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Report to the Chairman, Subcommittee on Oversight and Investigations Committee on Veterans' Affairs House of Representatives

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VA HEALTH CARE

Variabilities in Outpatient Care Eligibility and Rationing Decisions

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The Honorable Lane Evans
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

This responds to your request concerning veterans' access to Department of Veterans Affairs outpatient care.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, copies of this report will be sent to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties.

This report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues, who may be reached on (202) 512-7101 if you or your staff have any questions about this report. Other major contributors to this report are listed in appendix VI.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Enclosure

Executive Summary

Purpose

The Department of Veterans Affairs (VA) operates the largest health care system in the United States, serving veterans in 158 medical centers. One of VA's goals is to provide high-quality medical care to eligible veterans. In recent years, veterans have complained that some centers were denying outpatient care to certain veterans while other centers were serving all veterans. The Chairman of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, questioned whether veterans have equal access to VA care systemwide. Specifically, the Chairman asked GAO to examine how VA (1) determines veterans' eligibility for outpatient care and (2) rations such care when resources are insufficient to serve all eligible veterans.

Background

VA medical centers served about 2.5 million veterans in fiscal year 1991, at a cost of about $12 billion. Through its medical centers, VA provides inpatient and outpatient services in medical specialty areas, ranging from cardiology and chemotherapy to dermatology and substance abuse. Veterans made about 23 million visits to VA outpatient clinics in fiscal year 1991.

The Congress established outpatient eligibility criteria, which are generally based on the veteran's medical condition or military service. For example, veterans are eligible for care related to a service-connected disability. For most veterans, however, eligibility for outpatient care for nonservice-connected conditions depends on whether care is needed to "obviate the need for hospitalization."

Recognizing that resources may not always be sufficient to treat all eligible veterans, the Congress prescribed priorities for VA to use when providing outpatient care. In general, these priorities require that veterans with service-connected disabilities be cared for before those without service-connected disabilities, and, of the veterans without such disabilities, those with lower incomes before those with higher incomes. Rationing is the term that GAO uses to describe situations in which VA medical centers implement such priorities when resources are insufficient to care for all veterans.

To evaluate VA's implementation of outpatient eligibility requirements, GAO used medical profiles of six veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations. In addition, GAO used a questionnaire to collect information from VA's 158 medical centers to determine the number of

medical centers rationing outpatient care and to identify the different types of outpatient care rationed. Also, GAO judgmentally selected seven medical centers to examine policies and procedures regarding eligibility and rationing determinations.

Because each medical center offers a unique combination of medical services to veterans, GAO used only those services available at a center for the highest priority veterans as a base-line when determining whether a medical center rationed outpatient care to other veterans. Therefore, if a medical center did not provide a certain service in its normal day-to-day operations, GAO did not consider the service to be rationed.

Results in Brief

Veterans' access to outpatient care at VA medical centers varies widely. The reasons are twofold: first, medical centers throughout the country interpret VA outpatient eligibility criteria differently; and second, medical centers' rationing decisions vary, including whether to ration and what rationing method to use. This results in veterans with similar medical conditions or income status receiving outpatient care at some medical centers but not at others.

VA medical centers used varying interpretations of the statutory outpatient eligibility criteria. The obviate the need for hospitalization criterion is difficult to define and consistently apply at the clinical level because it is based on subjective judgment. When GAO asked physicians at 19 medical centers to determine outpatient eligibility for six veterans with various medical conditions, GAO found that none of the veterans was consistently determined to be eligible or ineligible. For each veteran, some medical centers determined that the veteran was eligible, while others determined the same veteran to be ineligible.

Rationing of discretionary outpatient care to veterans also varied significantly among medical centers in fiscal year 1991. GAO found that 118 centers rationed some outpatient care, and 40 centers did not ration care. Individual centers also chose different methods to ration care, which resulted in different combinations of veterans receiving care at each medical center. For example, GAO found veterans with comparable conditions who received outpatient care at some medical centers but would not have received care at others. Further, at some centers, some higher income veterans received outpatient care for certain conditions when lower income veterans did not receive care for other conditions.

Principal Findings

Varying Eligibility Interpretations Lead to Inconsistencies in Access

To obviate the need for hospitalization is an ambiguous and difficult concept to define to achieve consistent results at all medical centers. VA physicians at the medical centers and in the Office of the Under Secretary for Health acknowledged that ambiguities caused by the obviate the need criterion have led to inconsistencies in veterans' access to outpatient care. A top VA Ambulatory Care official said that it is difficult to define because the term has no clinical meaning. Its definition can vary among physicians or even for the same physician.

GAO found widely ranging outpatient eligibility determinations among medical centers. For example, physicians in 5 of the 19 medical centers determined that all six of the veterans GAO profiled were eligible for outpatient care, indicating a permissive interpretation of the criterion. In contrast, physicians in three other centers used a much more restrictive interpretation of the criterion and determined only two of the six veterans eligible for care. The other 11 centers' interpretation of the criterion fell somewhere between permissive and restrictive.

The effect on veterans is that eligibility for outpatient care generally depends on which center they visit. For example, a veteran received a triple coronary artery bypass in 1988 and received medications and routine outpatient care at a VA medical center on the West Coast. In February 1992, after he had moved, a Midwest center told him he was ineligible for routine care for this condition because his condition was "very stable." The veteran stated that, if he had known he would not be eligible for care in his new location, he would not have moved.

Rationing Decisions Contribute to Inconsistencies in Access to Care

The law establishing priorities for providing discretionary outpatient care does not indicate whether priorities should be determined on a systemwide basis or individual medical center basis. Administratively, VA has delegated rationing decisions to individual medical centers, and each center makes choices concerning the extent to which it will ration care based on assessments of its available resources for the year.

In fiscal year 1991, VA medical centers' rationing of discretionary outpatient care varied widely. While 40 medical centers did not ration outpatient care, 118 did. Of the 118 medical centers that rationed care,

- 69 did so only to higher income veterans;
- 27 did so to higher and lower income veterans; and
- 22 did so to veterans with higher incomes, lower incomes, and service-connected disabilities.

Medical centers used different methods to ration care. Medical centers rationed discretionary outpatient care by

- income levels (for example, limiting care to higher income veterans while providing care to lower income veterans);
- medical service (for example, limiting care in certain specialty clinics while providing care in other clinics);
- medical condition (for example, limiting care to veterans with less serious conditions while providing care to veterans with more serious conditions); or
- some combination of these methods.

The method chosen to ration outpatient care affects which veterans—higher income, lower income, or those with service-connected disabilities—do not receive care and, therefore, contributes to the inconsistencies in access to discretionary care. For example, one medical center, using medical service as a rationing method, limited services in its neurology clinic. As a result, a lower income veteran with a neurological condition would have been turned away while a higher income veteran with a non-neurological condition, such as diabetes, would have received care in other clinics. By contrast, another medical center that rationed services by income level would have turned away the higher income veteran with diabetes and treated the lower income veteran with the neurological condition.

Recommendation to the Secretary of Veterans Affairs

The Secretary of Veterans Affairs should either develop and propose to the Congress alternative eligibility criteria that produce greater consistency among medical centers in eligibility determinations or provide better guidance to centers so that clinicians may achieve more consistent determinations when interpreting the current criteria.

Matter for Consideration by the Congress

If the Congress prefers that the current priorities for discretionary outpatient care be implemented consistently on a systemwide basis, it should direct the Secretary of Veterans Affairs to develop a different system for allocating its resources to the medical centers so that veterans

within the same priority categories, to the extent practical, are provided access to discretionary outpatient care at each medical center.

Agency Comments

GAO provided a draft of this report to the Secretary of Veterans Affairs and discussed its findings with officials whom he designated to comment on the report. In general, VA agreed that medical centers have used varying interpretations of statutory criteria when determining veterans' eligibility for outpatient care. VA also generally agreed that medical centers' rationing practices have varied widely systemwide. VA plans to provide an eligibility reform proposal for consideration by the Congress and, in fiscal year 1994, to implement a new resource allocation process. VA believes these actions will address the types of service variabilities that GAO found.

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Abbreviations

VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Introduction

In February 1991, the House Committee on Veterans' Affairs heard testimony that some Department of Veterans Affairs (VA) medical centers were denying outpatient care to certain veterans while other centers were serving all veterans seeking such care. In one instance, a veteran reported that he received medication at one VA medical center but, after moving to a different part of the country, another center refused to provide him the same medication.

The Chairman of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, asked us to examine (1) how VA determines veterans' eligibility for outpatient care and (2) how medical centers ration outpatient care when they lack sufficient resources to serve all eligible veterans requesting such care.

VA Health Care System

VA medical centers served about 2.5 million veterans in fiscal year 1991 at a cost of about $12 billion. The Veterans Health Administration (VHA) operates VA's 158 medical centers, which include 171 hospitals and 240 outpatient clinics. Through these centers, VA provides outpatient services in medical specialty areas, ranging from cardiology and chemotherapy to dermatology and substance abuse. Veterans made about 23 million visits to outpatient clinics in fiscal year 1991.

Eligibility Criteria for Outpatient Care

Outpatient eligibility at VA medical centers is generally based on veterans' medical condition or status during military service.[1] Veterans are eligible to receive outpatient care for medical conditions incurred or aggravated during military service. Most veterans are also eligible for outpatient treatment of conditions unrelated to a service disability if the care is needed to

- obviate the need for hospitalization or
- prepare for hospitalization or complete treatment after hospitalization.

It is VA policy for medical center staff to make an eligibility determination each time a veteran applies for care or is scheduled for treatment in a clinic. (See app. I for a more detailed description of veterans' eligibility criteria.)

[1]See 38 U.S.C. section 1712 for veterans' eligibility requirements for VA outpatient services, including rationing priorities.

Priorities for Rationing Outpatient Care

Before July 1988, VA was to provide outpatient medical care to all eligible veterans on a space-available basis. After July 1988, it became mandatory that VA provide outpatient care to certain eligible veterans, such those seeking care for service disabilities. For other veterans, VA outpatient care remains discretionary; that is, VA may provide care according to prescribed priorities if it has sufficient resources.

When resources are insufficient to care for all eligible veterans, centers ration discretionary outpatient care to veterans without service-connected disabilities before rationing to those with service-connected disabilities. For those with nonservice-connected disabilities, care is rationed first to higher income veterans before those with lower incomes. Centers may ignore these priorities, however, if compelling medical reasons such as emergent conditions exist. (See app. I for the specific priorities for rationing.)

Scope and Methodology

We reviewed VA's regulations, policies, and procedures on outpatient eligibility and rationing and discussed them with numerous officials in VA's Office of the Under Secretary for Health, VA's Office of General Counsel, and a veterans' service organization that conducted a study that focused, in part, on veterans' eligibility issues. In addition, we reviewed reports relating to VA's delivery of outpatient care services, including reports by VA's Office of Inspector General.

To obtain a nationwide perspective, we sent a questionnaire to 158 VA medical centers and they all responded. In addition, we used the questionnaire information to select seven medical centers to visit. We selected centers to visit that rationed outpatient care and ones that did not ration care. We selected some centers based on the types of outpatient care that they rationed. The seven VA medical centers we selected were located at Bay Pines, Florida; Boise, Idaho; Boston, Massachusetts; Gainesville, Florida; Iowa City, Iowa; Manchester, New Hampshire; and Tampa, Florida.

To examine how VA determines veteran eligibility for outpatient care at the seven medical centers visited, we interviewed officials responsible for interpreting and implementing VA's outpatient eligibility guidance. In addition, to examine how centers used eligibility criteria to make outpatient eligibility determinations, we used medical profiles of six veterans developed from actual medical center records. We selected 19 medical centers that reported on our questionnaire that they were not

rationing outpatient care. This helped ensure that we were dealing with eligibility determinations, not rationing decisions. We discussed the veterans' profiles with either the respective centers' Associate Chiefs of Staff or Chiefs of Staff for Ambulatory Care who determined if the veterans in our profile met VA's outpatient eligibility criteria.

To examine how VA rations discretionary outpatient care, we used the nationwide questionnaire to identify (1) VA medical centers that rationed discretionary outpatient care in fiscal year 1991 and (2) the different types of outpatient care these centers rationed.

The questionnaire responses may have understated the extent to which medical centers rationed discretionary outpatient care. During our medical center visits, we discovered that some centers constrain or relax the outpatient eligibility criterion in response to resource availability. Although some medical centers claimed this was an eligibility decision and not a rationing decision, we believe adjusting the eligibility criterion in response to resource availability is a rationing decision. In addition, not all the medical centers we visited included in their questionnaire responses all the types of outpatient care that they rationed.

During visits to seven centers, we confirmed whether the centers were rationing discretionary outpatient care, identified the methods the centers used to ration care, and ascertained whether the centers had imposed limitations on outpatient care that were not reflected in their questionnaire responses.

In determining whether a medical center rationed outpatient care to veterans, we included only the available services at that medical center. If a center did not provide a particular service to its top priority veterans as part of its normal day-to-day operations, we did not consider that service to be rationed. In addition, our definition of rationing includes only medical centers that were advising veterans to seek care elsewhere.

We conducted our review between April 1991 and February 1993 in accordance with generally accepted government auditing standards.

Varying Interpretations of Outpatient Eligibility Criterion Lead to Inconsistencies in Access

VA has broadly defined the statutory eligibility criterion, to obviate the need for hospitalization; consequently, medical centers' staffs have based eligibility decisions primarily on subjective judgments. Medical centers' interpretation of the criterion varies, and medical centers differ on whether certain veterans are eligible or not. This leads to inconsistencies in veterans' access to outpatient care, frequently causing veterans to find that they are eligible for care at one center but not at another.

Medical Centers Interpret Outpatient Eligibility Criterion Differently

Medical centers' interpretation of the criterion ranges from permissive (care for any medical condition) to restrictive (care for only certain medical conditions). As a result, veterans with similar medical conditions can be eligible for outpatient care at one medical center but ineligible at another.

To implement the outpatient eligibility requirement to obviate the need for hospitalization, VA provided guidance to its medical centers that says that the medical determination

> "... shall be based on the physician's judgement that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated, would reasonably be expected to require hospital care in the immediate future.... Routine treatment of a chronic condition which would not require hospitalization if left untreated is inadequate justification for placement or retention of a veteran in an [outpatient/ambulatory] care program...."

Obviate the Need for Hospitalization Interpretations Vary

Medical centers' interpretations of obviating the need for hospitalization when determining outpatient eligibility range from every medical condition meeting the criterion to certain medical conditions meeting it. For example, two medical centers we visited defined the criterion permissively. Officials at both medical centers said that any medical condition would meet the criterion. Therefore, any veteran needing outpatient medical care at these two centers would be considered eligible.

In contrast, two other medical centers we visited defined the criterion restrictively. At one center, officials stated that to be eligible based on obviating the need for hospitalization, a veteran's medical condition would have to be severe enough that, if left untreated, the veteran would require hospitalization within 30 days. At the other center, the officials said that a veteran with an unstable condition would be considered eligible for care, but, as soon as the condition was stabilized, the veteran would be

considered ineligible for continued clinic follow-up. For example, a veteran with unstable diabetes would be eligible to receive medications. Once the veteran's condition became stable, however, the veteran would be considered ineligible for routine care for diabetes. The veteran would be given a 30-day temporary supply of medication for diabetes and told to seek continuing routine care from a non-VA source.

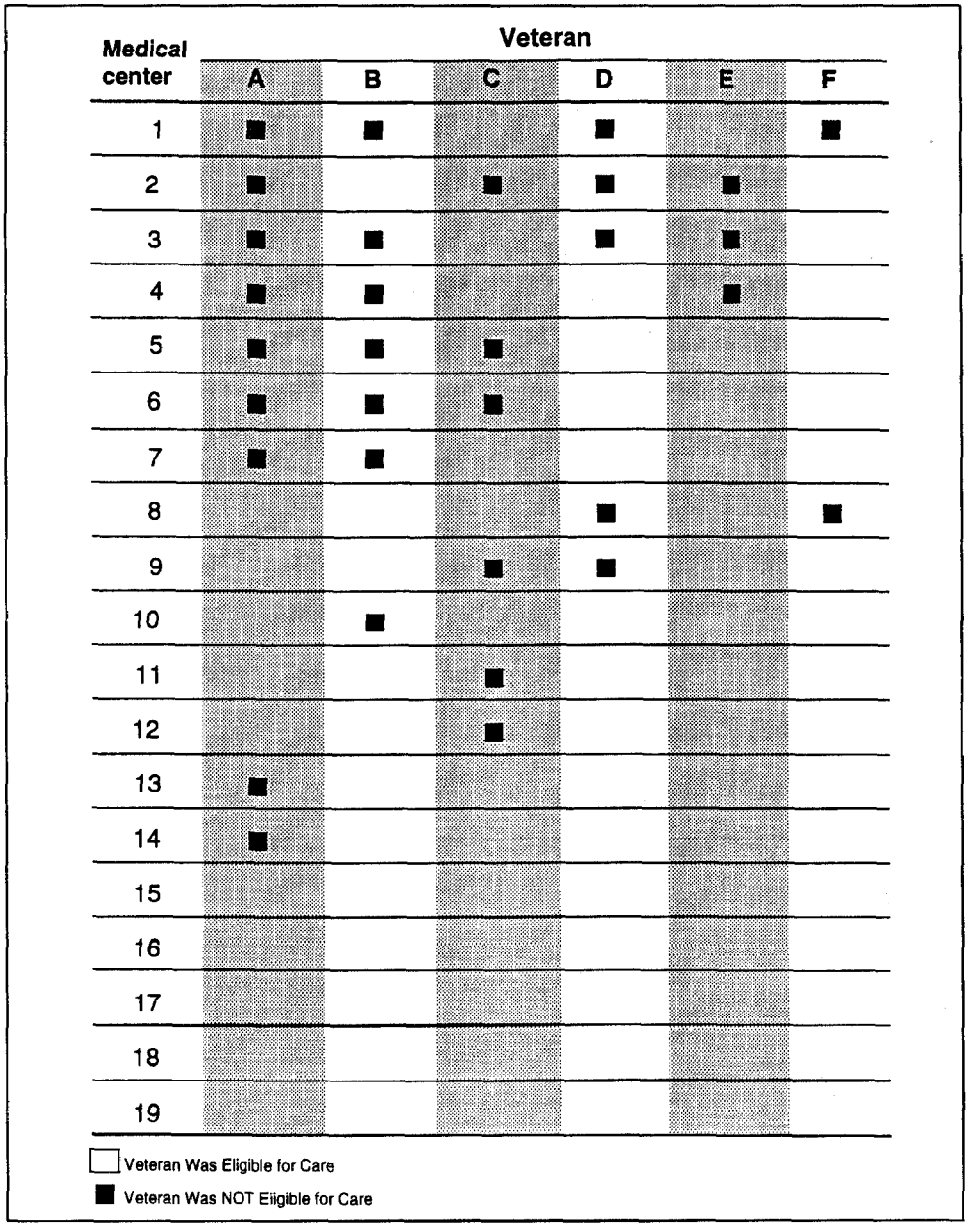
Medical Centers' Varied Interpretations Cause Inconsistent Eligibility Determinations

Disparities exist in the medical centers' determinations of veterans' eligibility for outpatient care that are based on obviating the need for hospitalization. We called ambulatory care officials at 19 medical centers and provided them with the same information about six veterans, including the veterans' descriptions of the medical condition needing treatment, vital signs, and results of any diagnostic tests done.[1] We asked those officials to determine if the veterans would be eligible for outpatient care.

As shown in figure 2.1, 5 of the 19 medical centers determined all six veterans eligible for outpatient care, thus used a permissive interpretation of the criterion. In contrast, three centers determined only two of the six veterans eligible for care, thus used a much more restrictive interpretation of the criterion. The other 11 centers' interpretations fell between permissive and restrictive.

[1]Appendix II describes the medical conditions of the six veterans.

Figure 2.1: Nineteen VA Medical Centers' Outpatient Eligibility Determinations for Six Veterans



Note: Data were sorted by medical center based on the number of veterans determined ineligible (from restrictive to permissive).

The potential effect on veterans is that their eligibility depends to some extent on which medical center they visit. None of the six veterans was consistently determined to be either eligible or ineligible by all 19 centers: any one of the six veterans seeking care at the 19 centers would be eligible for care at some centers but ineligible at others. For example, if veteran "A" had visited all 19 VA medical centers, he would have been determined eligible by 10 centers but ineligible by 9 centers.

This variability can have important consequences for veterans who change residences, as the following case shows. A veteran received a triple coronary artery bypass in 1988 and received medications and routine outpatient care at a VA medical center on the West Coast. In February 1992, after the veteran moved to the Midwest, officials at a VA center there told him he was ineligible for routine care for this condition because his condition was "very stable." The veteran stated that, if he had known he would not be eligible for routine care in his new location, he would not have moved.

The Criterion Is Difficult to Define and Apply

VA physicians at the medical centers we visited and in VA's Office of the Under Secretary for Health acknowledged that ambiguities in interpreting the obviate the need for hospitalization criterion lead to inconsistencies in veterans' access to outpatient care. The Deputy Associate Deputy Chief Medical Director for Ambulatory Care said that, because the term has no clinical meaning, its definition can vary among physicians or even for the same physician.

Officials at the medical centers agree that the criterion is inadequately defined. In a memorandum outlining outpatient eligibility criteria at one medical center, a center official stated that to obviate the need for hospitalization

"... is so vaguely worded that every doctor can come up with one or more interpretations that will suit any situation.... Having no clear policy, we have no uniformity. The same patient with the same condition may be denied care by one physician, only to walk out of clinic the next day with a handful of prescriptions supplied by the doctor in the next office...."

Medical staff of the VA Inspector General visited one medical center and reviewed a random sample of veterans who were determined to be eligible for outpatient care. Based on the medical reviewer's interpretation of obviating the need for hospitalization, they estimated that about 32 percent of the 11,763 patients[2] were ineligible for outpatient care. In a March 1992 report,[3] the Assistant Inspector General for Auditing concluded that VHA had not effectively disseminated criteria to physicians or other clinicians addressing when outpatient treatment is needed to obviate the need for hospitalization. He stated the following:

"We learned from our discussions with General Counsel staff that VHA has never requested a legal opinion of the meaning or intent of the language. Also, we are unaware of any attempt by VHA to define the term in its own program guides or other instructions to clinical staff. Instead, VHA's practice has been to allow each clinician to interpret its meaning and application for each individual patient. In practice, we found that the concept is either ignored or perfunctorily applied to every treatment provided to every patient."

The Assistant Inspector General recommended that the VHA develop regulations that address the conditions and circumstances under which outpatient treatment may be provided to obviate the need for hospitalization. VA's Under Secretary for Health, however, did not concur with this recommendation and responded that

"The phrase 'obviate the need for hospital care' is, however, a very difficult, if not impossible concept to define and to apply at the clinical level. It is one of the major problems clinicians face in attempting to determine eligibility for treatment. Often, conditions which appear stable and chronic, will deteriorate and result in hospitalization if treatment is discontinued. The decision to obviate the need for hospital care is made on individual cases by the clinician caring for the patient...."

In response, the Assistant Inspector General commented in his report that

"We do not believe there is a basis to conclude it is an 'impossible concept to define,' rather the absence of a definition creates a significant weakness in controls over VA's outpatient programs. Without a policy definition or other instructions to clinical staff, inconsistent application of criteria among facilities and clinicians is certain."

[2]Patients seen at the medical center from December 1, 1989, through January 31, 1990.

[3]Audit of the Outpatient Provisions of Public Law 100-322, March 31, 1992, Report Number 2AB-A02-059.

The Deputy Associate Deputy Chief Medical Director for Ambulatory Care also told us that VHA had no plans to further define the concept of obviating the need for hospitalization. He said the practice of medicine does not determine whether to treat patients on the basis of whether they will be hospitalized.

VA's Eligibility Reform Proposals

To address eligibility concerns, the Deputy Secretary of Veterans Affairs established an eligibility reform task force in March 1992. The task force's goals were to simplify veteran eligibility for VA health care and provide a full continuum of care to eligible veterans.

In November 1992, the task force sent the Acting Secretary of Veterans Affairs a package of alternative proposals for VA health care eligibility reform. In this package, the task force presented criteria by which any eligibility reform proposal should be measured. The criteria included whether the proposal is (1) fair and equitable to eligible veterans and (2) straightforward enough to be interpreted consistently by all medical centers.

The task force outlined nine fundamental values "which would be applicable regardless of the final details of a reform proposal, values which are so basic that they are relevant to every aspect of reform." (See fundamental values listed in app. III.) Three of the nine values follow:

- Eligibility rules will be simple enough that an entry level clerk can interpret and apply them.
- Health needs will determine the services provided to a veteran once eligibility had been established for a continuum of care.
- VA will assure reasonable access to care to all eligible veterans regardless of their geographic location.

As of April 22, 1993, VA was not advocating any of the alternative proposals the task force offered. VA indicated that the proposals may yet be further modified but not until after the White House task force completes its work on health care reform.

Conclusions

A vast difference exists in how officials at the medical centers interpret and apply the outpatient eligibility criterion based on the statutory provision to obviate the need for hospitalization. This is because, in the absence of better guidance on interpreting this language, the criterion depends largely on subjective judgments about whether veterans' medical

conditions will deteriorate if left untreated. VA officials believe that the statutory criterion is difficult, if not impossible, to define and apply at the clinical level. While we agree with VA that developing sufficient criteria will be difficult, it is not clear how the current criterion can ever be implemented in a consistent manner without better guidance.

VA has undertaken an eligibility reform effort to simplify veterans' eligibility for health care. VA's eligibility reform task force articulated nine fundamental values. As part of this effort, these fundamental values, among other things, point to greater consistency in eligibility and the ability to provide services to all eligible veterans. It is not clear whether an alternative set of eligibility criteria can satisfy both of these objectives perfectly. GAO believes that, to the extent that it is not possible to do both, it would be preferable to combine more predictable eligibility criteria with a conscious strategy to deal with shortfalls in resources on an equitable basis in accordance with priorities set by the Congress.

Recommendation to the Secretary of Veterans Affairs

The Secretary of Veterans Affairs should either (1) develop and propose to the Congress alternative eligibility criteria that produce greater consistency among medical centers in eligibility determinations or (2) provide better guidance to centers so that clinicians may achieve more consistent determinations when interpreting the current criteria.

Agency Comments

We provided copies of a draft of this report to the Secretary of Veterans Affairs for review. On June 18, 1993, we discussed our findings with and obtained oral comments from VA officials, including officials from the offices of the Associate Chief Medical Director for Clinical Affairs, the Associate Chief Medical Director for Administration, the Associate Chief Medical Director for Resources Management; and the Office of the Deputy Assistant Secretary for Policy.

In general, these officials agreed that medical centers were using varying interpretations of the statutory criterion when determining veterans' eligibility for outpatient care. They also reaffirmed VA's commitment to developing an eligibility reform proposal for consideration by the Congress. The officials believe that the proposal will overcome the inconsistencies discussed in our report, principally because it focuses on the treatment of a veteran's total medical needs as opposed to the treatment of only certain medical conditions. However, the Secretary does not plan to move forward with a full eligibility reform proposal until the

Administration's current national health care reform initiative is announced. Nevertheless, VA officials prefer eligibility reform because VA has previously developed and implemented guidance intended to clarify the eligibility criteria. However, as the report shows, greater consistency of determinations among medical centers remains elusive.

Rationing of Discretionary Outpatient Care Contributes to Inconsistencies in Access

Most VA medical centers rationed outpatient care, while others provided a full range of available services to all eligible veterans. When centers rationed discretionary outpatient care, they used widely varying methods. As a result, veterans' access to care often depended on which medical center they visited.

VA Delegated Rationing Decisions to Medical Centers

Although the Congress set out specific priorities for providing outpatient care when resources are not available to care for all veterans, it did not clearly indicate whether rationing decisions are intended to be made on a systemwide basis or individual medical center basis. Administratively, VA has delegated rationing decisions to each medical center, and each center makes choices about how it will ration care. Each center decides the extent to which it will ration care based on assessments of its available annual resources.

Rationing of discretionary outpatient care among VA medical centers is widespread. Of the 158 medical centers we surveyed, 118 told us in response to our questionnaire that they rationed outpatient care to veterans in fiscal year 1991 while the remaining 40 centers reported that they did not ration care.

Extent of Rationing Outpatient Care Varies Widely Among Medical Centers

In fiscal year 1991, medical centers' rationing of discretionary outpatient care varied widely. Some medical centers rationed all discretionary outpatient care to veterans while other centers provided all discretionary care. Of the 118 medical centers that rationed care,

- 69 rationed care only to higher income veterans;
- 27 rationed care to higher and lower income veterans; and
- 22 rationed care to veterans with higher incomes, lower incomes, and service-connected disabilities.[1]

The remaining 40 medical centers provided all discretionary care to eligible veterans,[2] including higher income veterans.

[1]When we refer to outpatient care rationed to veterans with service-connected disabilities, we are referring only to those who are rated from 0 to 20 percent and who need care for their nonservice-connected conditions. Care for service-connected conditions is mandatory and not subject to rationing.

[2]See appendix IV for a map showing the locations of the 40 VA medical centers that did not ration discretionary outpatient care.

Veterans who live near a VA medical center that rations discretionary outpatient care to a significant extent are disadvantaged compared with similar veterans who live near a medical center that does not ration care. For example, at one medical center we visited, a lower income veteran came to VA with increasing shortness of breath and probable cancer of the lung. Although diagnosed with chronic obstructive pulmonary disease, the veteran was prescribed medications and told to seek care elsewhere due to rationing. At another center we visited, a veteran diagnosed with probable chronic obstructive pulmonary disease would have been accepted and referred to a specialty clinic for care, even if he were a higher income veteran.

Medical Centers Implement Rationing Differently

Medical centers used various methods to ration discretionary outpatient care. Although the Congress prescribed veterans' categories as the primary method for prioritizing discretionary care, not all medical centers use these categories as the basis for rationing care. Some medical centers ration care by medical service or by medical condition or some combination of veteran category, medical service, or medical condition. The rationing methods used affect which veterans receive outpatient care and therefore can contribute to inconsistent access to discretionary care.

Rationing by Veteran Category

When medical centers ration discretionary outpatient care by veterans' category, they generally follow the priorities set by Congress. In this regard, medical centers limit care first to higher income veterans, then to lower income veterans, and finally to veterans with a service-connected disability. Four of the medical centers we visited rationed some outpatient care by category. For example, at one of those centers, higher income veterans seeking discretionary outpatient care were told to go elsewhere for care.

Rationing by Medical Service

A medical center that rations by medical service limits access to discretionary care in certain specialty clinics while providing discretionary care in other clinics or by limiting discretionary care if the wait for the next appointment exceeds a specified period. Four of the centers we visited rationed some discretionary care by medical service. For example, one center limited all discretionary care in its orthopedics, neurology, and dermatology clinics. This meant that only mandatory care was provided by those clinics. Veterans could receive discretionary care, however, at the center's other specialty clinics.

Another medical center we visited limited discretionary care in its clinics when the next available appointment was more than 30 days in the future. Over the years, as resources became tighter, medical center officials reduced the period from 90 days to 60 days to 30 days. This meant that veterans seeking discretionary care in a clinic where the next available appointment was more than 30 days in the future would not get care, whereas veterans needing care in a clinic with the next available appointment within 15 days would receive care.

Using medical service rather than veteran category for rationing can result in different veterans receiving care. For example, one medical center limited services in its neurology clinic. As a result, a lower income veteran with a neurological condition would have been turned away while a higher income veteran with a non-neurological condition, such as diabetes, would have received care in other clinics. By contrast, another medical center that rationed by veteran category would have turned away the higher income veteran with diabetes whereas the lower income veteran with the neurological condition would have been treated.

Rationing by Medical Condition

Finally, a medical center that rations outpatient discretionary care by medical condition limits

- care to veterans with less serious conditions while providing care to veterans with more serious conditions,
- certain medications while providing other medications, or
- certain procedures while providing other procedures.

Three of the centers we visited rationed discretionary care by medical condition. For example, one of the centers only allowed one colonoscopy per veteran when it was not related to a service-connected disability, and another center would not provide transplant medications to veterans unless VA had performed the organ transplant. As a result, depending on the specific discretionary care needed, a veteran would or would not get care.

Rationing outpatient discretionary care by medical condition results in different veterans receiving care than if care is rationed by category or medical service. For example, if two veterans, one a higher income veteran with a serious but nonemergent cardiac condition and the other a lower income veteran whose nonemergent cardiac condition is less serious,

visited three medical centers that used different rationing methods, each medical center might have cared for a different mix of the veterans.

More specifically, one medical center we visited that rationed by medical condition would have performed a cardiac catheterization on the higher income veteran, but the lower income veteran would have been told to go elsewhere for care. At the center that rationed by category, however, the lower income veteran would have received the catheterization and the higher income veteran would have been told to get care elsewhere. At the center that rationed by medical service, both veterans would have received a cardiac catheterization since discretionary care was not rationed in the cardiology clinic.

Conclusions

The statutory priorities for providing outpatient care provide an objective way of deciding which veterans should receive outpatient care when resources are limited. It is not clear, however, whether the priorities are intended to be implemented on a systemwide basis or on a medical center basis. Because VA decided to use a medical center basis, resources at 118 medical centers did not always match veterans' demand in fiscal year 1991, and, as a result, those centers rationed care to some or all higher income veterans as well as many veterans with lower incomes or service-connected conditions. Forty centers had sufficient resources to provide outpatient care to all eligible veterans, including higher income veterans.

VA could reduce such inconsistencies in veterans' access to care by better matching its resource allocations among medical centers to the volume of eligible veterans demanding services at each. In effect, VA would be shifting its rationing perspective from the current center-by-center approach to one producing more systemwide uniformity. This may well require shifting some resources from the 40 medical centers that did not ration care. Such resource shifts could mean that some higher income veterans who have been receiving outpatient care at the 40 medical centers might not obtain such care in the future. But, it would also mean that some veterans with lower incomes or service-connected disabilities who had not received care at other medical centers might receive care in the future.

Because it is unclear how the priorities were intended to work, we are reluctant to recommend that the Secretary of Veterans Affairs significantly modify VA's rationing policies. If the Congress would prefer that VA strive

to achieve a more equitable distribution of outpatient services using the current priorities, however, it should direct the Secretary to implement the priorities on a systemwide basis. If VA's rationing policies satisfy the intent of the current congressional priorities, no policy changes are necessary.

Matter for Consideration by the Congress

If the Congress prefers that the current priorities for discretionary outpatient care be implemented consistently on a systemwide basis, it should direct the Secretary of Veterans Affairs to develop a different system for allocating its resources to the medical centers so that veterans within the same priority categories, to the extent practical, receive access to discretionary outpatient care at each medical center.

Agency Comments

In our June 18, 1993, meeting with VA officials they agreed that medical centers' rationing practices have resulted in wide variations in veterans' access to health care systemwide. To address this issue, VA is designing a new resource planning and management process that has several objectives, including the elimination of gaps in service for veterans systemwide. In this regard, the officials expect that this new system should, among other things, overcome some of the inconsistencies discussed in our report. VA plans to implement this new resource allocation process in fiscal year 1994.

Eligibility Criteria and Rationing Priorities

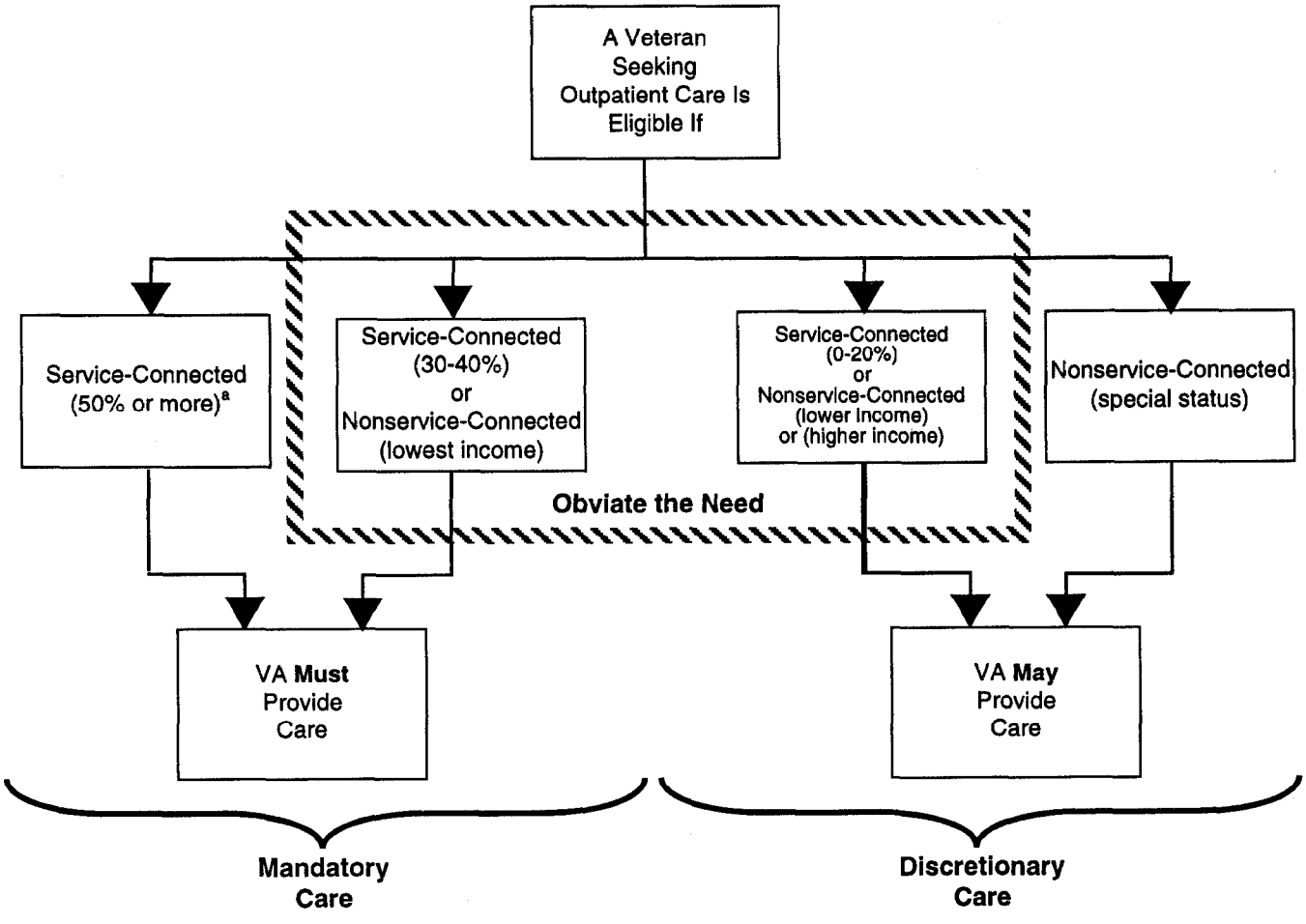
Veterans are eligible for outpatient care related to their service-connected disability. For most categories of veterans, however, eligibility for outpatient care for nonservice-connected conditions is subject to the obviate the need for hospitalization criterion. Two categories of veterans are not subject to this criterion: veterans who have a 50 percent or higher service-connected disability or those who have a special status, such as former prisoners of war. (See table I.1.)

Table I.1: Veterans' Eligibility Categories for Outpatient Care for Nonservice-Connected Conditions

Veteran Category	Description
Service-connected (50% or more)	50 percent or more disabled from a service-connected injury
Service-connected (30-40%)	30-40 percent disabled from a service-connected injury
Nonservice-connected (lowest income)	Annual income less than $10,338, with no dependents; no service-connected injury
Service-connected (0-20%)	0-20 percent disabled from a service-connected injury
Nonservice-connected (special status)	Former prisoners of war, World War I veterans, and others
Nonservice-connected (lower income)	Annual income between $10,338 and $16,518, with no dependents
Nonservice-connected (higher income)	Annual income in excess of $16,518, with no dependents

Although veterans may be determined eligible for outpatient medical care for nonservice-connected conditions, some will receive care while others may be turned away. Figure I.1 illustrates the veterans' categories subject to the obviate the need for hospitalization criterion for nonservice-connected conditions. It also shows the veterans for whom VA must provide outpatient care for nonservice-connected conditions (mandatory care) or those for whom VA may provide care of nonservice-connected conditions (discretionary care). Discretionary care may be subject to rationing when resources are insufficient to serve all eligible veterans.

Figure I.1: Outpatient Eligibility Criteria for Nonservice-Connected Conditions



[a]Number in parentheses represents percent of disability.

Table I.2 lists the priorities for providing discretionary outpatient care to veterans when center resources are insufficient to serve all eligible veterans; for example, priority 4 is the first category subject to rationing and priority 1 is the last category subject to rationing.

Table I.2: Priorities for Providing Discretionary Outpatient Care to Veterans

Priority	Veteran Category
1	Service-connected (0-20%)
2	Nonservice-connected (special status)
3	Nonservice-connected (lower income)
4	Nonservice-connected (higher income)

Medical Conditions of Six Profiled Veterans

Table II.1 summarizes the medical conditions of the six veterans that GAO profiled. We used the profiles to assess 19 medical centers' outpatient eligibility determinations based on obviating the need for hospitalization.

Table II.1: Medical Conditions of Six Profiled Veterans

Veteran	Description of Medical Condition
A	A 66-year-old, asymptomatic, noninsulin-dependent diabetic being monitored in the endocrinology clinic.
B	A 65-year-old, walk-in patient with right arm pain and numbness for 6 weeks, numbness in both legs for 13 years, and an elevated glucose level. He received a diagnostic workup and was assessed as having some loss of feeling and function plus diabetes.
C	A 68-year-old, stable diabetic being monitored in the general medicine clinic but not complying with medication instructions. He was assessed as having stable coronary artery disease and diabetes controlled with oral medication.
D	A 41-year-old, walk-in patient who received a diagnostic workup. She complained of progressive generalized weakness, fatigue, and dizziness for 2 months but was in no pain or obvious distress.
E	A 54-year-old, walk-in patient with intermittent shortness of breath and chest pains affected by speed of swallowing. He received a diagnostic workup and was assessed as having borderline hypertension, peptic disease, and alcohol abuse.
F	A 52-year-old, walk-in patient who reported several complaints (chest cold, shoulder pain, blood in sputum) and received a diagnostic workup. He was assessed as having minimal blood in his sputum of unknown cause.

Fundamental Values Contained in VA's Eligibility Reform Proposals

1. Health needs (medical and social) will determine the services provided to a veteran once eligibility has been established for a continuum of care.

2. All eligible beneficiaries will have access to all VA inpatient and outpatient services.

3. VA will assure reasonable access to care for all eligible veterans regardless of their geographic location.

4. VA will emphasize quality of medical and health related services rather than quantity.

5. VA's continuum of care will be the source of a broad spectrum of services that are medically necessary and appropriate for a veteran.

6. VA will use non-institutional and outpatient care for traditional institutional bed care when appropriate and effective.

7. Eligibility and continuum of care will be defined to ensure that the resources available to VA will enable quality care to be provided.

8. VA will emphasize quality of life factors, such as compassion and dignity for veterans and their families, in terms of medical and health related services.

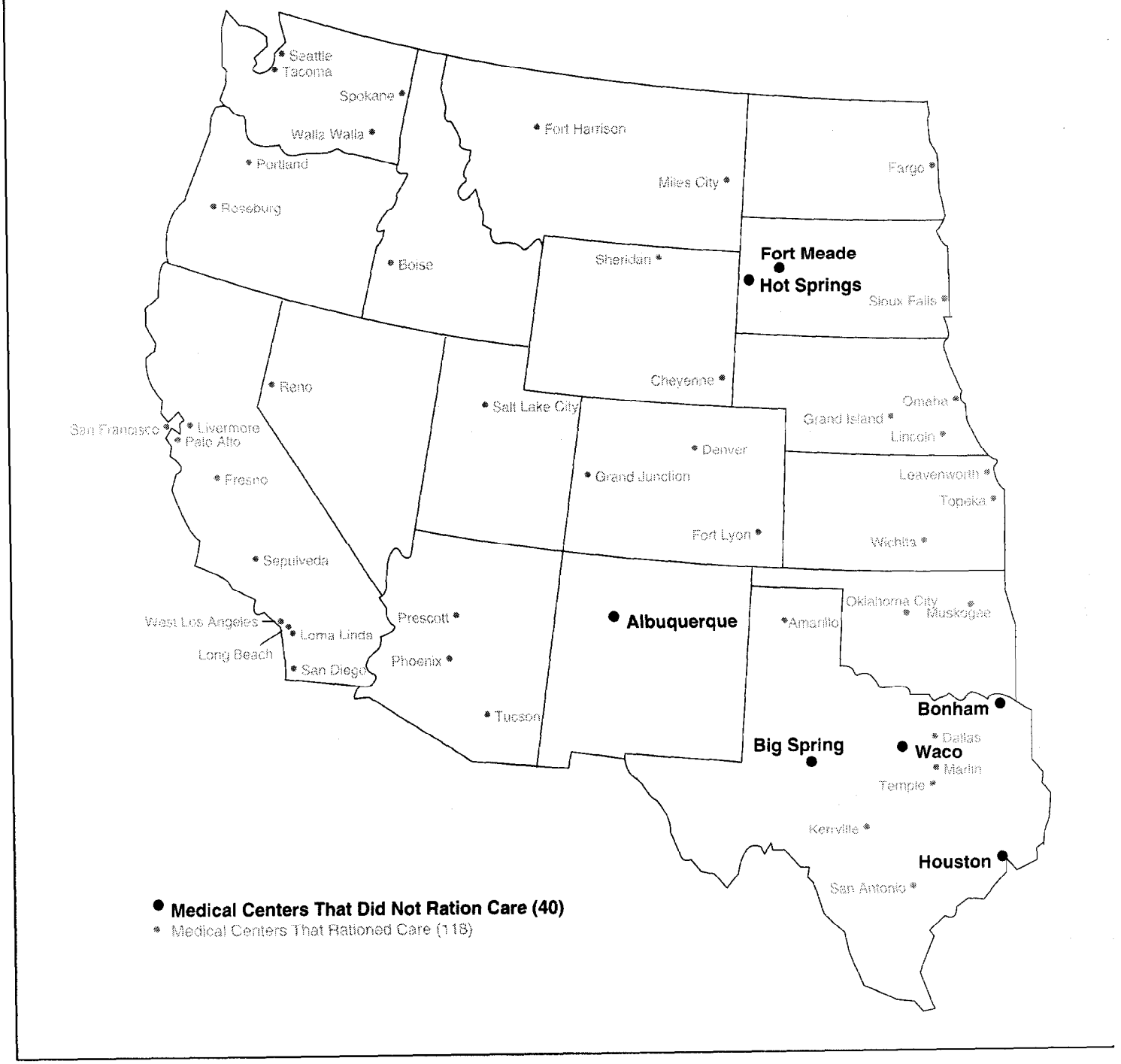
9. Eligibility rules will be simple enough that an entry level clerk can interpret and apply them.

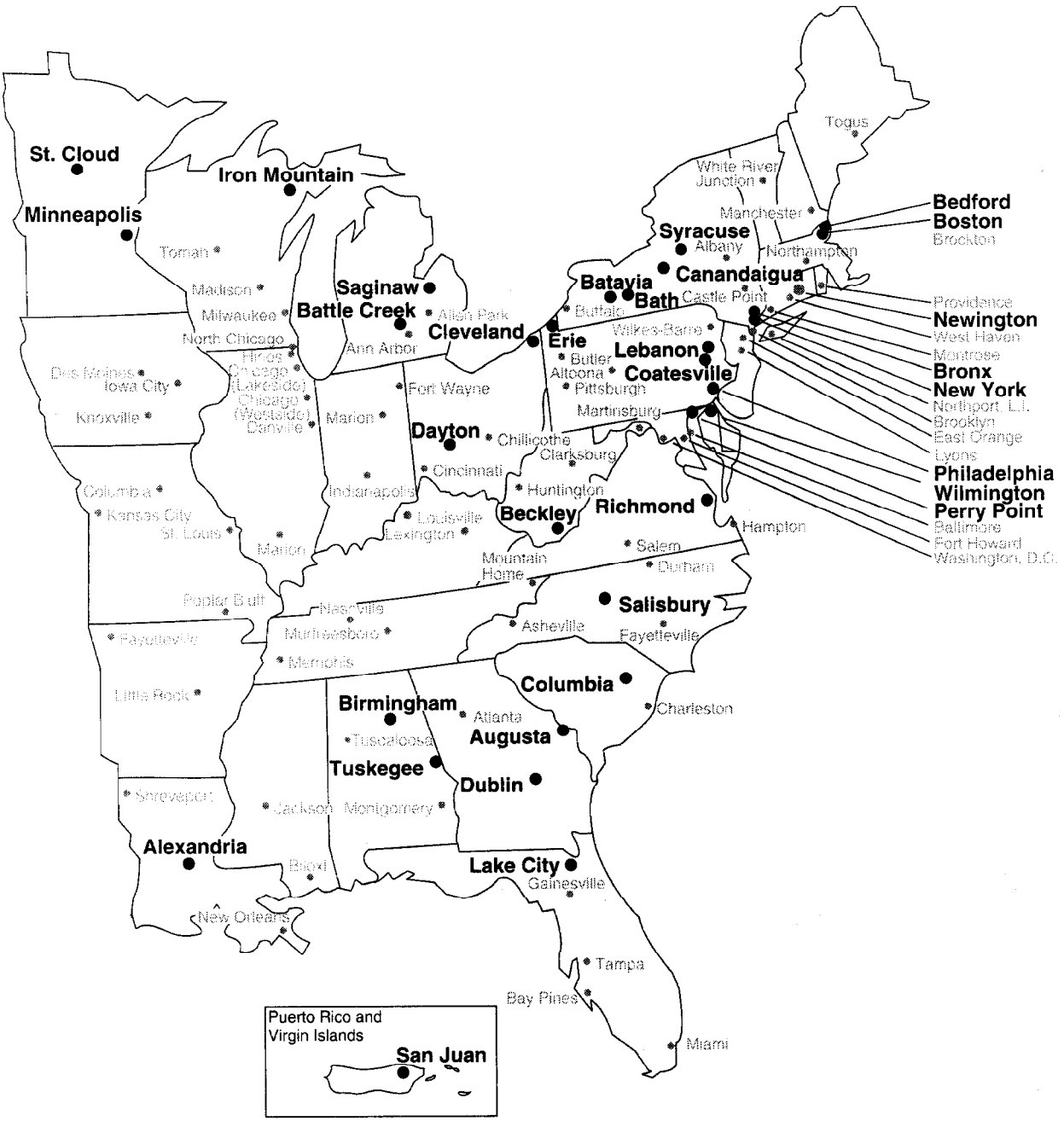
U.S. Map Showing Locations of Nonrationing VA Medical Centers

Figure IV.1 highlights the 40 VA medical centers that did not ration discretionary outpatient care to veterans in fiscal year 1991. We could not identify any common characteristics to explain why these medical centers did not ration care.

The map shows that the medical centers that did not ration discretionary outpatient care were primarily in the eastern half of the country: not only in the Northeast but also encompassing the Southeast, North Central, and South Central regions. The medical centers that did not ration care included primary, secondary, and tertiary care hospitals, as well as both medical and psychiatric centers.

Figure IV.1: Nonrationing VA Medical Centers in Fiscal Year 1991




St. Cloud
Iron Mountain
Minneapolis
Toman
Madison
Milwaukee
North Chicago
Hines
Chicago (Lakeside)
Chicago (Westside)
Des Moines
Iowa City
Knoxville
Danville
Saginaw
Battle Creek
Allen Park
Ann Arbor
Cleveland
Fort Wayne
Marion
Dayton
Chillicothe
Cincinnati
Columbia
Kansas City
St. Louis
Marion
Indianapolis
Louisville
Lexington
Huntington
Beckley
Clarksburg
Richmond
Hampton
Salem
Durham
Mountain Home
Salisbury
Asheville
Fayetteville
Poplar Bluff
Nashville
Murfreesboro
Memphis
Fayetteville
Little Rock
Columbia
Charleston
Birmingham
Atlanta
Tuscaloosa
Augusta
Tuskegee
Dublin
Shreveport
Jackson
Montgomery
Alexandria
Biloxi
Lake City
Gainesville
New Orleans
Tampa
Bay Pines
Miami
Puerto Rico and Virgin Islands
San Juan
Togus
White River Junction
Manchester
Bedford
Boston
Brockton
Syracuse
Albany
Northampton
Batavia
Bath
Canandaigua
Castle Point
Providence
Newington
West Haven
Montrose
Bronx
New York
Northport, L.I.
Brooklyn
East Orange
Lyons
Philadelphia
Wilmington
Perry Point
Baltimore
Fort Howard
Washington, D.C.
Buffalo
Erie
Wilkes-Barre
Lebanon
Butler
Altoona
Coatesville
Pittsburgh
Martinsburg

GAO Questionnaire Results

U.S. GENERAL ACCOUNTING OFFICE

Survey of Veterans Affairs Medical Centers

Availability of Medical Services to Veterans

At the request of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, the U.S. General Accounting Office (GAO), an agency of the U.S. Congress, is conducting a survey of the availability of medical services to veterans at VA Medical Centers across the United States. The purpose of this study is to better understand the effects of resource constraints in recent years on the care of veterans. Since 1988, a number of VA Medical Centers have limited health care services available to discretionary veterans as one way of managing resource limitations. This questionnaire will be used to obtain information about the extent of such practices.

This questionnaire is being sent to all VA Medical Centers nationwide. We suggest that it be completed by the Chief of Medical Administration Services. It may be necessary that s/he consult other staff members. Please return the completed questionnaire within three weeks of receipt to:

U.S. General Accounting Office
Attn: Arthur Fine
Room 575
10 Causeway Street
Boston, MA 02222

A preaddressed business reply envelope is included for your convenience. If you have any questions, please call Arthur Fine or Michelle St. Pierre at (617) 565-7500, FTS, 835-7500.

Your participation in this survey is essential. We can provide the Congress with complete information about service availability at VA Medical Centers only if you and the other VA hospital administrators respond fully.

Thank you for your cooperation.

Please enter the name, title, and telephone number of the person who completed this questionnaire.

NAME: _____

TITLE: _____

TELEPHONE NUMBER: (_____) _____

I. INTRODUCTION

Although this questionnaire appears lengthy, most questions can be answered quickly by checking a box. In addition, most of the questions follow a similar pattern. They ask for separate information about:

1. each of three categories of discretionary veterans defined below, and

2. each of two fiscal years from the beginning of fiscal year 1990 through the end of fiscal year 1991.

In the first part of the questionnaire, we ask you about the services your VA Medical Center was capable of providing to all veterans, including mandatory veterans. Throughout the rest of the questionnaire, we ask specifically about the care you provided to discretionary veterans.

DEFINITION OF TERMS USED IN THIS QUESTIONNAIRE

DISCRETIONARY VETERAN
When the term "discretionary veteran" is used in this questionnaire, it refers to a veteran who is eligible for VA health care services, but is not entitled to them. Discretionary veterans are in the following categories:

1. Non-Service Connected Category "C" veterans (including those previously classified as Category "B"),

2. Non-Service Connected Category "A" veterans, except for those non-service connected "A" veterans with incomes below the maximum annual pension rate for aid and attendance when they are entitled to outpatient care in order to obviate the need for hospitalization,

3. Service Connected Category "A" veterans (less than 50% disability) seeking treatment for a non-service connected injury or condition, except for those service connected "A" veterans with a 30-40% disability when they are entitled to outpatient care in order to obviate the need for hospitalization.

Do not include in these categories any veterans who may, in some instances, be classified as MANDATORY.

LIMITED SERVICES
In this questionnaire, "limited services" refers to any instances where your VA Medical Center provided, either in-house or through a sharing agreement, medical service to 100% service connected disabled veterans while not providing the same medical service to discretionary veterans. In other words, medical service was limited solely on the basis of veteran category. For purposes of this questionnaire, however, DO NOT INCLUDE:

1. legally mandated limitations,
2. limitations applying to all veterans,
3. limitations that apply to fee basis care,
4. limitations that apply to dental care,
5. delays in scheduling clinical appointments, or
6. limitations lasting less than 1 month.

II. SERVICES AVAILABLE

1. In order to better understand your Medical Center's practices, we would like to know what services were available. Consider the specific services listed below. Check the boxes to indicate in which years, if any, each service WAS AVAILABLE AT ALL at your VA Medical Center. Do not include fee basis care or contract hospital care. If a service was not available during either of the years, check the box indicating that this service was not available. **(CHECK ALL THAT APPLY.)** *(N=158)*

	FY 1990	FY 1991	This service was not available during either year.
INPATIENT CARE: MEDICAL			
Specialized (high cost) diagnostics (e.g., CAT Scan, MRI, PET Scan)	*81.6%*	*83.5%*	*16.5%*
Specialized (high cost) medication (e.g., Cyclosporin, AZT, Epoeitin)	*94.3%*	*94.9%*	*3.2%*
INPATIENT CARE: SURGICAL			
Lithotripsy	*9.5%*	*11.4%*	*88.6%*
Open heart surgery	*27.2%*	*27.2%*	*72.2%*
Organ transplants	*10.1%*	*10.1%*	*89.9%*
INPATIENT CARE: PSYCHIATRIC			
Treatment of post-traumatic stress disorder	*69.0%*	*71.5%*	*27.8%*
Drug/alcohol rehabilitation	*81.0%*	*83.5%*	*15.8%*
Acute psychiatric care	*84.2%*	*84.8%*	*14.6%*

1. (continued) *(N=158)*

	FY 1990	FY 1991	This service was not available during either year.
OUTPATIENT CARE: MEDICAL			
Routine diagnostic work-ups (e.g., X-Ray, EKG, Lab test)	*99.4%*	*99.4%*	*0.6%*
Specialized (high cost) diagnostics (e.g., CAT Scan, MRI, PET Scan)	*80.4%*	*82.9%*	*17.1%*
Specialized (high cost) medication (e.g., Cyclosporin, AZT, Epoeitin)	*93.7%*	*94.3%*	*5.1%*
Initial prescription of medication other than specialized (high cost) medication	*99.4%*	*99.4%*	*0.6%*
Continued refills of medication other than specialized (high cost) medication	*99.4%*	*98.7%*	*0.6%*
Referral for follow-up to VA specialty clinics	*99.4%*	*99.4%*	*0.6%*
OUTPATIENT CARE: SURGICAL			
Lithotripsy	*3.8%*	*5.1%*	*94.3%*
OUTPATIENT CARE: PSYCHIATRIC			
Day treatment	*54.4%*	*56.3%*	*43.0%*
Treatment of post-traumatic stress disorder	*82.3%*	*87.3%*	*12.7%*
Drug/alcohol rehabilitation	*84.8%*	*89.2%*	*10.1%*
LONG TERM CARE			
Initial placement in VA Nursing Homes, Domiciliaries, and State Homes	*93.0%*	*93.7%*	*7.0%*
Initial placement in VA sponsored Community Nursing Homes	*99.4%*	*99.4%*	*0.6%*
Chronic care units	*55.7%*	*56.3%*	*43.0%*
Chronic psychiatric units	*32.3%*	*32.3%*	*67.7%*

III. LIMITATIONS OF SERVICES FOR DISCRETIONARY VETERANS

2. Listed below are various types of outpatient care and three categories of discretionary veterans. For each type of outpatient care, indicate those categories of veterans for whom during **FY 1990** this service was limited for a period of one month or longer. That is, the service or care was not provided to this category of veterans, although it was provided to 100% service connected disabled veterans. Check the appropriate boxes to indicate those categories of veterans for whom the service was limited. Please do not include any limitations that apply to all veterans and remember not to include dental care. If the service was not limited for any of these discretionary veterans during FY 1990, check the box indicating that this service was not limited; if this service was not available during FY 1990, check the box indicating that the service was not available. **(CHECK ALL THAT APPLY.)** *(N=158)*

FY 1990

OUTPATIENT CARE: MEDICAL	Non-Service Connected "C" Veterans	Non-Service Connected "A" Veterans	Service Connected "A" Veterans (less than 50% disability)	This service was NOT LIMITED for discretionary veterans during FY 1990.	This service was not available during FY 1990.
Routine diagnostic work-ups (e.g., X-Ray, EKG, Lab test)	*50.6%*	*5.7%*	*3.8%*	*49.4%*	*0%*
Specialized (high cost) diagnostics (e.g., CAT Scan, MRI, PET Scan)	*48.7%*	*6.3%*	*3.8%*	*36.7%*	*14.6%*
Specialized (high cost) medication (e.g., Cyclosporin, AZT, Epoeitin)	*53.2%*	*7.0%*	*3.8%*	*44.3%*	*1.9%*
Initial prescription of medication other than specialized (high cost) medication	*50.0%*	*7.6%*	*4.4%*	*50.0%*	*0%*
Continued refills of medication other than specialized (high cost) medication	*60.8%*	*12.7%*	*7.0%*	*39.2%*	*0%*
Other non-emergent care **(PLEASE SPECIFY.)** _____ _____ _____	*31.6%*	*4.4%*	*3.2%*	*22.8%*	*1.9%*
Referral for follow-up to VA specialty clinics **(IF NOT ALL CLINICS, PLEASE SPECIFY WHICH ONES.)**___ _____ _____ _____	*67.1%*	*19.0%*	*10.1%*	*31.0%*	*0%*

2. (continued) *(N=158)*

OUTPATIENT CARE: SURGICAL	Non-Service Connected "C" Veterans	Non-Service Connected "A" Veterans	Service Connected "A" Veterans (less than 50% disability)	This service was NOT LIMITED for discretionary veterans during FY 1990.	This service was not available during FY 1990.
Lithotripsy	*2.5%*	*0.6%*	*0%*	*4.4%*	*92.4%*
Other non-emergent procedures (PLEASE SPECIFY.)_____ _____ _____ _____ _____	*27.8%*	*4.4%*	*2.5%*	*19.0%*	*5.7%*

OUTPATIENT CARE: PSYCHIATRIC

Long-term psychotherapy	*50.0%*	*11.4%*	*5.1%*	*33.5%*	*16.5%*
Treatment of post-traumatic stress disorder	*41.8%*	*7.6%*	*1.9%*	*43.7%*	*15.2%*
Drug/alcohol rehabilitation	*47.5%*	*5.7%*	*1.9%*	*42.4%*	*10.1%*
Other (PLEASE SPECIFY.) _____ _____ _____ _____ _____	*13.9%*	*3.2%*	*1.9%*		

2. (continued) *(N=158)*

LONG TERM CARE	Non-Service Connected "C" Veterans	Non-Service Connected "A" Veterans	Service Connected "A" Veterans (less than 50% disability)	This service was NOT LIMITED for discretionary veterans during FY 1990.	This service was not available during FY 1990.
Initial placement in VA Nursing Homes, Domiciliaries, and State Homes	*51.9%*	*3.2%*	*0.6%*	*44.9%*	*3.2%*
Initial placement in VA sponsored Community Nursing Homes	*51.3%*	*3.8%*	*3.2%*	*48.1%*	*0.6%*
Chronic psychiatric units	*19.6%*	*0.6%*	*0.6%*	*19.6%*	*60.1%*
Other chronic care units **(IF NOT ALL UNITS, PLEASE SPECIFY WHICH ONES.)** _____ _____ _____ _____ _____	*16.5%*	*0%*	*0%*	*23.4%*	*39.2%*

OTHER			
If any other types of care to discretionary veterans were limited in FY 1990, please specify the types of care. _____ _____ _____ _____ _____ _____ _____	*9.5%*	*1.3%*	*0%*

3. Listed below are various types of outpatient care and three categories of discretionary veterans. For each type of outpatient care, indicate those categories of veterans for whom during **FY 1991** this service was limited for a period of one month or longer. That is, the service or care was not provided to this category of veterans, although it was provided to 100% service connected disabled veterans. Check the appropriate boxes to indicate those categories of veterans for whom the service was limited. Please do not include any limitations that apply to all veterans and remember not to include dental care. If the service was not limited for any of these discretionary veterans during FY 1991, check the box indicating that this service was not limited; if this service was not available during FY 1991, check the box indicating that the service was not available. **(CHECK ALL THAT APPLY.)** *(N=158)*

FY 1991

OUTPATIENT CARE: MEDICAL	Non-Service Connected "C" Veterans	Non-Service Connected "A" Veterans	Service Connected "A" Veterans (less than 50% disability)	This service was NOT LIMITED for discretionary veterans during FY 1991.	This service was not available during FY 1991.
Routine diagnostic work-ups (e.g., X-Ray, EKG, Lab test)	*53.8%*	*9.5%*	*3.8%*	*46.2%*	*0%*
Specialized (high cost) diagnostics (e.g., CAT Scan, MRI, PET Scan)	*50.0%*	*10.1%*	*3.8%*	*36.1%*	*13.9%*
Specialized (high cost) medication (e.g., Cyclosporin, AZT, Epoeitin)	*55.1%*	*9.5%*	*3.8%*	*42.4%*	*1.9%*
Initial prescription of medication other than specialized (high cost) medication	*50.6%*	*9.5%*	*3.8%*	*48.7%*	*0%*
Continued refills of medication other than specialized (high cost) medication	*62.7%*	*17.1%*	*7.6%*	*37.3%*	*0%*
Other non-emergent care **(PLEASE SPECIFY.)**_____	*31.6%*	*7.0%*	*3.8%*	*22.2%*	*0%*
Referral for follow-up to VA specialty clinics **(IF NOT ALL CLINICS, PLEASE SPECIFY WHICH ONES.)**___	*64.6%*	*25.9%*	*14.6%*	*31.0%*	*0%*

3. (continued) *(N=158)*

OUTPATIENT CARE: SURGICAL	Non-Service Connected "C" Veterans	Non-Service Connected "A" Veterans	Service Connected "A" Veterans (less than 50% disability)	This service was NOT LIMITED for discretionary veterans during FY 1991.	This service was not available during FY 1991.
Lithotripsy	*3.2%*	*0.6%*	*0%*	*3.8%*	*91.8%*
Other non-emergent procedures (PLEASE SPECIFY.)_____ _____ _____ _____ _____	*26.6%*	*5.1%*	*2.5%*	*20.3%*	*3.8%*

OUTPATIENT CARE: PSYCHIATRIC

Long-term psychotherapy	*46.2%*	*12.7%*	*7.6%*	*32.3%*	*21.5%*
Treatment of post-traumatic stress disorder	*43.0%*	*8.9%*	*2.5%*	*41.1%*	*14.6%*
Drug/alcohol rehabilitation	*50.6%*	*8.2%*	*3.8%*	*41.1%*	*8.2%*
Other (PLEASE SPECIFY.) _____ _____ _____ _____ _____	*15.8%*	*3.8%*	*2.5%*		

3. (continued) *(N=158)*

	Non-Service Connected "C" Veterans	Non-Service Connected "A" Veterans	Service Connected "A" Veterans (less than 50% disability)	This service was NOT LIMITED for discretionary veterans during FY 1991.	This service was not available during FY 1991.
LONG TERM CARE					
Initial placement in VA Nursing Homes, Domiciliaries, and State Homes	*55.1%*	*3.8%*	*0%*	*42.4%*	*2.5%*
Initial placement in VA sponsored Community Nursing Homes	*55.1%*	*6.3%*	*3.2%*	*44.9%*	*0%*
Chronic psychiatric units	*20.3%*	*0.6%*	*0.6%*	*20.3%*	*59.5%*
Other chronic care units **(IF NOT ALL UNITS, PLEASE SPECIFY WHICH ONES.)** _____ _____ _____ _____ _____	*20.9%*	*0%*	*0%*	*20.3%*	*36.7%*
OTHER					
If any other types of care to discretionary veterans were limited in FY 1991, please specify the types of care. _____ _____ _____ _____ _____ _____	*8.9%*	*1.3%*	*1.3%*		

4. At any time from the beginning of FY 1990 through the end of FY 1991, did your VA Medical Center DECLINE TO ADMIT a Non-Service Connected "C" veteran who needed inpatient care on a non-emergency basis? *(N=156)*

65.4% YES

34.6% NO

5. At any time from the beginning of FY 1990 through the end of FY 1991, did your VA Medical Center limit services for NON-SERVICE CONNECTED "C" veterans after they were admitted for inpatient care? *(N=157)*

   10.2% YES

   89.8% NO ---> **If "NO," skip to question 7.**

6. Consider the inpatient services listed below. For each, check the boxes to indicate in which years, if any, the service was limited for NON-SERVICE CONNECTED "C" veterans after they were admitted for inpatient care. Please do not include any limitations that apply to all veterans and remember not to include dental care. If the service was not limited for Non-Service Connected "C" veterans during either of the years, check the box indicating that it was not limited; if this service was not available during either year, check the box indicating that the service was not available.
   (CHECK ALL THAT APPLY.) *(N=16)*

	FY 1990	FY 1991	This service was NOT LIMITED for discretionary veterans during these years.	This service was not available during these years.
INPATIENT CARE: MEDICAL				
Specialized (high cost) diagnostics (e.g., CAT Scan, MRI, PET Scan)	*43.7%*	*31.3%*	*43.7%*	*12.5%*
Specialized (high cost) medication (e.g., Cyclosporin, AZT, Epoeitin)	*50.0%*	*50.0%*	*37.5%*	*0%*
INPATIENT CARE: SURGICAL				
Lithotripsy	*6.2%*	*0%*	*0%*	*93.7%*
Open heart surgery	*12.5%*	*12.5%*	*6.2%*	*81.2%*
Organ transplants	*0%*	*0%*	*0%*	*100%*
Other **(PLEASE SPECIFY.)**_____	*18.8%*	*12.5%*	*0%*	*12.5%*
INPATIENT CARE: PSYCHIATRIC				
Treatment of post-traumatic stress disorder	*31.3%*	*31.3%*	*25.0%*	*37.5%*
Drug/alcohol rehabilitation	*31.3%*	*43.7%*	*31.3%*	*25.0%*
Acute psychiatric care	*25.0%*	*25.0%*	*43.7%*	*31.3%*

6. (continued) *(N=16)*

OTHER	FY 1990	FY 1991
If any other types of inpatient care for Non-Service Connected "C" veterans were limited in either FY 1990 or FY 1991, please specify the types of care. _____ _____ _____ _____ _____ _____ _____	*43.7%*	*43.7%*

7. At any time from the beginning of FY 1990 through the end of FY 1991, did your VA Medical Center DECLINE TO ACCEPT for care a discretionary veteran formally referred from another VA Medical Center? *(N=158)*

39.9% YES

60.1% NO ---> **If "NO," skip to question 9.**

8. We would like to know what limits, if any, your VA Medical Center has placed on care for discretionary veterans referred by other VA Medical Centers. Listed below are three categories of veterans, two fiscal years, and three types of referrals for patient care. For each category of discretionary veteran, fiscal year, and type of referral, indicate whether you accepted for care ALL, SOME or NONE of the formal referrals of discretionary veterans made by other VA Medical Centers. **(FOR EACH CATEGORY OF VETERAN, CHECK ONE RESPONSE FOR EACH TYPE OF REFERRAL IN EACH YEAR.)** *(N=63)*

			Accepted ALL	Accepted SOME	Accepted NONE
Non-service connected "C" (and those previously classified as "B")	FY 1990	INPATIENT CARE referrals	*14.3%*	*66.7%*	*19.0%*
		OUTPATIENT CARE referrals	*6.3%*	*47.6%*	*44.4%*
		LONG TERM CARE referrals	*3.2%*	*28.6%*	*58.7%*
	FY 1991	INPATIENT CARE referrals	*12.7%*	*65.1%*	*22.2%*
		OUTPATIENT CARE referrals	*3.2%*	*47.6%*	*47.6%*
		LONG TERM CARE referrals	*3.2%*	*28.6%*	*58.7%*
Non-service connected "A"	FY 1990	INPATIENT CARE referrals	*74.6%*	*25.4%*	*0%*
		OUTPATIENT CARE referrals	*63.5%*	*33.3%*	*3.2%*
		LONG TERM CARE referrals	*52.4%*	*25.4%*	*14.3%*
	FY 1991	INPATIENT CARE referrals	*71.4%*	*28.6%*	*0%*
		OUTPATIENT CARE referrals	*60.3%*	*36.5%*	*3.2%*
		LONG TERM CARE referrals	*50.8%*	*30.2%*	*11.1%*
Service connected "A" (less than 50%)	FY 1990	INPATIENT CARE referrals	*76.2%*	*23.8%*	*0%*
		OUTPATIENT CARE referrals	*73.0%*	*25.4%*	*1.6%*
		LONG TERM CARE referrals	*57.1%*	*25.4%*	*9.5%*
	FY 1991	INPATIENT CARE referrals	*73.0%*	*27.0%*	*0%*
		OUTPATIENT CARE referrals	*71.4%*	*27.0%*	*1.6%*
		LONG TERM CARE referrals	*54.0%*	*30.2%*	*7.9%*

9. At any time from the beginning of FY 1990 through the end of FY 1991, did your VA Medical Center restrict INPATIENT CARE, OUTPATIENT CARE or LONG TERM CARE of discretionary veterans to ONLY those discretionary veterans residing in your VA Medical Center's Primary Service Area? **(CHECK ONE RESPONSE.)** *(N=158)*

8.2% YES

91.8% NO ---> **If "NO," skip to question 11.**

10. We would like to know to what extent, if at all, your VA Medical Center restricted the INPATIENT CARE, OUTPATIENT CARE or LONG TERM CARE of discretionary veterans to ONLY those discretionary veterans residing in YOUR Primary Service Area. For each category of veteran, fiscal year, and type of patient care listed below, indicate whether you restricted ALL, SOME or NONE of the services available to discretionary veterans to ONLY THOSE discretionary veterans residing in your Primary Service Area. **(FOR EACH CATEGORY OF VETERAN, CHECK ONE RESPONSE FOR EACH TYPE OF CARE IN EACH YEAR.)** *(N=13)*

			ALL services restricted only to your Primary Service Area	SOME services restricted only to your Primary Service Area	NO services restricted only to your Primary Service Area
Non-service connected "C" (and those previously classified as "B")	FY 1990	INPATIENT care	*46.2%*	*38.5%*	*15.4%*
		OUTPATIENT care	*46.2%*	*53.8%*	*0%*
		LONG TERM care	*69.2%*	*15.4%*	*15.4%*
	FY 1991	INPATIENT care	*53.8%*	*30.8%*	*15.4%*
		OUTPATIENT care	*53.8%*	*46.2%*	*0%*
		LONG TERM care	*76.9%*	*15.4%*	*7.7%*

10. (continued) *(N=13)*

			ALL services restricted only to your Primary Service Area	SOME services restricted only to your Primary Service Area	NO services restricted only to your Primary Service Area
Non-service connected "A"	FY 1990	INPATIENT care	*7.7%*	*23.1%*	*69.2%*
		OUTPATIENT care	*7.7%*	*61.5%*	*30.8%*
		LONG TERM care	*23.1%*	*30.8%*	*46.2%*
	FY 1991	INPATIENT care	*7.7%*	*23.1%*	*69.2%*
		OUTPATIENT care	*7.7%*	*61.5%*	*30.8%*
		LONG TERM care	*23.1%*	*30.8%*	*46.2%*
Service connected "A" (less than 50%)	FY 1990	INPATIENT care	*7.7%*	*23.1%*	*69.2%*
		OUTPATIENT care	*7.7%*	*46.2%*	*46.2%*
		LONG TERM care	*23.1%*	*30.8%*	*46.2%*
	FY 1991	INPATIENT care	*7.7%*	*23.1%*	*69.2%*
		OUTPATIENT care	*7.7%*	*46.2%*	*46.2%*
		LONG TERM care	*23.1%*	*30.8%*	*46.2%*

11. Listed below are three categories of discretionary veterans. For each category, check the boxes to indicate in which years, if any, your VA Medical Center placed a limitation, in addition to any legally mandated limitations, on that category of veterans': LENGTH OF TREATMENT in specialty clinics, LENGTH OF CONTRACT PERIOD in long term care or LENGTH OF STAY in chronic care units. If the length of treatment, contract period or stay was not limited for any discretionary veteran in either year, check the box indicating that it was not limited. **(FOR EACH CATEGORY OF VETERAN, CHECK ONE RESPONSE FOR EACH ITEM.)** ***(N=158)***

Discretionary Veterans:		Length limited in FY 1990	Length limited in FY 1991	Length not limited during either year
Non-service connected "C" (and those previously classified as "B")	*Length of treatment in one or more VA specialty clinics*	*37.3%*	*40.5%*	*53.2%*
	Length of contract period in VA Nursing Homes and Domiciliaries	*19.0%*	*20.3%*	*66.5%*
	Length of contract period in VA sponsored Community Nursing Homes	*40.5%*	*37.3%*	*53.8%*
	Length of stay in chronic care units	*15.2%*	*13.9%*	*60.1%*
Non-service connected "A"	*Length of treatment in one or more VA specialty clinics*	*12.0%*	*15.2%*	*83.5%*
	Length of contract period in VA Nursing Homes and Domiciliaries	*4.4%*	*5.1%*	*87.3%*
	Length of contract period in VA sponsored Community Nursing Homes	*28.5%*	*27.2%*	*68.4%*
	Length of stay in chronic care units	*2.5%*	*3.2%*	*75.3%*
Service connected "A" (less than 50%)	*Length of treatment in one or more VA specialty clinics*	*9.5%*	*13.9%*	*85.4%*
	Length of contract period in VA Nursing Homes and Domiciliaries	*3.2%*	*4.4%*	*88.0%*
	Length of contract period in VA sponsored Community Nursing Homes	*23.4%*	*22.2%*	*73.4%*
	Length of stay in chronic care units	*1.3%*	*2.5%*	*75.9%*

12. At any time from the beginning of FY 1990 through the end of FY 1991, did any of the outpatient clinics at your VA Medical Center ever discharge a discretionary veteran who had a condition requiring ongoing medication in order to remain stable? *(N=158)*

60.8% YES

39.2% ---> **If "NO," skip to 14.**

13. For each category of discretionary veteran and fiscal year, approximately what percentage of the clinics at your VA Medical Center discharged **ALL, SOME** or **NONE** of the discretionary patients who had a condition requiring on going medication in order to remain stable? **(ENTER A PERCENTAGE FOR EACH.)** *(N=92)*

Range for each 0-100%		Percentage of clinics that discharged ALL		Percentage of clinics that discharged SOME		Percentage of clinics that discharged NONE		
Non-service connected "C"	FY 1990	*Mean = 36.7*	%	*Mean = 46.0*	%	*Mean = 17.0*	%	= 100%
	FY 1991	*Mean = 39.0*	%	*Mean = 43.1*	%	*Mean = 17.9*	%	= 100%
Non-service connected "A"	FY 1990	*Mean = 6.1*	%	*Mean = 36.3*	%	*Mean = 55.5*	%	= 100%
	FY 1991	*Mean = 5.1*	%	*Mean = 40.3*	%	*Mean = 53.6*	%	= 100%
Service connected "A" (less than 50%)	FY 1990	*Mean = 5.0*	%	*Mean = 29.2*	%	*Mean = 63.7*	%	= 100%
	FY 1991	*Mean = 4.1*	%	*Mean = 32.6*	%	*Mean = 62.3*	%	= 100%

14. At any time from the beginning of FY 1990 through the end of FY 1991, did any of the outpatient clinics at your VA Medical Center ever discharge a discretionary veteran who had a condition requiring periodic, routine monitoring by physician, but did not require ongoing medication? *(N=158)*

64.6% YES

35.4% NO ---> **If "NO," skip to 16.**

15. For each category of discretionary veteran and fiscal year, approximately what percentage of the clinics at your VA Medical Center discharged **ALL, SOME** or **NONE** of the discretionary patients who had a condition requiring periodic, routine monitoring by a physician, but did not require ongoing medication? **(ENTER A PERCENTAGE FOR EACH.)**
(N=97)

Range for each 0-100%		Percentage of clinics that discharged ALL		Percentage of clinics that discharged SOME		Percentage of clinics that discharged NONE		
Non-service connected "C"	FY 1990	*Mean = 44.2*	%	*Mean = 41.3*	%	*Mean = 13.5*	%	= 100%
	FY 1991	*Mean = 44.5*	%	*Mean = 38.1*	%	*Mean = 17.3*	%	= 100%
Non-service connected "A"	FY 1990	*Mean = 8.3*	%	*Mean = 37.0*	%	*Mean = 52.7*	%	= 100%
	FY 1991	*Mean = 7.3*	%	*Mean = 41.2*	%	*Mean = 50.4*	%	= 100%
Service connected "A" (less than 50%)	FY 1990	*Mean = 6.1*	%	*Mean = 31.3*	%	*Mean = 60.6*	%	= 100%
	FY 1991	*Mean = 5.2*	%	*Mean = 35.1*	%	*Mean = 58.8*	%	= 100%

16. Did you indicate when answering any of the previous questions that your VA Medical Center limited the care available for discretionary veterans at any time from the beginning of fiscal year **1990** through the end of fiscal year **1991**?
(N=158)

77.8% YES

22.2% NO ---> **If "NO," skip to question 18.**

17. Listed below are two fiscal years and reasons why a VA Medical Center might find it necessary to limit care. For each fiscal year, indicate if your VA Medical Center limited care because of each of the listed reasons. If your VA Medical Center did not limit care, check the box indicating that care was not limited during that year. **(CHOOSE ONE RESPONSE FOR EACH REASON.)** *(N=114)*

		Did you limit care for each of these reasons?		
	Reasons for limiting care:	NO	YES	Did not limit care in this fiscal year.
FY 1990	Staffing constraints	*26.3%*	*73.7%*	*0*
	Facility, equipment or supply constraints	*44.7%*	*55.3%*	
	Equity of Access Initiative	*35.1%*	*64.9%*	
	Other (PLEASE SPECIFY.) _____	*N/A*	*25.4%*	
FY 1991	Staffing constraints	*22.6%*	*77.4%*	*0*
	Facility, equipment or supply constraints	*40.9%*	*59.1%*	
	Equity of Access Initiative	*40.9%*	*59.1%*	
	Other (PLEASE SPECIFY.) _____	*N/A*	*28.7%*	

18. Listed below are two fiscal years and several actions that a VA Medical Center might take. For each fiscal year, indicate whether or not your VA Medical Center took each of the listed actions because of constraints on resources, such as staffing, facility, equipment or supplies. **(CHOOSE ONE RESPONSE FOR EACH ACTION.)** *(N=158)*

		Did your VA Medical Center take each action because of resource constraints?	
		NO	YES
FY 1990	Delayed planned renovations	*53.8%*	*46.2%*
	Delayed equipment purchases	*36.1%*	*63.9%*
	Reduced staff	*57.3%*	*42.7%*
	Converted beds from one medical service or level of care to another	*68.4%*	*31.6%*
	Closed beds	*54.1%*	*45.9%*
	Closed medical services	*88.0%*	*12.0%*
	Initiated "sharing agreements" with non-VA facilities	*64.3%*	*35.7%*
FY 1991	Delayed planned renovations	*48.7%*	*51.3%*
	Delayed equipment purchases	*36.7%*	*63.3%*
	Reduced staff	*42.4%*	*57.6%*
	Converted beds from one medical service or level of care to another	*67.1%*	*32.9%*
	Closed beds	*55.7%*	*44.3%*
	Closed medical services	*89.2%*	*10.8%*
	Initiated "sharing agreements" with non-VA facilities	*61.5%*	*38.5%*

19. Did you indicate when answering any of the previous questions that your VA Medical Center limited the care available for discretionary veterans during fiscal year 1991? *(N=158)*

76.6% YES

23.4% NO ---> **If "NO," skip to question 21.**

20. Listed below are several REFERRAL ACTIVITIES. During fiscal year 1991, in about what proportion of the cases where a discretionary veteran's care was limited, did your VA Medical Center provide each of the following referral services? **(PLEASE MARK ONE RESPONSE FOR EACH ACTIVITY.)** *(N=119)*

Referral or Follow-up Activities:	Few If Any (1)	Some (2)	About Half (3)	Most (4)	All or Almost All (5)
Suggest an alternative VA health-care facility	*65.3%*	*22.9%*	*0%*	*3.4%*	*8.5%*
Suggest an alternative non-VA health-care facility	*8.4%*	*22.7%*	*1.7%*	*25.2%*	*42.0%*
Make telephone call to determine availability of service in an alternative VA facility	*59.7%*	*28.6%*	*0%*	*5.9%*	*5.9%*
Make telephone call to determine availability of service in an alternative non-VA facility	*31.9%*	*42.0%*	*3.4%*	*10.1%*	*12.6%*
Transport veteran to an alternative VA facility	*83.2%*	*13.4%*	*0%*	*.8%*	*2.5%*
Transport veteran to an alternative non-VA facility	*84.7%*	*12.7%*	*0%*	*.8%*	*1.7%*
Arrange placement or appointment in an alternative VA facility	*67.2%*	*26.1%*	*1.7%*	*1.7%*	*3.4%*
Arrange placement or appointment in an alternative non-VA facility	*46.2%*	*40.3%*	*3.4%*	*5.9%*	*4.2%*
Call a veteran ONCE to see if s/he needs assistance locating health-care elsewhere	*64.7%*	*26.1%*	*2.5%*	*2.5%*	*4.2%*
Call a veteran MORE THAN ONCE to see if s/he continues to need assistance locating health-care elsewhere	*89.1%*	*10.1%*	*.8%*	*0%*	*0%*
Write to a veteran ONCE to see if s/he needs assistance locating health-care elsewhere	*76.5%*	*16.0%*	*.8%*	*.8%*	*5.9%*
Write to a veteran MORE THAN ONCE to see if s/he continues to need assistance locating health-care elsewhere	*91.6%*	*7.6%*	*.8%*	*0%*	*0%*

21. Since FY 1988, has this VA Medical Center ever collected any information on the number of discretionary veterans for whom care has been limited? *(N=158)*

    22.8% YES

    77.2% NO

22. Since FY 1988, has this VA Medical Center ever studied the IMPACT of limiting care provided for discretionary veterans? *(N=158)*

    6.3% YES

    93.7% NO

23. If the answer to either question 21 or question 22 is "YES," please enclose a copy of the information or study with this questionnaire and send it to:

    US General Accounting Office
    ATTN: Arthur Fine
    10 Causeway Street, Room 575
    Boston, MA 02222

24. If you would like to include any additional information or would like to comment on the care of discretionary veterans, please use the space below.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Paul Reynolds, Assistant Director (202) 512-7116 Walter Gembacz, Assignment Manager Mark Vinkenes, Senior Social Science Analyst Linda Stinson, Social Science Analyst
Boston Regional Office	Michelle Roman, Regional Management Representative Arthur Fine, Evaluator-in-Charge Michelle St. Pierre, Evaluator

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