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

HUMAN RESOURCES
DIVISION

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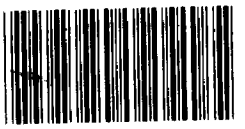
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The Honorable G. V. Montgomery
Chairman, Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

Subject: [VA's Contract Hospitalization Program: Timely Transfers of Veterans from Non-VA Hospitals to VA Medical Centers Can Reduce Costs] (HRD-81-88)

In an April 8, 1981, meeting with your office, we discussed ways that the Veterans Administration (VA) could realize savings through improved administrative controls and thereby lessen the strain of budget cuts on VA programs. Your office was interested in our review of VA's contract hospitalization program and subsequently requested that we provide you with the results of our work.

Our limited review was made to evaluate VA's procedures for transferring patients from public and private hospitals to VA health care facilities and identify areas where savings can be achieved. In summary, we found:

--VA clinics of jurisdiction 1/ did not routinely know when veterans in non-VA hospitals had stabilized enough to be moved to a VA facility. Physician-to-physician contact is necessary to effectively monitor the medical condition of veterans in contract care hospitals.

--VA clinics of jurisdiction and other VA facilities did not effectively coordinate veterans' transfers to available VA beds once they learned that it was medically feasible to move them.

1/The contract hospitalization program, in addition to other fee basis medical programs, is administered primarily by 80 VA medical centers which have been designated "clinics of jurisdiction" for this purpose.

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Also, as agreed with your office, we are sending copies of this report to the Chairmen of the House and Senate Committees on Appropriations, House Committee on Government Operations, Senate Committee on Governmental Affairs, and Senate Committee on Veterans' Affairs; the Director, Office of Management and Budget; and the Acting Administrator of Veterans Affairs. Copies will be available to other interested parties upon request.

Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 3

ENCLOSURE I

VA'S CONTRACT HOSPITALIZATION PROGRAM: TIMELY TRANSFERS OF VETERANS FROM NON-VA HOSPITALS TO VA MEDICAL CENTERS CAN REDUCE COSTS

BACKGROUND

The Veterans Administration (VA) is authorized 1/ in certain circumstances to contract with public or private hospitals for the care of veterans. VA authorizes the admission of a patient to a public or private hospital at VA expense only when (1) the medical condition necessitates emergency care, (2) a long distance of travel is involved, or (3) the nature of the treatment required makes using public or private facilities instead of VA facilities necessary or economically advisable. Except in medical emergencies, authorizations for care by non-VA hospitals at VA expense must be authorized in advance. In emergencies, this authorization can be obtained if the veteran, or someone on his behalf, notifies VA within 3 days after admission to the non-VA hospital.

According to VA regulations, a veteran will be treated in non-VA hospitals only until the patient's condition stabilizes or improves enough to permit movement to a VA medical facility. The only exception is when the veteran is scheduled for discharge from a public or private hospital and movement to a VA medical facility is impractical.

The contract hospitalization program, in addition to other fee basis medical programs, is administered primarily by 80 VA medical centers which have been designated "clinics of jurisdiction" for this purpose. VA spent about $65 million during fiscal year 1979 to provide care at non-VA hospitals for about 29,000 veterans. During fiscal year 1980, care at non-VA hospitals for about the same number of veterans cost VA about $74 million. For fiscal year 1981, VA estimates that contract hospitalization costs for about 30,000 veterans will be about $77 million (see enc. II).

In a January 1979 circular, VA clarified its policy on transferring veterans from non-VA hospitals to VA medical facilities because veterans receiving non-VA hospital care at VA expense frequently were not being transferred to VA medical facilities as early as possible. VA's Deputy Chief Medical Director noted that

--non-VA hospitals should treat authorized veterans only until their conditions permitted moving them to a VA facility and appropriate VA beds were available,

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practices for monitoring veterans in non-VA hospitals and obtain their contract hospitalization cost figures for the same period.

--Phoenix, Arizona.

--San Francisco, California.

--Bay Pines, Florida.

--Allen Park, Michigan.

--Minneapolis, Minnesota.

--St. Louis, Missouri.

--Cleveland, Ohio.

--Philadelphia, Pennsylvania.

--El Paso, Texas.

--Wood, Wisconsin.

We used telephone interviews at the above-mentioned locations because the amount and types of information we needed did not justify making site visits to these locations.

During fiscal year 1980, the Seattle VA clinic of jurisdiction authorized non-VA hospitalization at VA expense for 342 veterans throughout Washington. Of this total, 113 veterans were hospitalized over 5 days. We reviewed the medical case files for 90 of the 113 veterans in non-VA hospitals over 5 days to determine if the procedures followed by the Seattle clinic of jurisdiction were effective in transferring veterans to VA medical facilities as soon as possible. Medical case files for the remaining 23 veterans were unavailable for review. Forty-two of the 90 records contained insufficient information for us to determine if or when the veterans should have been transferred. We limited our sample to veterans hospitalized over 5 days because we believed they represent the greatest potential for transfers from non-VA hospitals to VA facilities.

We computed the cost savings by multiplying the veteran's average daily cost of non-VA hospitalization by the number of days that could have been eliminated had the veteran been transferred as soon as possible. The savings estimate was reduced by the estimated cost of transporting these veterans to VA facilities. This approach may have overstated the savings somewhat because the first few days of hospitalization are typically more expensive. However, we used this method because it was not possible to identify the specific dates of service from the hospital billings.

ENCLOSURE I

This was in line with the findings of a June 1980 VA Inspector General report conducted at the Bay Pines (Florida) VA clinic of jurisdiction. The report noted that the delays in transferring veterans from non-VA hospitals to VA facilities were primarily due to difficulties in reaching the private physician, and/or his or her lack of cooperation in determining the medical feasibility of moving the patient. The report concluded that more VA professional involvement is needed to expedite transfers of veterans from non-VA hospitals.

Private physicians play a major role in implementing VA's transfer policy because VA must rely on them to determine when moving a veteran is medically feasible. However, the chief of VA's fee service section at the Seattle clinic told us that private physicians have little incentive to transfer their patients to a VA medical facility, since they know that VA will pay for the entire stay at the private hospital. This official also said some private physicians refuse to contact a VA hospital to arrange for a transfer because of the cost of the call and problems or delays experienced in trying to contact the proper VA hospital officials.

Limited success in transferring veterans

In fiscal year 1980, the Seattle VA clinic of jurisdiction authorized non-VA hospitalization at VA expense for 342 veterans throughout Washington. Of this total, 113 veterans were hospitalized over 5 days. As the following table shows, Seattle was successful in transferring only about 10 percent of these 113 veterans from non-VA hospitals to VA medical facilities.

Period of hospitalization	Veterans hospitalized	Veterans transferred	
		Number	Percent of group
(days)			
6 to 10	70	6	9
11 to 15	24	2	8
Over 15	19	3	16
Total	113	11	10

The Seattle clinic of jurisdiction had greater success transferring psychiatric patients than medical or surgical patients as the table on the next page illustrates. The Seattle clinic transferred about 17 percent (7 of 41) of the veterans with psychiatric problems from non-VA hospitals to VA facilities. In contrast, Seattle transferred only about 6 percent (4 of 72) of the veterans with other medical problems to VA facilities.

ENCLOSURE I

	Type of medical case reviewed		
	Medical and surgical	Psychiatric	Total
Veterans whose stay in non-VA hospitals appeared proper	4	4	8
Veterans who should have been transferred	20	20	40
Veterans whose medical records were insufficient to determine when transfer should have occurred	39	3	42
Total	63	27	90

Of the 48 cases where medical records were sufficient to make a determination, we identified 40 cases in which veterans were not transferred to available VA medical facility beds as soon as their conditions permitted. We estimate that the Seattle clinic of jurisdiction could have reduced contract hospitalization costs by about $107,000 in fiscal year 1980, if these 40 veterans had been transferred from non-VA hospitals to VA medical facilities as soon as possible.

The following examples illustrate the need for VA clinics of jurisdiction to more closely monitor veterans in non-VA hospitals and coordinate their transfer to vacant VA facility beds.

--A veteran with a service-connected spinal condition entered a private hospital on May 23, 1980, with back pains. The private physician reported that he tried unsuccessfully to transfer the veteran to a VA facility before surgery on June 6, 1980. The Seattle VA hospital had 57 vacant medical and surgical beds when the veteran entered the private hospital; however, VA records do not indicate why the transfer was not made.

After surgery the patient spent 3 days in intensive care. He was transferred out of intensive care on June 9 when his condition stabilized. The veteran remained in the private hospital for an additional 24 days before being discharged. VA paid $15,118.34 for this veteran's non-VA hospitalization.

--A veteran with a 100-percent service-connected disability entered a private hospital on January 12, 1980, with injuries suffered in a motor vehicle accident. The hospital

in non-VA hospitals. The VA physician then calls the veterans' private physicians to discuss the possibility of transferring the veterans to VA facilities. The VA admitting physician continues to monitor each veteran until his condition is stable for transfer.

However, even after implementing these new procedures, we found that the Seattle VA clinic continued to have limited success in transferring veterans to VA facilities. During the first 2 months of fiscal year 1981, Seattle transferred only 1 of the 14 medical or surgical patients at non-VA hospitals for over 5 days.

The limited success was due to several factors. First, the Seattle clinic's admitting physicians attempted to monitor only veterans in non-VA hospitals within the medical center's service area, rather than the entire State of Washington where it has jurisdiction. Most of the 14 veterans were in hospitals outside Seattle's service area. Second, the Seattle clinic had not publicized, as required by VA regulations, its transfer policy or procedures to promote their acceptance by the veteran population or non-VA hospitals and physicians providing care under the contract hospitalization program.

Although many veterans enter non-VA hospitals outside the Seattle clinic of jurisdiction's service area, Seattle does not monitor the condition of these veterans to determine when they can be transferred to VA facilities. Instead, Seattle has contacted the other VA hospitals throughout Washington in an attempt to get them to monitor the veterans in their service areas. The chief of the fee service section at the Seattle clinic of jurisdiction told us that the Seattle clinic has had mixed results. She said Seattle tries to encourage the other VA hospitals to have a VA physician make contact with the private physician as the Seattle clinic is doing now, but some VA physicians refuse to do so.

This same official told us that the VA hospital in Walla Walla, Washington, still uses an administrative clerk to monitor the condition of veterans in non-VA hospitals. This approach has proven to be ineffective in identifying veterans who can be transferred to VA facilities.

The Seattle VA Medical Center director believed that each VA hospital should be responsible for monitoring the condition of veterans in non-VA hospitals within its own service areas. However, he also believed that a physician-to-physician contact must exist between VA and the private attending physician for the transfer policy to be effective.

new procedures require VA physicians to monitor them by periodically calling the attending physicians. The assistant chief told us the clinic had sent letters to hospitals and doctors throughout Florida explaining its transfer procedures.

The medical administration chiefs at the Cleveland and Philadelphia VA clinics of jurisdiction said that their procedures also call for a VA physician to be involved in monitoring veterans in private hospitals. These officials said that they initiated these procedures to make more timely transfers of veterans to VA facilities, thereby reducing contract hospitalization costs.

The VA clinics of jurisdiction at San Francisco, California; El Paso, Texas; St Louis, Missouri; Minneapolis, Minnesota; Wood, Wisconsin; Allen Park, Michigan; and Portland, Oregon, followed procedures similar to those used by the Seattle VA clinic of jurisdiction--administrative clerks did the monitoring.

VA CENTRAL OFFICE OFFICIALS AGREE THAT IMPROVED PROCEDURES ARE NEEDED

We discussed our findings with VA central office medical administration officials. These officials agreed that our findings at the VA Seattle clinic of jurisdiction were not isolated examples and that other clinics of jurisdiction had not aggressively enforced regulations requiring that veterans in non-VA hospitals be transferred to VA facilities as soon as possible. They also agreed that VA needs to establish (1) procedures for monitoring veterans in non-VA hospitals and (2) a system for monitoring compliance with established transfer policies. They said that, to be effective, the new procedures must provide for periodic communication between VA physicians and private physicians when a veteran enters a non-VA hospital.

CONCLUSIONS

VA needs to improve the management of its contract hospitalization program. Specifically, we found that:

--VA clinics of jurisdiction did not routinely know when veterans in non-VA hospitals had stabilized enough to be moved to a VA facility. Physician-to-physician contact is necessary to effectively monitor the medical condition of veterans in contract care hospitals.

--VA clinics of jurisdiction and other VA facilities did not effectively coordinate veterans' transfers to available VA beds once they learned that it was medically feasible to move them.

ENCLOSURE II

CONTRACT HOSPITALIZATION PROGRAM SUMMARY

	Fiscal year 1979 actual	Fiscal year 1980 actual	Fiscal year 1981 estimate
Total costs	$64,812,000	$73,841,000	$77,255,000
Average daily census	1,182	1,213	1,160
Length of stay (days)	15.9	15.7	14.7
Patients treated	29,268	29,456	30,000