA's acute care bed needs could be met within the already renovated portion of Tripler Army Medical Center without having veterans scattered throughout the hospital. Under the joint venture agreement between VA and the Air Force for use of the excess acute care capacity at the VA medical center in Albuquerque, entire wards were turned over to the Air Force. The Air Force portion of the medical center is clearly distinguished from the VA portion. A similar arrangement could work at Tripler.

As discussed on page 22, another option would be to fully integrate VA and DOD staff and beneficiaries. Such an approach is being used for psychiatric care at Tripler and is being planned for a joint venture between VA and the Air Force in Las Vegas. The dean of the University of Hawaii medical school told us that having patients located throughout a hospital under such an arrangement would not pose a problem.

Can a VA Presence Be Established Before 1997?

Concern

Turning E-Wing over to VA right now will not speed up the project because the design process will not be completed for roughly 1-1/2 years.

GAO Evaluation

VA's emphasis on use of Tripler's E-Wing for construction of additional acute care beds is delaying its establishment of a medical center. While design work to renovate E-Wing into an acute care facility will take, VA estimates, 1-1/2 years, already renovated acute care wards could very quickly be made available in Tripler to meet VA's acute care needs. E-Wing could then be used on an interim basis, with only minor renovations, to meet some of the other health care needs of Hawaii veterans. Potential uses include nursing home care, hospice care, and an inpatient post-traumatic stress disorder unit.

E-Wing was used for patient care up to 1989 and, with minor initial renovations, could be used for patient care while design plans are developed. Tripler Army Medical Center officials told us that renovations to the main hospital were handled on a floor-by-floor basis; patient care continued on floors above and below the floor being renovated.

Concern

Even if several wards in the renovated Tripler were made available to VA immediately, VA would be unable to staff them quickly because the University of Hawaii does not have enough residents.

GAO Evaluation

The dean of the University of Hawaii medical school told us that staffing should not be a major problem. He said that the university could quickly provide enough residents to staff unused wards in Tripler.

VA Would Lose Its Acute Care Beds Under a Military Contingency

Concern

VA patients could be displaced in the event of a military contingency.

GAO Evaluation

Because of VA's mission as the primary backup to DOD in the event of a military contingency, there will always be some risk that veterans could be displaced during a major conflict. This risk would exist regardless of whether VA uses existing acute care beds or constructs additional acute care beds to establish the VA hospital.

Under a joint venture agreement similar to the Albuquerque agreement between VA and the Air Force, wards would be transferred to VA control and DOD could reclaim the beds only under the terms agreed to under the joint venture agreement. At the August hearing, the commanding general at Tripler Army Medical Center testified that Tripler has significant reserve capacity and could increase its number of operating beds three- or four-fold.

Veterans Cannot Obtain Quality Care at Tripler Army Medical Center

Concern

In the 1987 hearings, complaints were voiced about the quality of care provided to veterans at Tripler. Quality of care delivered by Tripler to veterans may still be a problem.

GAO Evaluation

The 1987 hearings and VA's 1987 task force cited anecdotal evidence of problems with the care at Tripler but did not assess the actual quality of care. These complaints came in the midst of the renovation and construction at Tripler. Tripler is now a state-of-the-art DOD facility that has one of the highest ratings given by the Joint Commission on Accreditation of Healthcare Organizations.[1] Tripler routinely performs numerous quality assurance reviews and patient satisfaction surveys, including some focused specifically on veterans. These surveys show a high level of satisfaction with how veterans are treated at Tripler and with the quality of care provided. Similarly, the director of the VA medical and regional office in Hawaii told us that he rarely receives complaints about the care provided at Tripler.

Concern

VA cannot fulfill its mission with respect to education with beds interspersed in Tripler

GAO Evaluation

The dean of the University of Hawaii School of Medicine told us that the physical location of VA beds would not be a problem for education. An assistant to the dean noted that a physician typically has patients scattered throughout any teaching hospital.

Sharing of Tripler Acute Care Capabilities May Not Persist Beyond the Personalities Involved

Concern

Although the current commanding general at Tripler has worked to improve VA/DOD sharing, such improvements may be temporary if his successor is not similarly committed to sharing.

[1]The Joint Commission's purpose is to establish and enforce national standards for health care organizations in the United States and survey these organizations for compliance. Both civilian and military hospitals are reviewed.

GAO Evaluation

While sharing agreements are temporary and may not persist beyond the personalities involved, joint venture agreements are more permanent. Once an agreement is reached, it can be revised only through the mutual consent of the parties involved. In other words, if a joint venture agreement were developed under which one or more wards in Tripler were turned over to VA, DOD could reclaim those wards only with VA's consent. It is just such an agreement that is planned to turn E-Wing over to VA. Without such an agreement, VA might renovate E-Wing into an acute care hospital and then run the risk of having DOD reclaim the newly renovated facility. We believe similar joint venture agreements could be developed to turn renovated acute care wards over to VA on a permanent basis.

VA Services in Hawaii Are Underutilized Because of Suppressed Demand

Concern

Veterans have the lowest priority for care at Tripler. Many veterans have applied for medical services, surgery, and other kinds of acute care at Tripler and have been turned down.

GAO Evaluation

Army regulations state that veterans have a lower priority for care than other DOD beneficiaries. However, at Tripler this priority list is applied only when there is a shortage of available beds. Because Tripler operates at 75- to 85-percent occupancy, the priority list for rationing care is usually not in effect, and veterans are admitted with the same priority as active duty personnel. Once admitted, all patients are treated strictly according to the needs of their medical condition regardless of their eligibility status. We found no data to support the suggestion that veterans are being turned away from Tripler except when Tripler cannot provide the specific service(s) required.

The director of the VA outpatient clinic and regional office told us in a September 10, 1991, meeting that 10 veterans had been refused admission to Tripler over the past weekend. Further information on the 10 veterans showed that they were admitted to Tripler and then referred to community providers because the treatment required for their episode of care was not available at Tripler. Tripler's commanding general told us that no VA

patient has been refused services for medical care that was available at Tripler. He said that active duty personnel and their dependents are given preference when there is a staff shortage in a given specialty that limits the number of patients that can be treated. Because VA will continue to rely on Tripler for specialty care if the new VA hospital were built, the construction of additional VA acute care beds will not overcome such problems.

Transferring one or more wards in the renovated Tripler to VA would enable VA to set its own priorities for care in the same manner that it would by constructing additional acute care beds. In other words, VA, not DOD, would control admissions and discharges of veteran patients.

Concern

Hawaii has the distinction of having the highest ratio of veterans per capita in the nation, yet has one of the lowest per capita expenditures on veterans' health care.

GAO Evaluation

Hawaii has one of the lowest ratios of veterans per capita in the nation—129.6 veterans per 1,000 civilian population age 18 and over. Only Utah, Mississippi, Kentucky, and the District of Columbia have lower ratios. Although per capita expenditures on veterans' health care in Hawaii ($378) are below the national average of $463 per veteran, they are higher than those in 15 other states. Per capita expenditures varied widely, from $260 in New Hampshire to $1,201 in South Dakota.[2]

[2]Per capita health and administrative expenditures were reported to be $14,549 in Washington, D.C. We excluded this figure from our analysis because it includes overall administrative costs for VA's central office.

Chronology of Key Events Concerning the Establishment of a VA Medical Center in Hawaii

1974

DOD began initial planning for the renovation of Tripler Army Medical Center. Tripler's E-Wing was not included in the renovation project.

May 1978

On the basis of work done at the request of Senator Inouye, GAO issued a report, Better Coordination Could Improve Provision of Federal Health Care in Hawaii (HRD-78-99, May 22, 1978). The report recommended that the renovation of Tripler be planned with other federal health care providers' needs in mind so that it would be capable of serving as the state's only federal hospital.

July 1978

The sizing of the renovated Tripler facility included 69 acute care beds for veterans and 12 for trust territory beneficiaries. This allocation was based on communications between the Administrator of Veterans Affairs and the Secretary of Defense.

October 1980

VA's Assistant Chief Medical Director for Planning and Programming informed DOD officials that VA had no intention of building acute care capacity in Hawaii.

December 1981

VA established an ad-hoc planning group to evaluate VA's role in meeting veterans' health care needs in Hawaii. The group determined that

- the acute medical, surgical, and psychiatric needs of veterans were being met and could continue to be met by the current arrangements with Tripler and the community and
- VA's need was for long-term psychiatric and nursing home beds.

The group recommended that VA acquire and renovate Tripler's E-Wing to support a 60-bed nursing home and long-term psychiatric beds. The Chief Medical Director approved the plan for renovation at an estimated cost of $42 million.

1981-84	Low-level planning and negotiations continued on the transfer of E-Wing to VA upon completion of construction and renovation work at Tripler.
1985	The Army sent VA a proposed agreement to transfer E-Wing in the fall of 1989. Tripler was also to maintain acute care beds for veterans.
May 1986	In a letter to Senator Spark Matsunaga, VA's Chief Medical Director stated that VA had not canceled plans for E-Wing and had proposed fiscal year 1989 design funding ($3.5 million) and fiscal year 1990 construction money ($31.5 million).
August 1986	VA's Office of Inspector General issued a report on the proposed E-Wing remodeling project. The report concluded that the project was not needed and should be canceled. This recommendation was based on the lack of justification for the project, poor planning, and the unusually high construction costs. Priority for the E-Wing project was reduced.
October 1986	VA's 1986 regional plan examined VA health care in Hawaii. The report made several conclusions and recommendations, including the following: • alternatives to the E-Wing project should be actively pursued; • there is not sufficient demand for inpatient services to warrant building a separate VA medical center; • VA should not develop its own surgery capability but should continue to contract for this care with Tripler and the community; and • VA should not add any additional acute care beds to the statewide system.
November 1986	In a letter to Tripler, VA said it would perform a cost-benefit analysis of several options for delivering inpatient care to veterans.
January 1987	VA's Chief Medical Director sent Senator Matsunaga letter stating that the E-Wing project was being reassessed.

April 1987

Senator Matsunaga chaired a Senate Veterans' Affairs Committee hearing on the health care needs of Hawaii's veterans. At the hearing:

- The Senator expressed concern over the time it would take VA to renovate E-Wing and the need for VA to develop interim plans to improve the availability and accessibility of services.
- Veterans expressed concern over the quality of care provided at Tripler.
- A representative from the state health planning office noted that the statewide hospital system has capacity to serve the needs of veterans and that the primary statewide health needs are in long-term care.

May 1987

In response to the Senate hearing, VA established the Hawaii Veterans' Health Care Task Force to examine the health care needs of Hawaii's veterans. The task force concluded that

- VA spends less per capita on veterans in Hawaii than certain mainland states;
- VA's utilization of inpatient care is below the national average;
- the lower utilization is evidence of suppressed demand, which is caused by (1) incomplete knowledge of benefits, (2) distance from the outpatient clinic in Honolulu, and (3) VA's firm interpretation and application of eligibility rules.

The task force made numerous recommendations, including the construction of a freestanding VA medical center composed of 105 acute care and 60 nursing home beds.

January 1988

VA's Chief Medical Director signed a decision memorandum outlining the rationale for building a medical center in Hawaii. The memorandum relied on information gathered by the 1987 task force.

March 1988

The Hawaii Implementation Plan was submitted and approved by VA's Chief Medical Director. The plan outlined a course of action for achieving the approved policy recommendations made by the task force concerning VA health care services in Hawaii. Subsequently, VA established primary care clinics on the outer islands, and the Honolulu clinic was approved for a post-traumatic stress disorder clinic team.

August 1988	The conference report on the fiscal year 1989 appropriations act directed that $3 million of VA's advance planning funds be used for start-up planning of a new VA facility in Hawaii.
June 1989	VA notified DOD that it no longer had a requirement for Tripler's E-Wing.
April 1990	At the Secretary's direction, the VA Western Region issued a report updating the analysis of options for the delivery of VA health care services in Hawaii. The report updated the bed need projections of the 1987 task force and evaluated three options to meet the health care needs of Hawaii veterans. The report found E-Wing not to be a viable option and did not consider it for in-depth analysis.
August 1990	Senate Veterans' Affairs Committee hearing chaired by Senator Daniel Akaka reviewed VA's current plans for a new VA medical facility in Hawaii. Veterans expressed frustration with the delays in the project and voiced opposition to VA's plans to require outer island veterans to travel to Oahu for care. VA's Chief Medical Director explained that unless VA requires outer island veterans to use the new facility, it will be severely underutilized.
September 1990	DOD and VA established a Joint Venture Committee. Based on a review of Tripler facilities and options for the configuration of the E-Wing, the committee developed three options to be further evaluated. One option called for VA to take control of two recently renovated wards in the main Tripler building and an existing eight-bed intensive care ward.
February 1991	The Assistant Secretary of the Army stated that staff from Tripler, the Army Surgeon General, Army Health Services, and Installations, Logistics, and Environment have reviewed the three options developed by the joint venture team and can wholeheartedly support any of them.

March 1991	VA decided to build a new VA medical center on the Tripler grounds. E-Wing will be used to locate 105 VA acute care beds. A freestanding outpatient clinic will be built adjacent to Tripler's new clinic, and a freestanding 60-bed nursing home and administrative office will be built on 12 acres of land currently being used by the Army.
August 1991	A House Veterans' Affairs Committee hearing chaired by Congressman Lane Evans was held in Hawaii. GAO testified that Tripler was built to serve VA patients and has adequate capacity to meet VA's present and future acute care bed needs.

Tripler Army Medical Center Constructed and Staffed Capacity (Oct. 1990-July 1991)

Ward type	Constructed beds	Closed beds	Staffed beds	Average daily census[a]	Percent of staffed beds occupied
Medical	100	16	84	73	87
Surgical	170	29	141	100	71
Psychiatric	96	15	81	73	90
Critical care	32	8	24	17	72
Total	**398**	**68**	**330**	**263**	**80**

Note: Excluded from this table are beds not suitable for use by VA patients, such as pediatric care beds including all wards, Tripler has a total of 517 constructed beds

[a]In fiscal year 1990 and the first three quarters of fiscal year 1991, Tripler provided care to an average of 40 VA patients per day

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

JAN 9 1992

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
Human Resources Division
U. S. General Accounting Office
441 G Street, Northwest
Washington, DC 20548

Dear Mr. Baine:

We have completed our review of your draft report VA Health Care: VA Plans Will Delay Establishment of Hawaii Medical Center (GAO/HRD-92-41). For years now, the Department has acknowledged the need for an increased VA presence and more timely medical care for Hawaii's veterans. Because this need for action is long-standing, I am very concerned about any potential change that could result in delays which are inherently costly. We will closely examine the likely effects of GAO's suggestions, which must be considered in light of these concerns. We should also note that any substantive change in plans would require full discussion with Hawaii's Congressional delegation.

With respect to your recommendation that Tripler's E-Wing be occupied almost immediately for activating nursing home care beds, there are many deficiencies in the present E-Wing that will delay immediate implementation of this recommendation.

- o The E-Wing does not comply with current code for earthquake resistance. Major seismic upgrading is expected, and the least costly solution may require a completely empty building during construction.
- o There is known asbestos present in E-Wing. The Army is removing a portion of the asbestos, but other asbestos will still be present.
- o There is no air conditioning, and the existing heating and ventilating system is old and of unknown condition.
- o Patient privacy and handicapped accessibility are almost nonexistent.
- o Life safety and fire protection do not comply with current standards.
- o There is no emergency power, and the existing electrical service is deficient, with many temporary installations not conforming to code. There is no functioning nurse call system.

Given these concerns, we will duly consider your recommendations and keep you apprised of our progress. Thank you for the opportunity to comment on your draft report.

Sincerely yours,

Edward J. Derwinski

Major Contributors to This Report

Human Resources Division, Washington, D.C.	James Linz, Assistant Director (202) 512-7116
Far East Office, Honolulu, Hawaii	Priscilla Harrison, Evaluator-in-Charge David C. Trimble, Site Supervisor Susan Cohen, Evaluator