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[Review of VA's Proposed Hospital Bed and Staff Reductions for Fiscal Year 1979]. HRD-78-134; B-133044. July 18, 1978. 2 pp. + 3 enclosures (8 pp.).

Report to Sen. William Proxmire, Chairman, Senate Committee on Appropriations: HUD-Independent Agencies Subcommittee; by Elmer B. Staats, Comptroller General.

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Congressional Relevance: Senate Committee on Appropriations: HUD-Independent Agencies Subcommittee. Sen. William Proxmire.

An investigation was conducted of the Veterans Administration's (VA's) rationale for cutting over 3,000 operating hospital beds and associated staff from its hospital system. Over the past decade, VA hospitals have been treating a larger number of patients with fewer beds. During that period, about 20,000 hospital beds have been eliminated from the VA system because of improved staffing and an increase in the use of alternatives to hospitalization. To prevent the reduction of personnel and beds from impairing operations at an individual facility, the VA decided to attempt to close entire units such as wards. It was also decided that hospitals which were treating a high percentage of veterans for nonservice-connected conditions should lose more beds than those hospitals with a low percentage of such veterans. The following criteria were used to determine the locations and numbers of beds to be cut: construction and renovation requirements, patient privacy considerations, and occupancy rates. Most of the bed cuts were based on low occupancy rates. However, the VA did not identify the reasons for low or high occupancy rates; analysis of these factors could provide the VA with a basis to assess a hospital's performance and identify opportunities for improvement. It does not appear that the bed and staffing cuts will seriously affect VA hospital operations, and the bed and staffing cut is not a cut in the strictest sense because the cut positions are to be redistributed to other facilities. (HRS)

7038

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133044

JULY 18, 1978

The Honorable William Proxmire
Chairman, Subcommittee on
HUD-Independent Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

Your letter of March 30, 1978, requested that we review the Veterans Administration's (VA's) rationale for its proposed reduction of 3,132 operating beds in its hospital system for fiscal year 1979 as well as the reasons for the associated staffing and funding reductions.

Enclosure I to this letter describes in detail the results of our review. We briefed your staff on the general contents of this report on May 3, 1978.

VA's main rationale for selecting hospitals to absorb the bed "cuts" was to generally pick facilities with low occupancy rates. The announced reductions are not reductions in the strictest sense because the positions and funds associated with the beds being cut are to be redistributed among various VA health care facilities. Some of the hospitals which are to receive cuts will, in fact, actually show a net increase in staffing due to program expansion.

It should be emphasized that our review was limited in its scope to an evaluation of VA documents and interviews with key VA officials because you required that we complete our review in time for markup on VA's appropriation bill for fiscal year 1979. Also, for this reason, we did not obtain written comments from VA. We did, however, discuss a draft of the report with program officials in VA's Department of Medicine and Surgery, who expressed agreement with it.

HRD-78-134
(40168)

At your request, copies of this report are being sent to the Chairman, Subcommittee on HUD-Independent Agencies, House Committee on Appropriations; the Director, Office of Management and Budget; the Administrator of Veterans Affairs; and other interested parties on request.

Sincerely yours,

Comptroller General
of the United States

Enclosures - 2

ENCLOSURE I

STUDY OF THE VETERANS ADMINISTRATION'S PROPOSED BED AND STAFF REDUCTIONS FOR FISCAL YEAR 1979

INTRODUCTION

In a letter of March 30, 1978, the Chairman, Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, requested us to conduct an investigation of the Veterans Administration's (VA's) rationale to cut over 3,000 operating hospital beds and associated staff and funds from its hospital system. The Chairman noted that a low occupancy rate appeared to be the primary reason for selecting the hospitals where beds would be cut. He was concerned as to whether (1) the staffing and funding cuts should be directly tied to the number of beds reduced and (2) due consideration was being given to other factors, such as lengths of stay at the affected hospitals.

Background

Over the past decade VA hospitals have successfully been treating a larger number of patients with fewer beds. During that period about 20,000 hospital beds have been eliminated from the VA system. This has been made possible by improved staffing and an increase in the use of alternatives to hospitalization, such as outpatient care, hospital-based home care, personal care, and domiciliary and nursing home programs.

In its 1979 budget deliberations, the Office of Management and Budget (OMB), required VA to offset 1,500 of the additional full-time equivalent employees (FTEE) positions VA had requested by redistributing existing hospital positions. To facilitate this redistribution, OMB required VA to cut 2,300 operating beds and 0.6 FTEE per cut bed. This action was estimated to reduce costs by about $32 million. OMB also told VA that, in making the cut, no hospital could be closed.

VA had previously planned to remove, without associated staff cuts, over 600 beds from service because of replacement or renovation requirements. Coupling these cuts with OMB's required reduction resulted in a total reduction of 3,132 beds and reduced the FTEE cut from 0.6 to slightly less than 0.5 per cut bed.

ENCLOSURE I

Although beds are being cut, the associated staffing and funding cuts are more accurately described as a reallocation or redistribution of resources. Of the 76 hospitals scheduled for bed and staff cuts, 56 will actually be receiving new FTEEs if the fiscal year 1979 budget request is approved. At least nine of the hospitals will be gaining more employees than they are presently scheduled to lose.

Enclosure II shows the hospitals where the bed cuts are proposed, the number of beds to be reduced, and the reason for the cuts.

METHODOLOGY USED BY VA TO MAKE REDUCTIONS

To prevent the reduction of personnel and beds from seriously impairing operations at an individual facility, VA decided to attempt to close entire units, such as wards. VA also decided to (1) generally limit the reduction to no more than 70 beds and 35 FTEEs at any one facility and (2) not cut a specialty ward if it was the only one of its type at a facility.

In the process of identifying the facilities where the bed cuts were to occur, VA decided that hospitals treating a high percentage of veterans for nonservice-connected conditions should lose more beds than those hospitals treating a low percentage of such veterans.

VA computed a system-wide percentage of veterans treated for nonservice-connected conditions. Hospitals which exceeded the system-wide percentage by a certain degree were considered to be treating a high percentage of veterans with nonservice-connected conditions; and those which fell below the system-wide percentage by a certain degree were considered to be treating a low percentage of veterans for nonservice-connected conditions. According to VA records this effort was successful because hospitals treating a high percentage of veterans for nonservice-connected conditions lost, in total, four times as many beds as those hospitals treating a low percentage of veterans for nonservice-connected conditions.

ENCLOSURE I

VA also attempted to maintain the same bed mix VA-wide before and after the cut. According to VA records, although too many psychiatric and surgical beds and too few medical beds were cut to retain the exact mix VA-wide, the differences in the total VA bed mix before and after the reduction do not appear to be significant. The percentages for medical, surgical, and psychiatric beds changed less than 1 percent in each case.

After considering these matters, VA used the following to determine the locations and numbers of beds to be cut:

--construction and renovation requirements,

--patient privacy considerations, and

--occupancy rates.

Construction and renovation requirements

A total of 637 beds are proposed to be cut at 20 hospitals because of construction or renovation. According to VA records, 177 beds will be cut as a result of correction of VA's Life Safety Code deficiencies. For example, where a dead end wing exists, the Code requires an exit be not more than 30 feet from the door of the furthest room. Space used for construction of this exit may have to use existing bed space and this could result in a loss of several beds. An additional 170-bed reduction will occur because two new replacement hospitals--Martinsburg and Bronx--will have fewer beds than the structures being replaced. The remaining 290-bed loss will result from general construction and renovation projects at various hospitals. A common cause for this loss occurs when a specialty care unit, such as a respiratory care unit, is created and housed in a ward. The associated equipment and working space needed for the special care uses existing bed space.

Patient privacy considerations

A total of 328 beds in 11 hospitals are proposed for elimination due to the need for increased patient privacy. Because the Joint Commission on Accreditation of Hospitals' requirements for square footage per patient were greater than the space the patients presently have,

the renovations taking place to correct this problem will result in fewer beds in the same space.

Occupancy rate

A cut of 2,167 beds is proposed for 60 hospitals because of low occupancy rates. VA officials told us that the optimal occupancy rate for a general medical or surgical (GM&S) hospital is 80 percent and for psychiatric facilities 85 percent. VA generally selected for bed cuts GM&S and psychiatric hospitals which had occupancy rates below these optimums.

It should be noted that reductions due to low occupancy were spread among many hospitals because of VA's desire not to cause undue hardship on any particular hospital or type of hospital. Maximum bed loss at an individual facility due to low occupancy was 70 beds. 1/ As a result of the cuts, many of these hospitals' occupancy rates will meet or exceed the optimum levels, while the rest will, at the least, show improvement in their rates.

OBSERVATIONS ON VA'S METHODOLOGY

Most of the bed cuts were based on low occupancy rates. Low occupancy appears to be the best way of identifying locations where bed cuts are made. However, it should be noted that VA did not identify the reasons for high or low occupancy rates. A hospital's occupancy rate is a function of patient demand and length of stay in relation to total capacity. Analysis of these factors to identify the reasons for high or low occupancy rates should provide VA with a basis to assess a hospital's performance and identify opportunities for improvement.

1/The Long Beach VA Hospital lost 300 of its nearly 1,600 total beds. A loss of 275 beds, 50 FTEEs, and $836,000 had been agreed to prior to this current reduction. Hence only 25 beds, 15 FTEEs, and $223,000 are attributable to this current reduction.

ENCLOSURE I

Directly relating beds to staff is inappropriate

We believe that OMB's requirement that staff cuts be directly associated with bed cuts has resulted in some inequities that probably could have been avoided or at least minimized. The reason for this is because many of the beds cut at the hospitals were not being used and the staff which had been assigned to these beds had already been relocated to other beds in the hospital. This action has increased the staff-to-patient ratio which should lead to more effective medical care to the individual patients. Under the OMB requirement, however, a hospital losing unstaffed beds must make cuts from a staffed bed.

Another problem occurring when relating staff to beds is that not all hospitals have the same staff-to-patient ratio. Thus the efficiency of a hospital with a low ratio is affected considerably more than a hospital with a high ratio. For example, VA officials told us that Murfreesboro, Tennessee, and Togus, Maine, hospitals are going to be the most adversely affected hospitals because these facilities had a low staff-to-patient ratio before the bed cuts were ordered.

VA officials emphasized to us that if OMB had allowed VA to cut staff and beds independently of each other, the cuts would have been more equitably and easily made. Also, hospital directors are continually wanting to cut beds they no longer need but hesitate because they fear staff will also be cut.

We believe that by separating the two types of reductions, VA could cut beds from one hospital but cut staff from another, or cut more staff from a hospital with a high patient staff ratio than from a facility with a lower ratio. VA would then be able to more fairly make the necessary redistribution of staff and funds.

Effects of cuts on hospital operations

It does not appear that the bed and staffing cuts will seriously affect hospital operations for the majority of those suffering cuts. VA officials told us that some hospitals will be adversely affected, but only identified

those in Murfreesboro and Togus. Only 19 of the 76 hospitals will have a reduction of more than 2 percent in either staffing or funding. Only four hospitals will receive a cut of more than 4 percent in staffing or funding. These figures do not include the planned increases in staffing for fiscal year 1979. (See enc. III.) If these increases in FTEE's and attendant funding were included, the number of hospitals receiving reductions of 2 percent or more would decrease.

Similarly, it does not appear that personnel reduction-in-force actions will be necessary. The VA attrition rate for medical care occupations is about 15 percent a year. Thus, over 1,000 positions a month should normally be vacated. It would appear, therefore, that all affected stations should experience sufficient attrition over a period of several months to accomplish the staffing cuts.

CONCLUSIONS

VA's main rationale for selecting hospitals to receive bed and staff cuts was low occupancy rates. The announced bed and staffing cut is not a cut in the strictest sense because the cut positions are to be redistributed to other facilities. Almost one-half of the hospitals being cut will actually receive additional staff if the fiscal year 1979 budget is approved. Nine of the hospitals are scheduled to gain more employees than they are suppose to lose.

With the possible exception of the Murfreesboro and Togus hospitals, it does not appear that the bed and staffing cuts will seriously affect VA hospital operations. Only 19 of the 76 hospitals will have a reduction of more than 2 percent in either staffing or funding. Only 4 of the 76 hospitals will receive a cut of more than 4 percent in staffing or funding. It appears that the attrition rate is sufficiently high to preclude any reduction-in-force actions at the affected hospitals.

ENCLOSURE II

ENCLOSURE II

PROPOSED BED CUT
AND
REASON FOR CUT

	Low occupancy rate	Construction renovation/replacement	Patient privacy	Total bed reduction
Allen Park, Mich	37			37
Altoona, Pa.	19		12	31
Ann Arbor, Mich.	38			38
Atlanta, Ga.	32			32
Augusta, Ga.	16	54		70
Baltimore, Md.	10			10
Battle Creek, Mich.	70			70
Bedford, Mass.	29	5		34
Big Spring, Tex.	18			18
Brentwood, Calif.	20			20
Bronx, N.Y.		98		98
Brooklyn, N.Y.	60			60
Butler, Pa.	25			25
Chicago, Ill. (Lake Side)	21			21
Chicago, Ill. (West Side)		19		19
Chillicothe, Ohio	25			25
Cleveland, Ohio	70			70
Columbia, Mo.	30			30
Danville, Ill.			53	53
Dayton, Ohio	18	15		33
Des Moines, Iowa	26			26
Dublin, Ga.	16	5		21
East Orange, N.J.		27		27
Fort Lyon, Colo.		68		68
Fresno, Calif.	28			28
Grand Island, Nebr.	10			10
Hines, Ill.			10	10
Houston, Tex.	40			40
Indianapolis, Ind.	21		39	60
Iowa City, Iowa	34			34
Kansas City, Mo.	22			22
Knoxville, Iowa	10			10
Leavenworth, Kans.	23	12		35
Lincoln, Nebr.	29			29
Little Rock, Ark.	21			21
Long Beach, Calif.	29	25		54
Louisville, Ky.	300			300
Lyons, N.J.	21			21
Madison, Wisc.	36	34		70
Marion, Ill.	47			47
Marion, Ind.			4	4
Martinez, Calif.	41		77	77
Martinsburg, W. Va.				41
Miami, Fla.	33	72		72
Minneapolis, Minn.	64			33
Montrose, N.Y.	52			64
Murfreesboro, Tenn.				52
New Orleans, La.		45	45	90
New York, N.Y.	66	28		28
North Chicago, Ill.	12			66
Northport, N.Y.	10		22	34
Oklahoma City, Okla.	30			10
Omaha, Nebr.	27			30
Palo Alto, Calif.	56			27
Perry Point, Md.				56
Pittsburgh, Pa. (Univ. Div.)	31	26		26
Roseburg, Oreg.				31
Saginaw, Mich.	30	9		9
St. Louis, Mo.				30
Salisbury, N.C.	33		25	25
Salt Lake City, Utah	26			33
San Antonio, Tex.	30	6		32
San Diego, Calif.	45			30
San Francisco, Calif.				45
Sepulveda, Calif.	60	14	14	28
Shreveport, La.	27			60
Syracuse, N.Y.	31			27
Temple, Tex.	3			31
Togus, Maine			27	35
Tuskegee, Ala.	36	60		60
Wadsworth, Calif.	40			36
Walla Walla, Wash.	31			40
West Haven, Conn.	40			31
Wichita, Kans.	7			40
Wood, Wisc.	30	15		22
	2,167	637	378	50
				3,132

ENCLOSURE III

NET EFFECT ON HOSPITALS

RECEIVING STAFF INCREASES (note a)

Hospital	Requested staff increases: New hospital	Specialized medical program	Other new facilities	Proposed reduction	Net effect
Augusta, Ga.	+169			- 35	+134
Baltimore, Md.		+ 5		- 5	-
Battle Creek, Mich.			+ 4	- 35	- 31
Brooklyn, N.Y.			+ 1	- 30	- 29
Bronx, N.Y.	+ 62	+10		- 50	+ 22
Chicago (WS), Ill.			+ 4	- 10	- 6
Chillicothe, Ohio			+ 17	- 13	+ 4
Cleveland, Ohio		+ 5		- 35	- 30
Dayton, Ohio			+ 70	- 17	+ 53
Des Moines, Iowa			+ 14	- 11	+ 3
Fresno, Calif.			+ 2	- 5	- 3
Houston, Tex.			+ 10	- 30	- 20
Iowa City, Iowa			+ 8	- 11	- 3
Kansas City, Mo.		+10		- 10	-
Lincoln, Nebr.			+ 8	- 11	- 3
Long Beach, Calif.			+ 42	- 65	- 23
Louisville, Ky.			+ 18	- 11	+ 7
Madison, Wisc.			+ 92	- 24	+ 68
Marion, Ind.			+ 1	- 39	- 38
Martinez, Calif.			+ 5	- 21	- 16
Miami, Fla.			+ 10	- 17	- 7
Minneapolis, Minn.			+ 11	- 32	- 21
Montrose, N.Y.		+10	+ 12	- 27	- 5
Murfreesboro, Tenn.		+10		- 46	- 36
New Orleans, La.		+10		- 14	- 4
Omaha, Nebr.			+ 1	- 14	- 13
Palo Alto, Calif.			+ 48	- 28	+ 20
Perry Point, Md.			+ 10	- 13	- 3
San Diego, Calif.			+ 13	- 23	- 10
San Francisco, Calif.			+ 2	- 14	- 12
Sepulveda, Calif.			+ 11	- 30	- 19
Shreveport, La.			+ 2	- 14	- 12
St. Louis, Mo.		+10		- 13	- 3
Syracuse, N.Y.			+ 15	- 16	- 1
Togus, Maine			+ 10	- 31	- 21
Wadsworth, Calif.			+ 35	- 20	+ 15
	+231	+70	+476	-820	-43

a/VA was unable to provide the precise placement of 367 additional new positions--85 for other new facilities, and 287 for education and training. It is possible some of these staff increases are to be made at the 76 hospitals proposed to lose staff.