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Report to Congressional Requesters

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VA HEALTH CARE

More Veterans Are Being Served, but Better Oversight Is Needed

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Congressional Requesters

This report presents information on changes in veterans' access to health care in Veterans Integrated Service Network 3 (VISN 3) headquartered in Bronx, New York, and VISN 4 headquartered in Pittsburgh, Pennsylvania. It also discusses major reforms under way in the Department of Veterans Affairs' funding and managing of health care nationwide. This report is required by Conference Report No. 105-297 accompanying P.L. 105-65, Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 1998.

We are sending this report to the Secretary for Veterans Affairs and other interested parties. We will also make copies available upon request.

If you have any questions about the report, please call me at (202) 512-7101 or Bruce Layton, Assistant Director, at (202) 512-6837. Other major contributors are listed in appendix II.

Stephen P. Backhus

Director, Veterans' Affairs and
Military Health Care Issues

B-280054

List of Requesters

The Honorable Ted Stevens
Chairman
The Honorable Robert C. Byrd
Ranking Minority Member
Committee on Appropriations
United States Senate

The Honorable Bob Livingston
Chairman
The Honorable David R. Obey
Ranking Minority Member
Committee on Appropriations
House of Representatives

The Honorable Christopher S. (Kit) Bond
Chairman
The Honorable Barbara Mikulski
Ranking Minority Member
Subcommittee on VA, HUD,
and Independent Agencies
Committee on Appropriations
United States Senate

The Honorable Jerry Lewis
Chairman
The Honorable Louis Stokes
Ranking Minority Member
Subcommittee on VA, HUD,
and Independent Agencies
Committee on Appropriations
House of Representatives

Executive Summary

Purpose

In the last several years, the Department of Veterans Affairs (VA) has introduced two major initiatives to change the way it manages its $17 billion health care system. In fiscal year 1996, VA decentralized the management structure of its Veterans Health Administration (VHA) to form 22 Veterans Integrated Service Networks (VISN) to coordinate the activities of hundreds of hospitals, outpatient clinics, nursing homes, and other facilities. VA expected the geographically distinct VISNs to improve efficiency by reducing unnecessarily duplicative services (for example, by consolidating medical facilities and programs) and shifting services from costly inpatient care to less costly outpatient care. VA expected access to improve because it could redirect resources to serve more patients. To accomplish these goals, VA gave each VISN substantial operational autonomy and established performance measures to hold network and medical center directors accountable for achieving the goals.

In addition, in April 1997, VA began to phase in the Veterans Equitable Resource Allocation (VERA) system to allocate resources to the 22 VISNs. (Implementation of VERA will be complete in about 2000.) Before VERA, each medical center received and managed its own budget. VA designed VERA in response to 1996 legislation that required VA to reduce historic regional inequities in resource allocation and improve veterans' access to care.[1] Inequities had resulted from a dramatic shift in the veteran population from the Northeast and Midwest to the South and West that took place without a respective shift in resource allocation. To allocate resources more equitably, VA uses VERA to move funds among the networks. Each VISN is then responsible for allocating those resources among the facilities in its prescribed geographic area to ensure care and equitable access within the network and to accomplish other national VA goals such as reducing costs.

Concerned that some VISNs would be required to implement significant cost-saving steps to manage within the diminished resources they would receive under VERA and that these VISNs would reduce veterans access to care as a result, the Committees on Appropriations directed GAO to examine changes in access to care in two VISNs, VISN 3 headquartered in Bronx, New York, and VISN 4 headquartered in Pittsburgh, Pennsylvania. VA projected that VISN 3 (Bronx) would lose the largest proportion of resources compared with other networks and that VISN 4 (Pittsburgh) would lose some resources, but the change would be the smallest for any VISN. As requested, GAO is reporting on three issues: (1) changes in overall access to care, changes in access to certain specialized services, and a

[1]Section 429 of P.L. 104-204.

comparison of changes in these networks with VA national data from fiscal years 1995 to 1997; (2) the extent to which VA headquarters and VISNs are working to equitably allocate resources to facilities within VISNs; and (3) the adequacy of VA's oversight of changes in access to care.

Background

VA operates one of the nation's largest health care systems, encompassing approximately 400 service delivery locations. In fiscal year 1997, it provided care to about 2.7 million of the nation's 26 million veterans. The Congress requires VA to provide services on a priority basis to veterans with service-connected disabilities, low incomes, or special health care needs—also referred to as Category A veterans. It may also provide services to other veterans as resources allow.

To improve the efficiency of its system and veterans' access to care, VA is fundamentally changing its health care delivery. Borrowing ideas from the private sector, VA has increased its emphasis on applying managed care practices, such as primary, outpatient, and preventive care, and decreased its emphasis on providing inpatient care. VA is trying to reengineer its system, while maintaining its core mission of efficiently managing and financing the often costly care of special populations with chronic conditions such as spinal cord injury (SCI) or serious mental illness.

Results in Brief

Overall, VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA nationally have increased access as measured by increases in the number of veterans served. For example, between fiscal years 1995 and 1997, VISN 3 (Bronx) increased the number of veterans served by more than 2 percent; VISN 4 (Pittsburgh), by nearly 22 percent; and VA nationally, by more than 5 percent. Access to care, as measured by patient satisfaction, also seems to have improved according to responses to VA surveys and interviews GAO conducted. In addition, VA has improved geographic access to primary care by increasing the number of community-based clinics in these two VISNs. Although access has increased overall, access appears to have decreased for some specific services GAO reviewed. For example, VISN 3 (Bronx) served fewer patients with SCIs, and VISN 4 (Pittsburgh) served fewer patients with post-traumatic stress disorder (PTSD).

The two VISNs GAO reviewed used no specific criteria for allocating their resources to reduce historical access inequities among their facilities. VA headquarters neither provides criteria for VISNs to use to equitably allocate resources nor reviews the allocations for equity. Although VA has made

progress in improving the equity of resource allocations nationwide among the networks, it has done little to ensure that the networks fulfill VERA's promise as they allocate resources to their facilities.

Although GAO prepared an overall assessment of access to care, difficulties in working with the data cast doubt on whether VA can perform timely and effective oversight. The information GAO developed on changes in access to care at the facility and network levels for VISN 3 (Bronx) and VISN 4 (Pittsburgh), as well as for VA nationally, was gathered from many VA reports and databases—some of which had inconsistent or incompatible information that GAO was able to resolve. Moreover, medical center, VISN, and headquarters officials told us that such data are not available on a routine, timely basis—particularly for specific programs. Without such information, it is difficult for them to say conclusively whether VA has improved veterans' equity of access to care and whether veterans—particularly those who had been receiving high-cost care for chronic conditions—have not been adversely affected by the many changes under way to reduce costs and improve productivity.

By taking several actions, VA could improve its oversight of changes in access to care and its resource allocation process. These actions include improving data collection and dissemination efforts regarding changes in access to care and establishing criteria for VISNs to use for more equitably allocating resources to their facilities.

Principal Findings

Access to Care Continued to Increase Under VERA

Veterans' access to care generally continued to increase under VERA in VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA nationally as measured by the number of veterans served (see table 1). Increases in access to care predate VERA but appear to have accelerated with VERA's implementation in April 1997.

Table 1: Change in Patients Served, Fiscal Years 1995-97

Entity	All patients served[a] Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	Percentage change in all patients served, fiscal years 1995-97
VISN 3 (Bronx)	148,398	148,865	151,611	+2.2
VISN 4 (Pittsburgh)	139,049	145,641	169,398	+21.8
VA nationally	2,843,534	2,895,819	2,996,346	+5.4

[a]Unduplicated count of patients served each year.

Source: VA.

The two VISNs and VA nationally are improving access by providing more services on an outpatient basis; providing more health care service locations, for example, establishing community-based and mobile clinics; and shortening veterans' waiting times for receiving services. For example, VISN 3 (Bronx) opened seven new service sites, and VISN 4 (Pittsburgh) opened four during fiscal years 1996 and 1997, improving veterans' geographic access to care. The two VISNs have also used outreach efforts, namely, hospital- and community-based health fairs and screenings, to identify veterans not previously served. Veterans' satisfaction with access to care has improved according to responses to VA surveys and interviews GAO conducted.

Although VA served more veterans in nearly all the specific services GAO reviewed, fewer veterans received some VA services. For example, the number of SCI patients treated in SCI centers and clinics declined in VISN 3 (Bronx) from 467 in fiscal year 1995 to 441 in fiscal year 1997. The number of PTSD patients declined in VISN 4 (Pittsburgh) from 2,173 to 2,155. The number of patients treated with a primary diagnosis of substance abuse declined by about 5 percent nationwide and about 3 percent in VISN 3 (Bronx).

The two VISNs increased veterans' access to care despite reductions in the buying power of their allocations by increasing the efficiency of their health care delivery. For VISN 3 (Bronx), lower VERA allocations and VISN management decisions combined with inflation reduced the buying power of its more than a $1 billion budget by $91 million from fiscal year 1995 to fiscal year 1997. For VISN 4 (Pittsburgh), the buying power of its budget of more than $800 million declined $17 million in the same period. To achieve

efficiencies, VISN 3 (Bronx) reduced its full-time employee equivalents (FTEE) by 2,070 (about 15 percent) during this period, for a cost reduction of about $110 million. VISN 4 (Pittsburgh) reduced its FTEEs by 1,485 (about 14 percent) for a cost reduction of about $79 million. Both VISNs also increased their productivity—for example, by expanding clinic hours, increasing the number of examination rooms, and improving scheduling—resulting in each provider seeing more patients. Officials from both VISNs said they expect to continue increasing access to care in fiscal year 1998 by continuing to improve efficiency and obtaining new resources from third-party health insurance collections. For fiscal year 1998, VA set a collection goal of about $596 million nationally, about $44 million for VISN 3 (Bronx), and about $36 million for VISN 4 (Pittsburgh).

VA Has Done Little to Improve Equity of Resource Allocations to Facilities

As permitted under VA's decentralized management structure, the two VISNs use different methods to allocate resources among their facilities. Neither VISN used criteria, however, to address equitable allocation issues in facility allocations for fiscal years 1997 and 1998 nor did headquarters provide criteria for the VISNs to use. Historical inequities have existed within as well as among VISNs, and VISN 3 (Bronx) and VISN 4 (Pittsburgh) recognized historical inequities in their respective networks in their fiscal year 1998 strategic plans. Equitably allocating resources within each VISN is important in following through on VERA's promise of a more equitable allocation of resources for the nation's veterans. Without an equitable allocation of resources within their networks, VISN 3 (Bronx) and VISN 4 (Pittsburgh) face the risk of growth in access without progress in achieving equitable access.

VA Oversight of Access to Care Is Inadequate

Although GAO prepared an overall assessment of access to care, difficulties in working with the data cast doubt on whether VA can perform timely and effective oversight. The information GAO developed on changes in access to care at the facility and network levels for VISN 3 (Bronx) and VISN 4 (Pittsburgh), as well as VA nationally, was gathered from many VA reports and databases—some of which had inconsistent or incompatible information. Responsibility for generating data and reporting results is fragmented in VA's system; definitions for data on the number of patients served have changed several times, reducing their comparability; and managers lack timely and useful information on waiting times for care and satisfaction with access. VA managers told us they do not have timely, comparable, and comprehensive information, particularly for specific programs, that they need to monitor changes in access to care—including

changes in the equity of access within and among networks—to understand what is happening locally and nationwide. As a result, they cannot be certain that veterans—particularly those who have been receiving high-cost care for chronic conditions—are not adversely affected by the many changes under way to reduce costs and improve productivity.

Recommendations

To improve VA's oversight of changes in access to care, GAO is making several recommendations to the Secretary for Veterans Affairs. These recommendations require VA to develop uniform definitions and timely reporting of changes in access to care, develop criteria for equitably allocating resources to facilities, and monitor improvements to equity of access within and among VISNs.

Agency Comments and GAO'S Evaluation

In commenting on a draft of this report (see app. I), VA said it is working to improve its information systems so that they will be more useful to VISN and headquarters management. VA expressed concern, however, that GAO's recommendation to develop national criteria for equitably allocating resources to facilities with national oversight is contrary to VHA's reengineering philosophy, which decentralizes authority and accountability for these allocations to the network directors.

GAO supports VA's intention to improve its data systems. Improvements are essential to allow VA managers to identify problems and take corrective action in a more timely way to help ensure that veterans' access to care does not deteriorate in the environment of a transformed VA health care system. However, GAO believes VA can develop criteria for VISNs' use in equitably allocating resources to their respective facilities and review VISNs' performance in addressing these criteria without being so prescriptive that local authority and accountability are compromised. Having criteria does not preclude VISNs from using different methods for allocating resources to address local circumstances and VA's national criteria.

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Abbreviations

ARC	Allocation Resource Center
FTEE	full-time employee equivalent
PRRTP	Psychiatric Residential Rehabilitation Treatment Program
PTSD	post-traumatic stress disorder
SCI	spinal cord injury
SMI	serious mental illness
VA	Department of Veterans Affairs
VAMC	Veterans Affairs medical center
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Background

The Department of Veterans Affairs (VA), the nation's largest integrated health care system, has fundamentally changed the way it manages and delivers health care to veterans.[2] Two major initiatives have been central to its strategy to reduce costs and expand access. First, in fiscal year 1996, VA decentralized the management structure of its Veterans Health Administration (VHA) to form 22 Veterans Integrated Service Networks (VISN) to coordinate the activities of hundreds of hospitals, outpatient clinics, nursing homes, and other facilities in each area.[3] VA gave each network substantial operational autonomy and established performance measures to hold network and medical center directors accountable for achieving VA's goals.

In April 1997, VA began to phase in its second initiative, the Veterans Equitable Resource Allocation (VERA) system for allocating resources to the 22 VISNs. VERA is designed to allocate comparable resources for each veteran user among VISNs. When VERA is fully implemented in about 2000, VA expects it to shift resources from VISNs in the Northeast and Midwest, such as VISN 3 (Bronx) and VISN 4 (Pittsburgh), to VISNs in the South and West, correcting historic regional inequities in resource allocation. This allocation method requires that VISNs, in turn, equitably allocate the resources they receive to their respective medical facilities.

VA Has Changed Its Delivery of Health Care

The VA health care system, which has about 400 service delivery locations, spent about $17 billion to provide care to approximately 2.7 million of the nation's 26 million veterans in fiscal year 1997. The Congress requires VA to provide services on a priority basis to veterans with service-connected disabilities, low incomes, or special health care needs—commonly referred to as Category A veterans. VA may also provide services to other veterans as resources allow.

To improve the efficiency of its system and veterans' access to care, VA is fundamentally changing its health care delivery. Applying lessons learned from the private sector's experience with managed health care, VA has increased its emphasis on primary, outpatient, and preventive care and decreased its emphasis on inpatient care. VA has a particularly challenging task because its core mission includes caring for patients with chronic

[2]Vision for Change: A Plan to Restructure the Veterans Health Administration, VA (Washington, D.C.: Mar. 1995); Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System, VA (Washington, D.C.: Mar. 1996); and Journey of Change, VA (Washington, D.C.: Apr. 1997).

[3]VHA is the organizational unit within VA responsible for providing medical care to eligible veterans.

conditions such as spinal cord injuries (SCI) or serious mental illnesses (SMI). In addition, the often costly and longer term care of such patients has not typically been included on a large scale in the health care sector in general.[4]

Two Key Initiatives Have Reshaped Management of VA Health Care

In the last few years, VA has undertaken two major initiatives in reshaping its service delivery system to expand access, become a more efficient provider of care, and improve equity of resource allocations nationwide. These initiatives are the decentralization of VA's health care management structure and the creation of a new resource allocation system.

VA Health Care Management Structure Decentralized

In fiscal year 1996, VHA shifted management authority from headquarters to 22 newly created VISNs, each led by a director and a staff of medical, budget, and administrative officials. (See fig. 1.1 for a map of the VISNs.) VISNs have been organized in part on the basis of VHA's natural patient referral patterns and the aggregate number of beneficiaries and facilities needed to support their care. VISNs have substantial operational autonomy and perform the basic decisionmaking and budgetary duties of the VA health care system. Each network allocates funds and monitors the operations of the hospitals, outpatient clinics, nursing homes, domiciliaries, and other medical programs in its geographic area.[5] Before the creation of VISNs, each medical center received and managed its own budget. VISNs vary in several ways, including geographic size—ranging from about 10,000 square miles in VISN 3 (Bronx) to 885,000 square miles in VISN 20 (Portland)—and the services provided, reflecting, for example, historically longer inpatient and nursing home stays in the Northeast.

[4]For a discussion of related issues, see Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996).

[5]For a discussion of VA networks, see VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

Figure 1.1: Veterans Integrated Service Networks

Source: VA.

Under the decentralized VISN system, network and medical center directors are held accountable for increasing efficiency and improving access. VISNS are responsible for improving access and reducing costs in part by implementing efficiencies that shift resources from costly inpatient care to less costly outpatient care. They can consolidate programs and facilities to eliminate duplicative services. Network directors are held accountable by performance measures for systemwide and network-specific goals for increasing the number of outpatient surgeries, reducing the use of

inpatient care, and increasing the number of high-priority veterans served who had not previously received care from VA. These goals are generally similar to those identified in VA's Strategic Plan for fiscal years 1998 to 2003.[6]

VA has expanded outpatient care in existing medical centers and established more clinical settings to provide VA-provided or -sponsored care in the community. The Congress supported this strategy by enacting legislation in October 1996 that eliminated several restrictions on veterans' eligibility for VA outpatient care and enabled VA to serve more patients on an outpatient basis.[7] This legislation also permitted VA to contract with other health care providers to care for veterans in community-based clinics and other non-VA settings.

System Adopted to Improve Equity of Resource Allocation

The Congress required VA to address inequities in the allocation of resources nationwide. It required VA to develop a plan for equitably allocating resources to ". . . ensure that veterans who have similar economic status and eligibility priority and who are eligible for medical care have similar access to such care regardless of the region of the United States in which such veterans reside."[8] A dramatic shift in the veteran population from the Northeast and Midwest to the South and West without a respective shift in resource allocations caused the inequities. Allocations did not shift when the veteran population did because VA allocated resources to facilities primarily on the basis of their historical budgets, and facilities were disproportionately located in the Northeast and Midwest. As a result, VA's resources were not equitably allocated nationwide and VA could not ensure that veterans who had similar economic status and eligibility priority had similar access to care.

In response to the legislative requirement, VA developed VERA and began to phase it in during fiscal year 1997. VERA allocates resources to the networks and provides them incentives for achieving cost efficiencies and serving more veterans. VERA has improved the equity of resource allocation to networks because, compared with the system it replaced, it provides

[6]The Department of Veterans Affairs Strategic Plan, Fiscal Years 1998-2003, VA (Washington, D.C.: Sept. 30, 1997) is VA's first strategic plan based on the requirements of the Government Performance and Results Act of 1993. The act requires agencies to set goals, measure performance, and report on their accomplishments. The intent is for an agency to define what desired results it wishes to achieve, identify the strategy to achieve the desired results, and then determine how well it succeeded in reaching results-oriented goals and achieving objectives.

[7]P.L. 104-262.

[8]Section 429 of P.L. 104-204.

more comparable levels of resources to each network for each high-priority veteran served.[9] A crucial element in VA's overall allocation strategy is VISNs' allocations of VERA resources to their facilities. Each VISN is responsible for allocating resources among its facilities to achieve equitable access within its prescribed geographic area and to accomplish other national VA goals such as reducing costs. Allocations to an individual medical facility may increase or decrease in any year regardless of whether overall allocations to its VISN increase or decrease.

To improve equity of resource allocation, VA uses VERA to move funds among the networks. Networks that increase their patient workload compared with other networks gain resources under VERA; those whose patient workloads decrease compared with other networks lose resources. More efficient networks (that is, those whose patient care costs are below the VA national average cost) have more funds available for local initiatives. Less efficient networks (whose patient care costs are above the VA national average cost), however, must increase efficiency to have such funds available. Because patient costs in the Northeast and Midwest networks have generally been above the national average, after adjustments for case mix and labor costs, VA has projected that most VISNs in those regions will have reduced allocations under VERA.

VERA allocates about 89 percent of VA's medical care resources to the VISNs at the start of a fiscal year. For the most part, VISNs can use this general-purpose allocation as they deem appropriate. VA headquarters allocates almost all the remaining medical care appropriation to VISNs and to facilities throughout the fiscal year for specific purposes such as prosthetics, state veterans' homes, readjustment counseling, and other activities. The use of these funds is restricted to the purpose for which they are allocated.

The formula for the general-purpose allocation includes two key estimates: an estimate of the number of high-priority veterans a network can serve for routine services (called basic care) and an estimate of the number who could be served for more expensive, complex care for patients with chronic conditions (called special care).[10] The formula calculates a VISN's allocation on the basis of the number of veterans served in each category and the average national cost of care for a patient in each

[9]See VA Health Care: Resource Allocation Has Improved, but Better Oversight Is Needed (GAO/HEHS-97-178, Sept. 17, 1997) for a discussion of issues related to VERA.

[10]Each VISN also receives funding by formula for other health-related functions, including research, education, equipment, and nonrecurring maintenance through the use of national cost estimates for each activity.

category, which is referred to as the capitation rate. Adjustments for regional labor costs are also made. The special care capitation rate is higher to ensure that networks with disproportionately large numbers of patients with complex or chronic conditions, such as SCI, advanced acquired immunodeficiency syndrome, or chronic mental illness, have adequate funds to care for patients with these more costly conditions.[11] A facility's expenses for treating an individual patient or a group of patients in either the basic or the special care category, however, may exceed or be below the capitation rate for that category.

Objectives, Scope, and Methodology

Concerned that some VISNs would be required to implement significant cost-saving steps to manage within the diminished resources they would receive under VERA and that these VISNs would reduce veterans' access to care as a result, the Committees on Appropriations directed us to examine changes in access to care in two VISNs: VISN 3 headquartered in Bronx, New York, and VISN 4 headquartered in Pittsburgh, Pennsylvania. Additional concerns—that the quality of care was declining in VISN 3 (Bronx) as a result of allocation reductions—were being investigated by VA.[12] VA has projected that VISN 3 (Bronx) would lose the largest proportion of resources compared with other networks when VERA is fully implemented in about the year 2000. VA has also projected that VISN 4 (Pittsburgh) would lose some resources, but VA projected this VISN to have the smallest change of any VISN. Concerns were also expressed about the method used by VISN 4 (Pittsburgh) for allocating resources to facilities within its area. As requested, we are reporting on three issues: (1) changes in overall access to care, changes in access to certain specialized services, and a comparison of changes in these networks with VA national data from fiscal years 1995 to 1997; (2) the role of VA headquarters and VISNs in determining equitable allocations to facilities within VISNs; and (3) the adequacy of VA's oversight of changes in access to care.

VISN 3 (Bronx) provides VA health care in the southern Hudson River Valley of New York, New York City, Long Island, and northern New Jersey. The

[11]The VERA special care category also includes some adjustment for age to account for expected changes in the age distribution of veterans in a network.

[12]During our work, the Office of the Medical Inspector reported that quality of care problems it identified in the Hudson Valley Healthcare System were not related to changes in VISN 3's (Bronx) allocation. See Final Report, FDR Hospital, Montrose, N.Y., VA Medical Center Castle Point, N.Y., VA Hudson Valley Healthcare System, VISN 3, (6 volumes), VA Office of the Medical Inspector (Washington, D.C.: Dec. 1, 1997).

network has six medical centers[13] composed of nine geographically distinct facilities. The network recently implemented two facility integrations: East Orange and Lyons VA medical centers (VAMC) were integrated into the New Jersey Healthcare System in fiscal year 1996, and the Montrose and Castle Point VAMCs were integrated into the Hudson Valley Healthcare System in fiscal year 1997. A unique feature of this network is the geographic proximity of its medical centers—all are within a 60-mile radius in an area where an estimated 1.4 million veterans lived in 1997. VISN 3 (Bronx) covers the smallest geographic area of the 22 networks.

VISN 4 (Pittsburgh) provides VA health care in Delaware, most of Pennsylvania, southern New Jersey, and parts of West Virginia, Ohio, and New York. The network has 10 medical centers in 12 geographic locations.[14] In October 1996, VA integrated three facilities to form the Pittsburgh Healthcare System. The area the network covers had approximately 1.7 million veterans in 1997.

To assess changes in veterans' access to services and VA's monitoring of those changes, we reviewed data primarily from fiscal years 1995 to 1997. We used these data to assess overall changes in access for patients and to assess changes in access for specific patient groups: SCI patients; patients with mental illnesses, including SMI, post-traumatic stress disorder (PTSD), and substance abuse; and patients receiving surgical services. Finally, we used the data to assess the availability of prosthetics services. We chose most of these services because of concerns raised by veterans' service organizations and others that such services' relatively high cost could lead to pressures to decrease their availability. We chose to examine access to surgical services because of the major changes VA has implemented to expand the use of outpatient surgery, while reducing inpatient surgeries. We collected and analyzed data on the number of veterans served, waiting times, service locations, financial and employee resources, and veterans' satisfaction with access to services, among other indicators.

We visited network offices in VISN 3 (Bronx) and VISN 4 (Pittsburgh) and obtained documents from and interviewed network management and staff. In VISN 3 (Bronx), we visited three VAMCs in New York—Bronx, Montrose, and Castle Point—and two in New Jersey—East Orange and Lyons. In VISN

[13]Medical centers in VISN 3 (Bronx) include Bronx, Brooklyn, New York, Northport, Hudson Valley Healthcare System, and New Jersey Healthcare System.

[14]Medical centers in VISN 4 (Pittsburgh) include Altoona, Butler, Coatesville, Erie, Lebanon, Philadelphia, Pittsburgh, and Wilkes-Barre, Pa.; Wilmington, Del.; and Clarksburg, W. Va.

4 (Pittsburgh), we visited the Highland Drive and University Drive divisions of the Pittsburgh Healthcare System, and the VAMCs in Butler, Pennsylvania, and Clarksburg, West Virginia. In visiting these facilities, we obtained data from and interviewed directors, financial officers, physicians, nurses, union representatives, and local veterans' service organization representatives.

We gathered information on network allocation of resources to facilities from network offices and the facilities we visited. We also conducted telephone interviews with officials from the Philadelphia, Lebanon, and Wilkes-Barre, Pennsylvania, VAMCs concerning VISN 4's (Pittsburgh) method for allocating resources to its facilities.

To obtain or corroborate VA national, network, and facility data, we also interviewed officials and reviewed documents from VHA's many organizations. These included the Office of Policy and Planning; Office of Performance and Quality; Office of the Chief Financial Officer; Office of Inspector General; Program Evaluation and Resource Center, Palo Alto, California; Northeast Program Evaluation Center, West Haven, Connecticut; Allocation Resource Center, Boston, Massachusetts; National Performance Data Resource Center, Durham, North Carolina; National Customer Feedback Center, West Roxbury, Massachusetts; VISN Support Service Center, San Francisco, California; and headquarters strategic health care groups on surgery, prosthetics, and mental health. When we identified inconsistencies between databases, we tried to resolve them by interviewing officials responsible for creating or maintaining the databases, updating the databases with additional information VA provided, and requesting special data runs with parameters that we specified. We asked VA officials to review the data we used in this report to ensure accuracy.

We performed our review in accordance with generally accepted government auditing standards between October 1997 and August 1998.

Access to Care Continues to Increase Under VERA

The many data sources we reviewed showed generally improved veterans' access to care under VERA in VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA nationally. Even as VERA began shifting some resources from northeastern and midwestern VISNs to other areas in fiscal year 1997, overall, these two VISNs continued to provide increased access to care as they had before VERA's implementation.[15] Today, these two VISNs are serving more veterans, while the distance veterans need to travel for care in these VISNs is generally decreasing. Veterans' satisfaction with access to care and the amount of time veterans report waiting for care are also improving overall. Although access is improving overall, it appears to have decreased for some services in certain locations, according to our review.

VISN and VAMC officials told us they improved access in part by increasing their efficiency. In doing so, they served more veterans by using these efficiencies to offset their reduced buying power resulting from VERA and from inflation.

Overall Access to Care Is Improving in VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA Nationally

VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA nationally increased the number of unique patients and those who are high priority, that is, Category A veterans, served from fiscal year 1995 to fiscal year 1997 (see table 2.1).[16] VISN 4 (Pittsburgh) had the highest rate of increase of any VISN. Changes in total patients and Category A veterans served varied significantly by VISN.

Table 2.1: Change in Unique Patients Served, Fiscal Years 1995-97

	All patients served			Percentage change in all patients served, fiscal years 1995-97	Category A Veterans served			Percentage change in category A veterans served, fiscal years 1995-97
Entity	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997		Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	
VISN 3[a]	148,398	148,865	151,611	+2.2	115,758	115,502	118,217	+2.1
Bronx	24,689	23,963	22,229	–10.0	19,636	19,387	18,806	–4.2
Brooklyn	30,878	31,033	30,033	–2.7	23,867	23,771	23,467	–1.7
Hudson Valley[b]	15,440	16,774	19,807	+28.3	11,442	12,549	14,478	+26.5

(continued)

[15]VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

[16]VA counts unique patients using their Social Security numbers to establish the number of unduplicated users of its health care system.

Entity	All patients served			Percentage change in all patients served, fiscal years 1995-97	Category A Veterans served			Percentage change in category A veterans served, fiscal years 1995-97
	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997		Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	
New Jersey[c]	36,805	37,417	38,442	+4.4	29,312	29,902	30,240	+3.2
New York	30,938	31,650	29,009	–6.2	27,154	27,677	25,430	–6.3
Northport	22,208	22,819	23,949	+7.8	16,572	16,589	17,521	+5.7
VISN 4[a]	139,049	145,641	169,398	+21.8	118,240	124,817	144,018	+21.8
Altoona	7,449	8,106	8,894	+19.4	6,841	7,372	7,978	+16.6
Butler	7,146	8,869	11,333	+58.6	6,293	7,735	9,002	+43.0
Clarksburg	10,507	10,752	12,539	+19.3	9,259	9,652	11,069	+19.5
Coatesville	8,232	9,123	12,450	+51.2	6,402	7,373	10,275	+60.5
Erie	9,359	9,729	11,401	+21.8	8,205	8,416	9,706	+18.3
Lebanon	13,655	14,230	17,025	+24.7	11,513	12,219	14,574	+26.6
Philadelphia	27,971	28,270	30,941	+10.6	24,256	24,451	26,942	+11.1
Pittsburgh Healthcare System[d]	34,220	35,469	40,154	+17.3	28,626	30,306	34,761	+21.4
Wilkes-Barre	19,192	20,993	25,628	+33.5	17,276	18,767	22,487	+30.2
Wilmington	13,517	13,469	14,310	+5.9	11,638	11,714	12,242	+5.2
VA nationally	2,843,534	2,895,819	2,996,346	+5.4	2,421,476	2,451,766	2,555,512	+5.5

[a]The total number of unique patients served by each VISN is less than the sum of unique patients served by each of its facilities because some patients receive care at more than one facility.

[b]The Hudson Valley Healthcare System was formed by the integration of Montrose and Castle Point VAMCs.

[c]The New Jersey Healthcare System was formed by the integration of East Orange and Lyons VAMCs.

[d]The Pittsburgh Healthcare System was formed by the integration of Pittsburgh, Highland Drive; Pittsburgh, University Drive; and Aspinwall facilities.

Source: VISN Support Service Center, San Francisco, Cal., and National Performance Data Resource Center, Durham, N.C. At our request, these centers provided data for fiscal years 1995 to 1997 consistent with the fiscal year 1998 performance indicator. This indicator counts unique users for 12 months each year. Indicators VA used previously were not comparable.

VISN and medical center officials told us that they wanted to increase the number of veterans served for several reasons. They told us it helped them meet national VA goals for expanding access. Increasing this workload also increases a VISN's future allocation because VERA generally allocates resources to each VISN on the basis of the number of high-priority veterans (Category A) served. In addition, VAMC officials in VISN 4 (Pittsburgh) told

us they had another incentive to increase workload: the network allocated some resources to facilities for each additional veteran served in fiscal year 1997.

VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA nationally are continuing to increase the number of veterans they serve in fiscal year 1998. On the basis of veterans served through the first half of fiscal year 1998, VA projects that both the VISNs and VA will serve more Category A veterans in fiscal year 1998 than in fiscal year 1997 (see table 2.2).

Table 2.2: Projected Growth in Category a Veterans Served, Fiscal Years 1997-98

Entity	Category A veterans served, fiscal year 1997	Projected Category A veterans to be served, fiscal year 1998	Projected percentage change
VISN 3 (Bronx)	118,217	119,480	+1.1
VISN 4 (Pittsburgh)	144,018	154,655	+7.4
VA nationally	2,555,512	2,637,667	+3.2

Source: VHA 1998 2nd Quarter Network Performance Report.

The VISNs' and VA's efforts to increase outpatient care significantly affected the number of unique outpatients served in fiscal year 1997 (see table 2.3). Although increases in the use of outpatient care had been under way for more than a decade, the number of unique patients served on an outpatient basis increased noticeably in fiscal year 1997.

Table 2.3: Changes in Unique Veterans Seen on an Outpatient Basis, Fiscal Years 1995-97

Entity	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	Percentage change, fiscal years 1995-97
VISN 3 (Bronx)	117,684	119,834	127,313	+8.2
VISN 4 (Pittsburgh)	115,268	122,631	148,323	+28.7
VA nationally	2,454,936	2,502,554	2,644,722	+7.7

Source: VA Office of Policy and Planning.

VISN and facility officials told us that they implemented a variety of initiatives to increase the number of patients served. Expanding the use of primary care teams in medical centers and community clinics significantly

contributed to serving more outpatients.[17] Medical center officials told us that to accommodate more outpatients, they also expanded clinic hours for seeing patients, improved scheduling, and expanded the number of examination rooms for each provider to improve productivity.

According to VISN and medical center officials, they could implement these initiatives by changing their service delivery and by shifting resources from inpatient to outpatient care. For example, Clarksburg VAMC officials told us they served more patients in their PTSD program as well as shortened the time veterans spent waiting to enter the program by changing it from an inpatient to a residential program, reducing the number of days in the program, and changing the staffing mix. Both VISNs have reduced their average daily inpatient census as has VA nationally.[18] (See table 2.4.)

Table 2.4: Change in Inpatient Average Daily Census, Fiscal Years 1995-97

Entity	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	Percentage change, fiscal years 1995-97
VISN 3 (Bronx)	3,055	2,626	2,000	–34.5
VISN 4 (Pittsburgh)	2,474	2,021	1,377	–44.3
VA nationally	37,003	31,666	24,047	–35.0

Source: VA Summary of Medical Programs, Fiscal Years 1995 to 1997.

Facilities in both VISNs also conducted active outreach efforts to identify and serve veterans who had either never come to VA for health care or not come in the last few years. In VISN 4 (Pittsburgh), these efforts were supported by a full-time marketing director for the network. Among the outreach efforts, the Butler VAMC held 8 health fairs in fiscal year 1996 and 19 the next year. These events, staffed at the medical center by physician assistants, registered nurses, social workers, and other health professionals, provided 15 services, including cholesterol screening, smoking cessation and stress management, immunizations, counseling, nutritional education, breathing tests, and more. Furthermore, in fiscal

[17]Primary care teams are intended to be a veteran's first point of contact with the VA health care system. They generally provide a comprehensive range of routine services, coordinate treatment for patients requiring specialized services, and manage the care to ensure that appropriate services are provided and duplicative services, such as unnecessary visits for care, are avoided. Although the composition of a team varies depending upon a facility's mission, it typically includes physicians, one or more health care professionals (for example, nurse practitioners, physician assistants, registered and licensed practical nurses), and administrative support staff.

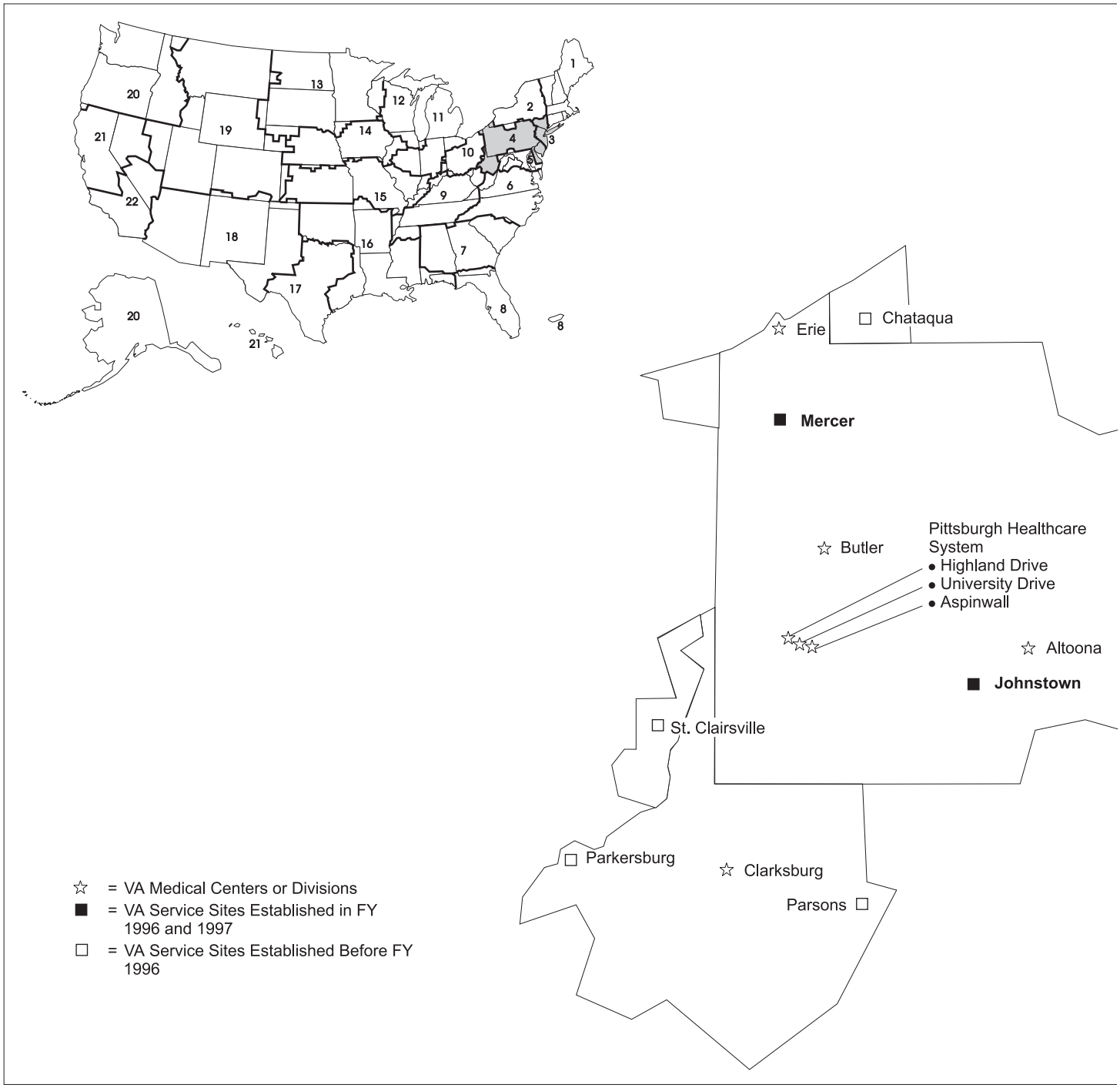
[18]See GAO/HEHS-98-48, Feb. 6, 1998, and VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998) for information on changes in VA's use of inpatient care.

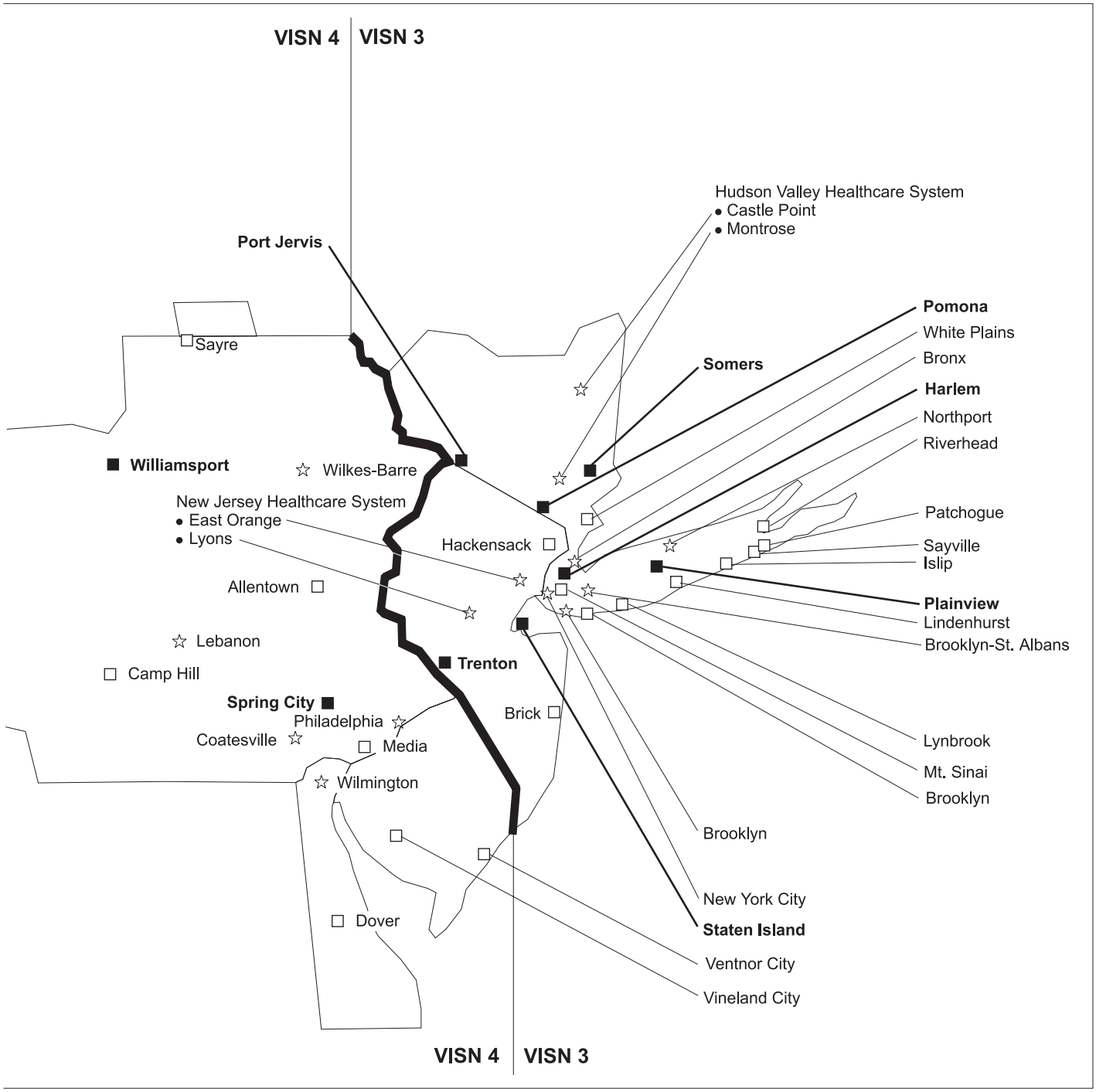
year 1997, Butler VAMC staff conducted 53 health screenings in the community (twice the number conducted in fiscal year 1995), offering some of the services provided at the health fairs.

The VISNs and facilities we visited served more patients overall in part by providing more services closer to veterans' homes, improving geographic access to care.[19] VISN 3 (Bronx) established seven new service sites in fiscal years 1996 and 1997, and VISN 4 (Pittsburgh) provided four new services sites (see fig. 2.1). VISN 3 (Bronx) also improved geographic access by providing care in different areas with mobile clinics; and both VISNs provided more specialty outpatient care in hospitals and community clinics. For example, the Pittsburgh Healthcare System introduced an outpatient telemedicine program in dermatology; the Bronx VAMC developed the capability of providing annual physical examinations for veterans with SCI at the medical center but in an outpatient setting; and the Clarksburg VAMC introduced PTSD group therapy sessions at its Parsons, West Virginia, community-based clinic.

[19]See VA Community Clinics: Networks' Efforts to Improve Veterans' Access to Primary Care Vary (GAO/HEHS-98-116, June 15, 1998).

Figure 2.1: Increased Service Locations, VISN 3 (Bronx) **and VISN 4** (Pittsburgh)**, Fiscal Years 1996-97**





(Figure notes on next page)

Source: VISN 3 (Bronx) and VISN 4 (Pittsburgh).

Veterans we interviewed in VISN 3 (Bronx) and VISN 4 (Pittsburgh) reported satisfaction with the increased availability of outpatient care through community-based clinics and in medical centers. They said that the VISNs had improved their scheduling of appointments to maximize the availability of primary care and provide more reliable appointment times. VA has reported similar information for the two networks and for VA overall from responses to its Ambulatory Care Patient Satisfaction Surveys.[20]

Veterans' service organization representatives told us, however, that difficulties remain in accessing care in some facilities. For example, they said that veterans who had to go to the Bronx VAMC because the care they needed was not available in the Hudson Valley Healthcare System had found van transportation to be a problem. The van made only one trip a day, and veterans sometimes had long waits before or after being seen by physicians. The medical centers have taken steps to address these concerns. For example, in May 1998, the van service made seven round trips a day between the Hudson Valley Healthcare System and the Bronx VAMC. In addition, New Jersey Healthcare System officials had to increase the number of administrative staff at its newly opened Hackensack clinic because the demand for services at the clinic exceeded its capacity to answer calls and schedule appointments, making access difficult for New Jersey veterans.

Medical center officials and veterans' service organization representatives told us that veterans have been delayed in getting access to particular specialty services, notably orthopedics and urology in both VISNs. Management told us that these delays were caused by difficulties in hiring physicians for those specialties. The delays affected some tertiary care medical centers' patients as well as those patients who had been referred from other medical facilities. To reduce delays for some orthopedic and emergency services, the Butler VAMC has contracted with Butler Memorial Hospital and has also referred its patients to the Pittsburgh Healthcare System for these services. Some veterans told us they believe that reduced staffing has made access to nursing staff in the inpatient setting more difficult. Analyses that VA generated at our request from its Inpatient Satisfaction Survey showed that veterans in VISN 3 (Bronx) were less

[20]Performance on Customer Service Standards: Ambulatory Care, 1995 and 1997 National Surveys, VHA National Customer Feedback Center (West Roxbury, Mass.: 1996 and 1997).

satisfied with access to nursing care in fiscal year 1997 than in fiscal year 1995.[21] The VA Office of Inspector General reported similar concerns at the Lyons VAMC.[22]

Access to Care Improved for Nearly All Selected Services

VISN 3 (Bronx) and VISN 4 (Pittsburgh) are generally improving access for the selected services we reviewed. In many instances, their improvements exceeded those of VA nationally for fiscal years 1995 through 1997. The networks differed, however, in the extent to which access has improved for specific services; and one or both of the networks served fewer veterans in this period. The services we reviewed include surgery, mental health services (including those for patients with SMI, PTSD, and substance abuse), treatment for patients with SCI, and prosthetics.

These services especially interest veterans for several reasons. Surgery, for example, is a key indicator of VA's success in increasing efficiency and veterans' access to health care by providing services in a less costly outpatient setting instead of the higher cost inpatient setting. The other specialized services we reviewed interest veterans because they involve relatively high-cost activities central to VA's mission to serve more vulnerable populations. Preserving access to care for these populations while under pressure to reduce costs is an essential test of VA's efforts to transform its health care system.

VISN 3 (Bronx) increased access for five of the seven services we reviewed (see table 2.5), and VISN 4 (Pittsburgh) increased access for six of these services (see table 2.6).

[21]Performance on Customer Service Standards: Recently Discharged Inpatients, 1995 and 1997 National Surveys, VHA National Customer Feedback Center (West Roxbury, Mass.: 1996 and 1997).

[22]Final Report—Inspection of Patient Care Allegations and Quality Program Assistance Review: Department of Veterans Affairs Medical Center Lyons, NJ, Report Number 8HI-F03-125, VA Office of Healthcare Inspections, Office of Inspector General (Washington, D.C.: July 16, 1998).

Table 2.5: VISN 3 (Bronx) Changes in Access for Selected Services, Fiscal Years 1995-97

Service (Indicator)	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	Percentage change, fiscal years 1995-97	
				VISN 3 (Bronx)	Nationally
Surgery (Percentage performed on outpatient basis for 11 selected procedures)	45.1	54.8	70.5	+56.3	+60.2
Mental health[a] (Unique patients)	29,557	31,858	32,487	+9.9	+5.4
SMI[b] (Unique patients)	17,871	18,329	18,442	+3.2	+2.6
PTSD[c] (Unique patients)	1,383	1,703	1,833	+32.5	+16.1
Substance abuse[d] (Unique patients)	8,657	8,910	8,407	–2.9	–5.2
SCI[e] (Unique patients)	467	477	441	–5.6	+7.0
Prosthetics (Number of orders)	Not available[f]	62,283	88,121	+41.5[g]	+20.2[g]

[a]Patients with a primary diagnosis of a mental health condition who were treated in specialized mental health programs. These patients include some of those treated in SMI programs and in programs for treating PTSD and substance abuse.

[b]Includes all patients treated for SMI.

[c]Includes all patients treated for PTSD.

[d]Patients with a primary diagnosis of substance abuse who were treated in a specialized substance abuse program.

[e]Patients treated in SCI centers or clinics.

[f]VA was unable to provide these data.

[g]Percentage change is from fiscal year 1996 to fiscal year 1997.

Sources: VHA Fiscal Years 1996 and 1997 Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans; National Mental Health Performance Monitoring System Reports (fiscal years 1995 to 1997); Surgical Performance Indicators from VA National Performance Data Research Center; National Delayed Prosthetics Report; and special tabulation from VHA's Allocation Resource Center.

Table 2.6: VISN 4 (Pittsburgh) Changes in Access for Selected Services, Fiscal Years 1995-97

Service (Indicator)	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	Percentage change, fiscal years 1995-97	
				VISN 4 (Pittsburgh)	Nationally
Surgery (Percentage performed on outpatient basis for 11 selected procedures)	44.6	52.8	76.0	+70.4	+60.2
Mental health[a] (Unique patients)	30,716	32,819	34,772	+13.2	+5.4
SMI[b] (Unique patients)	16,757	16,760	17,545	+4.7	+2.6
PTSD[c] (Unique patients)	2,173	2,103	2,155	–0.8	+16.1
Substance abuse[d] (Unique patients)	8,810	10,358	9,438	+7.1	–5.2
SCI[e] (Unique patients)	47	56	61	+29.8	+7.0
Prosthetics (Number of orders)	Not available[f]	61,486	78,156	+27.1[g]	+20.2[g]

[a]Patients with a primary diagnosis of a mental health condition who were treated in specialized mental health programs. These patients include some of those treated in SMI programs and programs for treating PTSD and substance abuse.

[b]Includes all patients treated for SMI.

[c]Includes all patients treated for PTSD.

[d]Patients with a primary diagnosis of substance abuse who were treated in a specialized substance abuse program.

[e]Patients treated in SCI centers or clinics.

[f]VA was unable to provide these data.

[g]Percentage change is from fiscal year 1996 to fiscal year 1997.

Sources: VHA Fiscal Years 1996 and 1997 Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans; National Mental Health Performance Monitoring System Reports (fiscal years 1995 to 1997); Surgical Performance Indicators from VA National Performance Data Research Center; National Delayed Prosthetics Report; and special tabulation from VHA's Allocation Resource Center.

Increasing the percentage of surgical procedures performed on an outpatient basis has been an important VA goal since 1996. Performing more surgical procedures on an outpatient basis improves access because it increases patient convenience, improves quality because it reduces the risk of infections associated with inpatient stays, and reduces overall costs. VA has made increasing the proportion of surgeries performed on an outpatient basis a critical measure in its annual assessment of VISN performance and has selected 11 categories of procedures to track in fiscal year 1998 as indicators of progress.[23] By mid-fiscal year 1998, VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA nationally had generally continued to increase the proportion of these services performed on an outpatient basis.

In addition, both networks and VA nationally served more mental health patients in fiscal year 1997 than in fiscal year 1995.[24] Both VISNs increased the number of patients served mainly by increasing the number of outpatients. Nonetheless, VA still provides a broad continuum of mental health services in intensive and subacute inpatient settings, nursing homes, domiciliaries, residential settings, and outpatient clinics located in and apart from medical centers. VISN 3 (Bronx) increased the number of its mental health outpatients by 12 percent (or 3,458 unique veterans), which is more than twice the rate of the national increase, while reducing the number of inpatients by 14 percent (or 1,075 unique veterans), which is approximately equivalent to the national decrease. The New Jersey Healthcare System and the Hudson Valley Healthcare System had the largest increases in the number of outpatients receiving mental health services. By providing mental health services at newly established community-based outpatient clinics as well as at their medical centers, these systems served more veterans. The largest percentage increases in VISN 4 (Pittsburgh) were at the Coatesville (57 percent or 1,490 patients) and Clarksburg (42 percent or 829 patients) VAMCs.

[23]To make comparisons over time, we obtained information from VA for fiscal years 1995 to 1997 on the 11 categories of surgical and invasive procedures used in the fiscal year 1998 indicator. (In previous years, different indicators were used. For example, the 1997 indicator was based on 97 categories of procedures.) The fiscal year 1998 indicator is based on the categories of procedures that VA expects to be routinely performed on an outpatient basis. VA chose these categories because the Health Care Financing Administration's Medicare program also expects them to be routinely performed on an outpatient basis. These procedures are arthroscopy, breast biopsy (and other diagnostic procedures), bronchoscopy and biopsy of bronchus, diagnostic cardiac catheterization, colonoscopy, cystoscopy, eyelids and other therapeutic procedures, endoscopy (upper), hernia repair (inguinal and femora), laparoscopy, and lens and cataract procedures. The percentage of each procedure expected to be performed on an outpatient basis varies.

[24]These include patients with a primary diagnosis of a mental health condition who were treated in specialized mental health programs. In fiscal year 1997, VA treated more than 600,000 unique patients in these programs.

VA has recognized the importance of providing regular follow-up therapy upon inpatient discharge when treating patients with mental illness. It has established access performance measures of the percentage of patients visiting a mental health practitioner within 30 days of discharge and within 6 months of discharge to support the patient's transition to the home or work environment. The proportion of VISN 4 (Pittsburgh) patients seen within 30 days of discharge increased from 41 percent in fiscal year 1995 to 52 percent in fiscal year 1997; the percentage in VISN 3 (Bronx) remained constant at 50 percent—approximately equivalent to VA's overall 52 percent. For appointments within 6 months of discharge, VISN 4 (Pittsburgh) increased the number from 75 to 82 percent of discharged veterans; VISN 3 (Bronx) dropped from 76 to 73 percent; and, nationally, VA increased from 75 to 78 percent. The number of days between an inpatient discharge and an outpatient visit remained the same for VISN 3 (Bronx) mental health patients—31 days in fiscal year 1995 and fiscal year 1997—while for VISN 4 (Pittsburgh) patients, it decreased from 40 to 34 days.

Of the three specific mental health services we reviewed, only changes in the number of SMI patients served were similar among VISNs 3 and 4 and VA nationally. (See tables 2.5 and 2.6.) Both networks and VA nationally increased the number of patients treated with an SMI diagnosis from fiscal year 1995 to fiscal year 1997.[25] SMIs are chronic debilitating conditions that require ongoing care. VA is trying to provide care to this population in less restricted environments outside institutional settings. We were unable to identify VA data showing changes in the number of SMI patients served in inpatient and outpatient settings.

VISN 3 (Bronx) and VA nationally increased the number of PTSD patients served; VISN 4 (Pittsburgh) treated fewer of these patients. VISN 3 (Bronx) served nearly a third more PTSD patients in fiscal year 1997 than it did in fiscal year 1995; in contrast, VISN 4 (Pittsburgh) served 1 percent less of these patients. Nationally, VA served 16 percent more PTSD patients in fiscal year 1997 than in fiscal year 1995.

PTSD treatment programs have changed in recent years in the networks and facilities we visited. Program officials we interviewed said that they have reduced their use of long-term inpatient treatment for PTSD and increased the use of short-term hospital treatment with outpatient follow-up care. VA

[25]Nationally, VA increased the number of SMI patients served by nearly 3 percent from fiscal year 1995 to more than 270,000 patients in fiscal year 1997.

researchers report that such care is equally effective but less costly.[26] For example, VA established the Psychiatric Residential Rehabilitation Treatment Program (PRRTP) to give medical centers another category of treatment for serving veterans with care that is less intense than acute, inpatient care but similar to other domiciliary programs. Clarksburg VAMC officials told us they are converting their inpatient PTSD program to this type of residential program. Because many PTSD patients also have problems associated with alcohol and other drugs, Clarksburg will locate the PTSD program patients next to the medical center's residential substance abuse program area to maximize and facilitate treatment. The Lyons VAMC has also established a PRRTP.

Both VA nationally and VISN 3 (Bronx) treated fewer veterans with a primary diagnosis of substance abuse in specialized substance abuse programs. VISN 4 (Pittsburgh), in contrast, served more such veterans in these programs. Nationally, the number of veterans VA treated with a primary diagnosis of substance abuse declined by 5 percent from fiscal year 1995 to fiscal year 1997; the number VISN 3 (Bronx) treated declined by 3 percent. VISN 4 (Pittsburgh) increased the number of these patients treated during this period by 7 percent.

VA's method for delivering substance abuse care has also been changing. VA has moved to providing treatment for alcohol and drug dependencies on an outpatient rather than an inpatient basis to those living in the community or in VA residential programs. Both VISNs we visited were making such changes. Outpatients increased 1 percent in VISN 3 (Bronx), 26 percent in VISN 4 (Pittsburgh), and 3 percent nationally. Inpatients decreased 25 percent in VISN 3 (Bronx), 63 percent in VISN 4 (Pittsburgh), and 49 percent nationally.

VA headquarters, network, and medical center officials told us they knew about the overall decline in the number of substance abuse patients served but have not been able to determine the reason for the decline. Because substance abuse patients often have other illnesses, they may be receiving substance abuse treatment but under a category of care other than the specialized category of substance abuse services, according to VA officials. Data for such patients might not appear in the databases we and VA used. VA is studying its substance abuse programs to determine the reasons for the decline.

[26]A. Fontana and R. Rosenheck, "Effectiveness and Cost of the Inpatient Treatment of Post Traumatic Stress Disorder: Comparison of Three Models of Treatment," American Journal of Psychiatry, Vol. 154, No. 6 (1997), pp. 758-65.

The number of SCI veterans who received care in SCI centers or clinics in VA nationally and in VISN 4 (Pittsburgh) increased between fiscal years 1995 and 1997; the number treated in VISN 3 (Bronx) declined. Nationally, VA served 7 percent more SCI patients (an increase of 582 SCI veterans); VISN 4 (Pittsburgh) served 30 percent more SCI veterans (14 additional veterans); VISN 3 (Bronx) served about 6 percent less (a decrease of 26 veterans). VA has 23 SCI centers nationwide and 28 SCI outpatient support clinics that provide less intensive care than facilities with an SCI center. Seven of VA's 22 VISNs do not have SCI centers and refer patients who need such care to other VISNs.[27]

VISN 3 (Bronx) integrated the provision of SCI care in the network to coordinate and maximize use of resources at its three SCI centers—located in the Bronx, Castle Point, and East Orange VAMCs. The Castle Point VAMC, part of the Hudson Valley Healthcare System, focuses on providing long-term care for SCI patients. Specialty care, such as plastic surgery, orthopedic services, and comprehensive urological care, which used to be provided at Castle Point, was recently transferred to the Bronx VAMC. The New Jersey Healthcare System's SCI center at the East Orange VAMC provides short-term SCI services, including initial screening of SCI veterans as they enter the VA system, and respite care. More veterans are receiving SCI services in VISN 3 (Bronx) on an outpatient basis. This increase has resulted in part from an increase in the number of annual exams performed on an outpatient basis rather than the multiday inpatient stay that had been the previous practice. However, the number of SCI patients treated in VISN 3 (Bronx) has declined overall. VISN 3 (Bronx) management, SCI product-line officials, and veterans' service organization representatives told us they believe the decline is partly due to patients from other VISNs, such as VISN 1 (Boston), VISN 2 (Albany), and VISN 4 (Pittsburgh), no longer using VISN 3 (Bronx) SCI centers to the extent that they were before. They think that these veterans are perhaps receiving care at VAMCs closer to their homes, but they have not directly assessed the reasons for the decline.

Veterans' waiting times for SCI acute-care admissions and routine outpatient appointments improved from fiscal year 1996 to fiscal year 1997 in VISN 3 (Bronx). The Bronx and Castle Point VAMCs met the VA standard

[27]The seven VISNs without SCI centers are VISN 2 (Albany), VISN 4 (Pittsburgh), VISN 5 (Baltimore), VISN 11 (Ann Arbor), VISN 13 (Minneapolis), VISN 14 (Omaha), and VISN 19 (Denver).

for acute-care admissions in fiscal year 1997.[28] Although the East Orange VAMC shortened the average number of days SCI patients had to wait for an acute-care admission, it still did not meet the standard in 1997. All three facilities met the standard for outpatient care waiting times, however, for SCI services in both fiscal years 1996 and 1997. VISN 3's (Bronx) progress in meeting these standards is similar to progress VA has made nationally. Only 9 of VA's 23 SCI centers met the goal of immediately treating SCI patients in need of acute specialty care in fiscal year 1996, but the number meeting the standard in fiscal year 1997 rose to 20. VA facilities also improved their performance in achieving the outpatient standard of referral within 1 week. In fiscal year 1996, 20 facilities met the standard; in fiscal year 1997, all 23 SCI centers met the standard. VA attributes these improvements in part to improved communication between SCI centers and the SCI primary care teams at referring medical centers.

VISN 4 (Pittsburgh) also served more SCI patients in its SCI clinics. VISN 4 (Pittsburgh) does not have an SCI center but has an SCI clinic at the Pittsburgh Healthcare System. VISN 4 (Pittsburgh) patients needing more intensive services are referred to SCI centers in East Orange (in VISN 3), Cleveland (in VISN 10), and Richmond (in VISN 6).

Regarding prosthetics, both VISNs and VA nationally considerably increased the number of prosthetics orders from fiscal year 1996 to 1997. (See tables 2.5 and 2.6.) Prosthetic, orthotic, and sensory aids and devices include artificial limbs and eyes, wheelchairs, canes, ostomy appliances, artificial hips, eyeglasses, and hearing aids. VISN 3 (Bronx) increased its prosthetics orders by about 41 percent, more than twice the 20-percent rate for VA overall. The number of prosthetics orders for the first half of fiscal year 1998 in VISN 3 (Bronx) suggests that the number of orders will increase substantially again. VISN 4 (Pittsburgh) also exceeded the national rate with a 27-percent increase from fiscal year 1996 to fiscal year 1997. VA facility staff in both VISNs told us that the number of eyeglasses and hearing aids provided has increased dramatically because of changes in veterans' eligibility for certain services.[29]

[28]VA's goals are to immediately transfer all patients needing acute SCI specialty care to an SCI center. The goal for waiting times for SCI outpatient care is to provide patients with an appointment within 7 days of referral.

[29]The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) enabled VA to provide prosthetics to patients on an outpatient basis and significantly expanded eligibility for eyeglasses and hearing aids.

VA monitors the number of prosthetics orders delayed for administrative reasons as a measure of access.[30] Although we identified some problems with delayed order data (discussed in ch. 4), VA reported progress in minimizing delays in fiscal year 1997 to less than 1 percent of all orders, exceeding its standard of 2 percent. Through the first half of fiscal year 1998, however, it reported almost as many delayed orders as for all of fiscal year 1997. VA officials told us they did not know why the delays had increased and were working to determine the cause.

Although VISN 3 (Bronx) had some delayed prosthetics orders in fiscal year 1996, the network reported no delays in fiscal year 1997. And, in contrast to VA's national trend of increased delayed orders in the first 6 months of fiscal year 1998, VISN 3 (Bronx) continued to report no delayed orders. Although below VA's 2-percent standard, VISN 4's (Pittsburgh) delayed orders increased from 0.5 percent (or 31 delayed orders a month) in fiscal year 1997 to 1.1 percent (or 71 delayed orders a month) in the second quarter of fiscal year 1998.

According to VA surveys, veterans in VISN 3 (Bronx) generally reported improved access to prosthetics from fiscal year 1995 to fiscal year 1998. The proportion of veterans reporting they received their prosthetic devices within 5 days of their being ordered by the Prosthetics Office increased from 45 percent in September 1995 to 66 percent in March 1998. Similarly, the proportion of veterans reporting that their prosthetic devices were repaired within 5 days of their indicating a need for repair increased from 56 percent in September 1995 to 60 percent in March 1998. However, the proportion of veterans who reported getting their appointments, for example, for a fitting of their prosthetic device, within 5 days of their initial call for an appointment declined from 52 to 48 percent in the same time period. In contrast, during this same period the percentage of VISN 4 (Pittsburgh) veterans who reported service within 5 days increased significantly: for device receipt, from 59 to 81 percent; for repairs, from 61 to 78 percent; and for appointments, from 51 to 77 percent.

[30]Data are not available on the number of unique users of prosthetic services.

Overall Increases in Access Achieved Despite Reduced Buying Power of Allocated Resources

VISNs 3 (Bronx) and 4 (Pittsburgh) increased access to services even though neither VISN received increased allocations to offset inflation as in the past. The VISNs served more veterans by increasing the efficiency of their health care delivery to offset their decreased buying power resulting from the combined effects of VERA allocation changes and inflation.

Both VISNs' allocations for fiscal year 1997 gave them less buying power than their allocations for fiscal year 1995. The phased-in implementation of VERA along with VISN 3 (Bronx) management decisions in fiscal year 1997 resulted in a decline in VISN 3 (Bronx) resources of about $21 million in year-end allocations compared with fiscal year 1995 (see table 2.7).[31] Year-end allocations reflect the total net impact of all VERA allocations, including both general-purpose allocations and specific-purpose allocations made by VA headquarters—and any reprogramming that took place during the year. The added impact of inflation on these resources for VISN 3 (Bronx) resulted in an overall reduced buying power of about $91 million for this period.[32] VISN 4 (Pittsburgh), in contrast, received an increase in its allocation from fiscal year 1995 to fiscal year 1997 but still had a net decreased buying power of $17 million due to inflation.

[31]VISN 3 (Bronx) returned $20 million to VA headquarters in fiscal year 1997 because, according to VISN management, all identified needs for that year had been met. It was the only network to return funds that year. According to VA headquarters, these funds became part of a larger specific-purpose allocation to the VISNs for information technology. VA allocated about $8 million of these funds to VISN 3 (Bronx) for its information technology initiatives. VA headquarters allocated about $4 million to VISN 4 (Pittsburgh) for its share of this specific-purpose allocation. VA could not provide information on the amount that would have been allocated to VISN 3 (Bronx) for information technology if the network had not returned $20 million.

[32]We calculated the impact of inflation on the basis of inflation factors that VA uses for its medical care appropriations request to the Congress.

Table 2.7: Changes in End-Of-Year VA Allocations and the Impact of Inflation, Fiscal Years 1995-97

Dollars in millions

Entity	Fiscal year 1995 allocation	Change in allocation, fiscal years 1995-97	Loss in buying power from inflation[a]	Net estimated change in buying power, fiscal years 1995-97	Percentage change in buying power, fiscal years 1995-97
VISN 3 (Bronx)	$1,092	–$21	–$70	–$91	–8.3%
VISN 4 (Pittsburgh)	817	+35	–52	–17	–2.2
VA nationally	16,189	+938	–1,039	–101	–0.6

Note: We included all medical care appropriations—and for VISN 3 (Bronx) the funds it returned to headquarters in fiscal year 1997—in our calculation of total year-end allocations. These totals differ from those VA publishes for the beginning of a fiscal year because at that time VA does not know what allocations will be made for specific purposes and program changes made throughout the year. Thus, while facilities have received some of their allocations for fiscal year 1998, when we prepared this report, VA had not made the final allocations.

[a]We calculated changes on the basis of allocation data and inflation factors provided by the Office of the Chief Financial Officer, VHA.

Source: VA and our calculations.

Officials in both VISNs told us that they compensated for the reduced buying power of their allocations by improving efficiency. With 13,735 full-time equivalent employees (FTEE) at the start of fiscal year 1996, VISN 3 (Bronx) reduced staffing by 2,070 FTEEs (about 15 percent) by the end of fiscal year 1997. This represented more than $110 million in cost reductions that could be used for offsetting allocation reductions and inflation. VISN 4 (Pittsburgh) started fiscal year 1996 with 10,850 FTEEs and reduced staffing by 1,485 (about 14 percent) through fiscal year 1997. Thus, VISN 4 (Pittsburgh) reduced costs by about $79 million to offset the effects of inflation. Both VISNs also increased employee productivity. For example, some facilities in VISN 3 (Bronx) changed primary care physician schedules to give the physicians more time to serve patients; and, in fact, more patients were seen by each physician. Both VISNs also consolidated laundry services to serve more than one facility from a single site.

VISN 3 (Bronx) and VISN 4 (Pittsburgh) officials told us they expect to continue increasing access in fiscal year 1998 by a combination of additional efficiencies and new resources. The new resources are primarily from third-party health insurance collections, which network officials told us they plan to use to offset the combined effects of VERA

allocation changes and inflation.[33] For fiscal year 1998, the first year it can retain these collections, VA set a goal of about $596 million nationally, about $44 million for VISN 3 (Bronx), and about $36 million for VISN 4 (Pittsburgh). For fiscal year 1999 and beyond, the degree to which the two VISNs will be able to offset the effects of VERA allocation changes and increased inflation is difficult to estimate given the many factors that will determine the resources available to them and the costs of the services that will be needed.[34] The VISN 3 (Bronx) director estimated the network will need additional resources in fiscal year 2000 to provide veterans appropriate access to health care, and the VISN 4 (Pittsburgh) chief financial officer estimated it will need additional resources in fiscal year 2001.

[33]The Balanced Budget Act of 1997 authorized VA to retain recoveries from third-party insurance and collections from the sale of excess services to beneficiaries of the Department of Defense, medical school hospitals, and other providers.

[34]Some of these factors include how one network fares relative to the other networks in increasing workloads and decreasing costs, the network's success in collecting third-party payments, and the rate of inflation. VA is also considering changes to VERA that could affect future resource allocation.

VA Has Done Little to Improve the Equity of Resource Allocations to Facilities

Although VA nationally has made progress in improving the equity of resource allocations among the networks, it has done little to ensure that the VISNs allocate resources to address past inequities within each network to ensure that veterans with similar economic status and eligibility priority have similar access to care. VA headquarters has not provided criteria or guidance for improving the equity of VISN resource allocations to facilities. Furthermore, VA headquarters does not review VISN allocation methods and results to determine whether allocations within each VISN are made equitably. VISN 3 (Bronx) and VISN 4 (Pittsburgh) use different methods to allocate most of the medical care resources to their facilities. To some extent these methods reflect differences in the resource allocation challenges the two VISNs face.

VISN 3 (Bronx) Method Reduced Facility Allocations

The VISN 3 (Bronx) network leadership council met in the spring of 1996 to develop a comprehensive list of cost-saving actions that would be needed to meet the expected allocation reductions for VERA's implementation in fiscal year 1997. At the time, network management estimated that their fiscal year 1997 allocation could have been at least $100 million (about 10 percent) less than the fiscal year 1996 allocation. Many of the cost-saving initiatives, including staff cuts and unit closures, that had been identified were begun in fiscal year 1996.

The reduction in fiscal year 1997 allocations to VISN 3 (Bronx) was less than network management had anticipated. To allow time for network management to implement less costly care while improving access, VA decided to gradually implement the allocation changes resulting from the VERA formula by capping the amount of funds removed from this network and others. Nonetheless, the cost-cutting initiatives VISN 3 (Bronx) management had begun in fiscal year 1996 continued, officials told us, because they were needed for the current year and officials expected additional reductions in fiscal year 1998 and beyond. As a result, VISN 3 (Bronx) management developed facility allocations in the context of reduced funding for the network.

VISN 3 (Bronx) based most of its fiscal year 1997 allocation to each facility on resources allocated in the previous year. The amounts to each facility were reduced by the amount of savings in operations—medical and support—that each medical center director had identified in the spring of 1996. For example, the Bronx and New York VAMCs consolidated their laboratory operations. Castle Point VAMC closed surgical beds because the VISN had decided to treat patients requiring inpatient surgery at the Bronx

VAMC. These changes reflect in part VISN 3 (Bronx) management's approach to building a network by integrating services among facilities. VISN 3 (Bronx) also made additional allocations from its operating reserve to the New Jersey Healthcare System for activating a new psychiatric facility at the Lyons VAMC.

Because VISN 3 (Bronx) had fewer resources, its allocation method generally reduced allocations to each facility. To calculate changes in allocations, we used fiscal year 1995 as a base because VISN 3 (Bronx) and its facilities began to implement changes in fiscal year 1996 in anticipation of VERA's start in fiscal year 1997. Five of the network's six facilities received reduced allocations in fiscal year 1997. (See table 3.1.) The Brooklyn VAMC, however, received a 5.3-percent increase in fiscal year 1997 mainly because of an increase in specific-purpose funds.

Table 3.1: End-Of-Year Resource Allocations for VISN 3 (Bronx) Facilities, Fiscal Years 1995-97

Dollars in millions

Allocations	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	Difference, fiscal years 1995-97	Percentage difference
Bronx VAMC	$143.1	$139.3	$133.5	–$9.6	–6.7
Brooklyn VAMC	197.3	200.7[a]	207.7[a]	+10.4	+5.3
Hudson Valley Healthcare System[b]	130.4	133.1	129.3	–1.2	–0.9
New Jersey Healthcare System[c]	267.9	264.4	252.1	–15.7	–5.9
New York VAMC	174.5	172.1	170.4	–4.1	–2.3
Northport VAMC	143.0	137.9	132.0	–11.0	–7.7
Capital accounts[d]	35.3	53.6	46.0	+10.6	+30.1
Total VISN 3 (Bronx)	**$1,091.5**	**$1,101.0**	**$1,071.0**	**$-20.6**	**–1.9**

Note: End-of-year resource allocations include VERA general- and specific-purpose funds and all reprogramming of resources throughout the fiscal year.

[a]Includes funds for VISN 3 (Bronx) network office operation.

[b]Includes Montrose and Castle Point VAMCs.

[c]Includes East Orange and Lyons VAMCs.

[d]Data for capital accounts include allocations for equipment and nonrecurring maintenance. Comparable information across fiscal years on funds distributed to each VAMC was not available.

VISN 3 (Bronx) used the same basic approach for allocating its fiscal year 1998 resources but added two new parts.[35] Each facility was allowed to keep all funds it collected from third-party insurance and the sale of excess services up to a facility-specific goal and 75 percent of collections above the goal. In addition, VISN 3 (Bronx) adjusted facilities' fiscal year 1998 allocations on the basis of changes in their respective workloads between fiscal years 1996 and 1997. If facilities served more patients in fiscal year 1997 than the preceding year, the VISN increased the allocation by $2,014 for each additional patient served. If the facility had served fewer patients, however, its allocation was reduced by the same amount.

Officials at the facilities we visited told us that they generally agree with the allocation method VISN 3 (Bronx) has used. Facility managers said that they like the method because it allows them to manage a defined facility budget during the year to achieve specified program efficiencies. Although facility directors are expected to manage their allocations, VISN 3 (Bronx) managers and facility directors told us that the system is flexible enough to provide resources for unforeseen circumstances through VISN reserves and reprogramming.

VISN 4 (Pittsburgh) Allocation Emphasized Incentives

VISN 4 (Pittsburgh), facing the prospect of a stable allocation under VERA, did not begin planning its allocation method until fiscal year 1997. VISN 4 (Pittsburgh) officials told us that the VISN office prepared the allocation method and allocated resources to the facilities with little input from the facilities. The allocation method was designed from the beginning with incentives for changing how facility directors manage health care, according to these officials. The network's method includes incentives for improving efficiency, operating as a network, and increasing access to care.

VISN 4 (Pittsburgh) allocated resources to facilities in fiscal year 1997 using a multistep process. It allocated to each facility a fixed amount for each veteran served in fiscal year 1996—regardless of eligibility priority—and each facility received resources based on its number of long-term care operating beds to account for the higher cost of such care.[36] In addition, each facility received $1,000 for each additional veteran served, up to a facility-specific limit. The network expected each facility to grow at the same rate. In addition, the network allocated resources to "buy out" early retiring employees. VISN 4 (Pittsburgh) allocated other resources, for

[35]Final allocations for fiscal year 1998 were not available when we prepared this report.

[36]These allocations were made for nursing home, psychiatric, intermediate, and domiciliary beds.

example, from its reserve fund and investment pool, throughout the fiscal year.

For fiscal year 1997, VISN 4 (Pittsburgh) used its method to estimate each facility's revenues and expenditures. Facilities did not receive a fixed allocation from the network as they had before. Instead, VISN 4 (Pittsburgh) management told us that they expected facility directors to manage the changing revenue and expenditure patterns throughout the year. Nonetheless, the VISN expected to make up any shortfalls both from VISN reserves and by redistributing surpluses at some facilities where revenues exceeded expenditures. The VISN did this, for example, at the Clarksburg VAMC by allocating an additional $2 million during fiscal year 1997 because its original allocations fell below expenditures.

The VISN 4 (Pittsburgh) fiscal year 1997 allocation method resulted mainly in facility increases because the network had more resources in fiscal year 1997 than in fiscal year 1995 (see table 3.2). End-of-year allocations increased in 9 of the 10 facilities during this period. The Erie VAMC had the highest rate of increase, which resulted from a laundry replacement program, increased workload, a telecommunications infrastructure project, and a telephone switch project.

Table 3.2: End-Of-Year Resource Allocations for VISN 4 (Pittsburgh) Facilities, Fiscal Years 1995-97

Dollars in millions

Allocations	Fiscal year 1995	Fiscal year 1996	Fiscal year 1997	Difference, fiscal years 1995-97	Percentage difference
Altoona VAMC	$31.7	$32.4	$33.3	$1.6	5.2
Butler VAMC	37.3	36.6	37.6	0.3	0.8
Clarksburg VAMC	44.3	45.1	48.2	3.9	8.7
Coatesville VAMC	82.2	86.5	85.1	2.9	3.5
Erie VAMC	30.4	33.3	41.8	11.4	37.6
Lebanon VAMC	76.8	78.6	78.0	1.2	1.6
Philadelphia VAMC	143.7	142.3	140.7	–3.0	–2.1
Pittsburgh Healthcare System[a]	207.9	209.5[b]	209.4[b]	1.5	0.7
Wilkes-Barre VAMC	81.6	83.6	84.5	2.8	3.5
Wilmington VAMC	53.0	57.3	54.2	1.2	2.3
Capital accounts[c]	27.9	44.0	38.8	10.9	39
Total VISN 4 (Pittsburgh)	**$817.0**	**$849.4**	**$851.7**	**$34.7**	**4.3**

Note: End-of-year resource allocations include VERA general- and specific-purpose funds and all reprogramming of resources throughout the fiscal year.

[a]Includes data from all Pittsburgh facilities.

[b]Includes funds for VISN 4 (Pittsburgh) network office operation.

[c]Data for capital accounts include allocations for equipment and nonrecurring maintenance. Comparable information across fiscal years on the funds distributed to each VAMC was not available.

VISN 4 (Pittsburgh) changed its fiscal year 1998 allocation method in several ways: It (1) changed the calculation of the number of veterans served by facility for which it received a fixed payment, (2) reduced allocations for additional patients served, and (3) added allocations for third-party health insurance collections.[37] In fiscal year 1998, the VISN determined the number of facility patients by establishing a catchment area for each facility using ZIP codes. A facility receives an allocation on

[37]Final allocations for fiscal year 1998 were not available when we prepared this report.

the basis of the number of veterans in its catchment area that VA served in a prior fiscal year. Because of the network's success in increasing the number of veterans served, VISN 4 (Pittsburgh) officials told us they reduced the amount of allocations for serving additional patients. In addition, the VISN allocated funds to each facility for third-party health insurance payments each facility was expected to collect.

The establishment of catchment areas permitted VISN 4 (Pittsburgh) management to introduce a major change in funding facilities: transfer pricing. According to VISN officials, transfer pricing is intended to foster close working relationships among facilities in the network, improving access. The officials also expected it to help lower the cost of care by introducing elements of competition. Under transfer pricing, the Clarksburg VAMC, for example, pays the Pittsburgh Healthcare System for services veterans from the Clarksburg catchment area receive in the Pittsburgh Healthcare System. This can happen in two ways: Clarksburg physicians can refer a patient from Clarksburg's catchment area to the Pittsburgh Healthcare System for care, or a patient from the Clarksburg catchment area can go to Pittsburgh for care without a referral. In either case, the Clarksburg VAMC pays the Pittsburgh facility for the services provided at a rate equivalent to 80 percent of the Medicare reimbursement for that service in the local area. The Clarksburg VAMC may also purchase care from non-VA providers, for example, for emergency care, when it cannot access care at the Pittsburgh Healthcare System, or if it determines that it can purchase care at a lower cost from a non-VA provider.

As a result of transfer pricing, the amount of resources allocated to a facility in VISN 4 (Pittsburgh) at the beginning of a fiscal year will probably vary significantly from the amount of its allocations at year's end.[38] For example, the Clarksburg VAMC's allocation will probably decline because it refers more patients to other facilities, such as the Pittsburgh Healthcare System, which has tertiary care, than it receives from them. In contrast, the Pittsburgh Healthcare System's allocation will probably increase over the year because it serves more patients from other facilities than it refers to them. Thus, initial facility allocations represent resources available to meet the needs of veterans who live in the facility's catchment area no matter where the veterans receive services. End-of-year allocations represent the resources spent at a facility on the health care it provides to veterans regardless of the catchment area in which the veteran lives. This means VISN 4 (Pittsburgh) facilities have no set budgets to count on as VISN

[38]In fiscal year 1998, VISN facilities do not use transfer pricing to pay for care in VA facilities that are located outside the VISN.

3 (Bronx) facilities have. VISN 4 (Pittsburgh) officials told us they want facility managers to learn to work with uncertain resources and financial obligations so that they can adapt to changing health care dynamics.

The medical center directors we spoke with from VISN 4 (Pittsburgh) had mixed views of transfer pricing. Directors of facilities that refer patients to tertiary care centers generally support the transfer pricing concept. According to these directors, transfer pricing provides more flexibility to hospitals that need to transfer patients to other providers and adequately compensates hospitals receiving patients from other areas. They also said that transfer pricing helps to increase veterans' access to care at tertiary facilities by encouraging those facilities to be more customer oriented. Managers, physicians, nurses, and social workers at referring facilities told us that the tertiary facilities in Pittsburgh and Philadelphia VAMCs are now more responsive and timely in accepting and serving veterans referred to them. In addition, according to directors at referring facilities, transfer pricing provides them information on the price of providing services within the network and outside of VA that will be useful in the future in determining where VA can most efficiently purchase and most conveniently provide services to veterans. The directors of the two tertiary care centers, however, told us that transfer pricing requires too much effort and expense to track an essentially small share of the health care workload and resources. These directors said that transfer pricing was not necessary for them to improve relations with the primary care referring facilities.

Both VISN managers and facility directors said that managing the allocation process with uncertain revenues and expenditures has been a difficult but important cultural change. To address continuing resource allocation issues, VISN 4 (Pittsburgh) created a Resource Allocation Committee in 1998 composed of facility managers, physicians, staff, and union officials.

VA Has Neither Provided Criteria Nor Reviewed VISN Allocation Methods for Equity

Although VERA has improved the equity of resource allocations among networks, neither VISN 3 (Bronx) nor VISN 4 (Pittsburgh) allocates resources to address past inequities within its network to ensure that veterans with similar economic status and eligibility priority have similar access to care. Achieving equity in VISN allocations to facilities is important because similar inequities exist within and among VISNs.[39] VA officials told us that VISNs should allocate resources equitably within their networks as part of VA's effort to achieve equitable access. However, fiscal year 1998

[39]Explanatory Model to Project Demand for Care at the National and Network Level: Analysis of Select VISNs, Abt Associates, Inc. (Cambridge, Mass.: Feb. 1998).

allocation guidelines, which headquarters issued to VISNs in response to our earlier recommendation, do not address equity criteria as we had recommended.[40] Furthermore, VA headquarters officials told us that they do not review VISN allocation methods and results to determine if allocations within VISNs are made equitably.

Neither VISN 3 (Bronx) nor VISN 4 (Pittsburgh) used criteria to address equitable allocation issues in facility allocations for fiscal years 1997 and 1998. Management officials in both VISNs told us they had not tried to improve the equitable allocation of resources in their VISNs.

The two VISNs have recognized, however, that their networks have inequities. For example, the VISN 4 (Pittsburgh) fiscal year 1998 strategic plan states that the proportion of eligible veterans using services is substantially lower in the eastern part of the network than the western part and that efforts to increase users should be concentrated in the eastern part.[41] In addition, the percentage of service-connected veterans who used services at each of the facilities in VISN 4 (Pittsburgh) varied from 27 to 50 percent in 1996. In its strategic plan, VISN 3 (Bronx) discussed lower usage rates among veterans in the catchment area for the New York VAMC compared with the rates in the catchment area for the Bronx VAMC, suggesting that the former area may have less access to care. VISN 3 (Bronx) management officials told us that they may include criteria in the fiscal year 1999 allocation process to address equity.

Although both VISNs' allocation methods provide incentives for increasing the number of veterans served consistent with VERA and VA national initiatives, neither the VISN 4 (Pittsburgh) nor the VISN 3 (Bronx) allocation method addresses access inequities identified in their respective strategic plans. In fact, in fiscal year 1997, the net year-end allocations to VISN 4's (Pittsburgh) western facilities increased more than those to the VISN's eastern facilities, where the VISN had identified equitable access problems. As a result, both VISNs face the risk of growth without equity.

[40]VA Health Care: Resource Allocation Has Improved, but Better Oversight Is Needed (GAO/HEHS-97-178, Sept. 17, 1997).

[41]Inequities can result from the lack of similar services for similarly situated veterans and lack of comparable resources for comparable workload. See Veterans' Health Care: Facilities' Resource Allocations Could Be More Equitable (GAO/HEHS-96-48, Feb. 7, 1996).

VA Oversight Is Inadequate

Although we prepared an overall assessment of access to care, difficulties in working with the data cast doubt on whether VA can perform timely and effective oversight. The information we developed on changes in access to care at the facility and network levels for VISN 3 (Bronx) and VISN 4 (Pittsburgh), as well as for VA nationally, was gathered from many VA reports and databases—some of which had inconsistent or incompatible information. Moreover, medical center, VISN, and headquarters officials told us that such data are not available on a routine, timely basis—particularly for specific programs. Without such information, it is difficult for them to say conclusively whether VA has improved veterans' equity of access to care and whether veterans—particularly those who had been receiving high-cost care for chronic conditions—have been adversely affected by the many changes under way to reduce costs and improve productivity.

Timely, Comparable, Comprehensive Data for Monitoring Access Are Lacking

To gather the information for this report, we extracted and reconciled information from many VA sources, including VA's Summary of Medical Programs; Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans; the VERA briefing booklets; the National Mental Health Performance Monitoring System Reports; and reports on quarterly performance indicators. In addition, we used many special computer runs and data requests from the Office of the Chief Financial Officer and its Boston Allocation Resource Center, the Office of the Chief Network Officer, the Office of Performance and Quality, and others.

Most of the available data on access, according to many officials we spoke with, are not timely enough for prudent program management. Information on the number of patients served in the selected programs we reviewed, for example, is available only at 1-year intervals. Thus, facility, VISN, and headquarters officials told us they do not have the information needed to assess the impact of program changes on access for identifying and correcting problems in a timely fashion or for measuring whether they are meeting their objectives such as improving access to appropriate care. Much of the data reported at 1-year intervals is not available until months after the end of the year for which it applies.

Although VA appears to have a great deal of data for measuring changes in access to care, closer examination shows that different measures are used for the same indicator, users sometimes do not clearly understand these measures, and obtaining the same measure over time for comparison

purposes can be difficult. To identify the impact of change, VA's managers need data that are comparable over time and systemwide. VA acknowledges that its data systems need improvement.[42]

One example we identified in our discussions with managers has been a recurring source of confusion: counting the number of patients VA serves. VA reports this number in several ways—each with a separate definition or purpose. One way it reports this information is to count the number of all unique patients—veterans and nonveterans—treated. VA does this, for example, to gauge whether it is meeting its strategic access goal of increasing the number of patients served from 1998 to 2002 by 4 percent each year. A second way, used in VA's annual Summary of Medical Programs, includes counting veterans and nonveterans, but the totals are for inpatient and outpatient visits rather than unique patients served. A third way, used by VA for determining the number of veterans served for VERA allocations, reports Category A veterans served but also includes some Category C veterans (lower priority veterans) and nonveterans in its calculations and uses a different time period (3 or 5 years) to calculate patients served. In contrast, VA's performance indicator data includes only Category A veterans and is based on the number of unique patients served during a 1-year period. Moreover, VA has changed the way it calculates this fourth indicator—twice for fiscal year 1997 and again for fiscal year 1998.

Data on the number of patients treated in the selected programs we reviewed have similar problems. For example, VA SCI data indicate that VISN 4 (Pittsburgh) treated 61 patients in its SCI clinics in fiscal year 1997, 56 of whom received treatment at the Pittsburgh Healthcare System SCI clinic. Similar data were available for fiscal year 1996, but for fiscal year 1995, VISN 4 (Pittsburgh) officials did not have the data until VA's Allocation Resource Center (ARC) provided the data at our request. Staff at the Pittsburgh Healthcare System SCI clinic told us that they treat about 100 patients a year. Later, the Pittsburgh Healthcare System informed us that it could not document the number of these patients served. Data provided by request from ARC for all SCI patients treated, both in SCI centers and elsewhere, showed that VISN 4 (Pittsburgh) treated 1,017 SCI patients in fiscal year 1997, 295 of whom received treatment in the Pittsburgh Healthcare System. We also found similar data inconsistencies for SCI patients treated in VISN 3 (Bronx). VISN and facility staff with whom we spoke did not know how VA's national data on SCI patients are defined or how to reconcile differences between these data and respective national

[42]VA Health Care: VA's Efforts to Maintain Services for Veterans With Special Disabilities (GAO/T-HEHS-98-220, July 23, 1998).

and local data. A veterans' service organization representative told us that his organization does not believe that the SCI data are accurate.

VISN officials also told us that information they wanted on patient satisfaction with access to care and reported waiting times has been hard to obtain. Although VA provides VISNs with an overall index of customer satisfaction with access to care, VA does not routinely provide them with responses to particular questions for each facility—even though doing so would help managers identify problems to correct. For example, a VISN's satisfaction index may show a composite decline in satisfaction with access to care. From this information, however, the VISN cannot determine by facility whether more veterans are reporting problems getting outpatient appointments when they want them or seeing their health care providers within 20 minutes of their scheduled appointments, one of VA's strategic goals. VISN 3 (Bronx) officials told us that they had difficulty getting this information for fiscal year 1997 and they did not have it for fiscal year 1995. Without such information, managers cannot identify the specific access problems they need to address. VA's Office of Inspector General also reported finding delays in disseminating information from the Ambulatory Care and Inpatient Care Surveys to managers.[43]

In addition, managers we interviewed told us that indicators of access to care for prosthetics are inadequate or not consistently available. One such measure is the delayed order, which is the indicator for access to prosthetics in VA's strategic plan. This indicator measures an administrative action: any prosthetic order that the local unit did not process within 5 workdays because of incomplete management or administrative action. According to headquarters officials, however, the measure may not be accurate because of the discretion granted to facility officials in defining the reasons for a delay. Furthermore, the measure does not assess a critical dimension of a veteran's access, namely, how long it takes a veteran to receive the prescribed prosthetic.

VA has additional measures of prosthetics access but does not use them as strategic indicators. One of these is the average time veterans wait for prosthetics appointments and receipt of prescribed prosthetic devices, which is noted in each facility's monthly delayed order report. Because neither headquarters nor the VISNs routinely monitor these data, we obtained facility-generated information. Data were not available for some facilities for the years requested. Headquarters and VISN officials told us,

[43]Review of Veterans Health Administration's National Customer Feedback Center Department of Veterans Affairs Medical Center, West Roxbury, Massachusetts, VA Office of Inspector General, , Office of Healthcare Inspections, 8HI-A28-069 (Washington, D.C.: Feb. 4, 1998).

however, that even when available, such data may be inaccurate because calculations at the medical centers were not done accurately or the same number was used every month rather than the correct number being calculated from that month's records. Our analysis of the available data raised concerns similar to those raised by others.[44]

VA officials told us that they think a more reliable measure comes from a twice yearly satisfaction survey of prosthetics users asked to report the time it takes them to get appointments, their devices, and repairs to their devices (discussed in ch. 2). Although VA managers told us that they believe the survey data are generally reliable, VA has not disseminated facility-level information for monitoring. However, VA's Prosthetics and Sensory Aids Service Strategic Healthcare Group distributed VISN-level results of the March 1998 survey in June 1998, and an official in that group told us of plans to disseminate VISN-level information every 6 months. She said they do not have the capability to provide facility-level information.

VA Does Not Know If Access Is More Equitable

In spite of VA's major effort to design and implement VERA and to provide VISN management with the opportunity to allocate resources more equitably within VISNs, VA does not know if it is making progress in providing similar services to similarly situated veterans. VA's strategic plan does not include a goal for achieving equitable access, and VA does not monitor the extent to which equitable access is being achieved among or within VISNs. Instead, VA has focused its efforts on increasing access generally—apparently expecting this to lead to more equitable access sometime in the future.[45] VA officials told us they have identified no indicators to be used for monitoring improvements in equitable access and they have no plans to do so.

Because VA officials are not monitoring improvements in equitable access to care, VA does not know if changes in allocations from VERA and other actions are equalizing access nationwide. Without monitoring changes in equitable access to care, VA can neither assure stakeholders that equitable access is improving nor take corrective actions, if needed, to improve resource allocation or other initiatives.

[44]Thomas H. Miller, Chairman, VA Federal Advisory Committee on Prosthetics and Special Disabilities Programs, testimony before the House Committee on Veterans' Affairs, Subcommittee on Health Oversight, Washington, D.C., July 23, 1998.

[45]We have expressed related concerns in VA Community Clinics: Networks' Efforts to Improve Veterans' Access to Primary Care Vary (GAO/HEHS-98-116, June 15, 1998).

Conclusions, Recommendations, and Agency Comments and Our Evaluation

Conclusions

Overall, VA has increased access to care for veterans in VISN 3 (Bronx), VISN 4 (Pittsburgh), and VA nationally, although access to some specific services has declined. VA has increased access mainly by expanding outpatient services through conversion of inpatient resources for that purpose. This has increased the efficiency of VA health care delivery and allowed VISN 3 (Bronx) and VISN 4 (Pittsburgh) to serve more veterans with fewer inflation-adjusted dollars under VERA.

Although various VA offices have a broad range of information on access that would be useful to managers, it is often generated as part of larger efforts for purposes other than monitoring access. As a result, the information is not always easily accessible or understandable to managers for monitoring access. Managers are unaware of useful access information and unclear about how some of the information is defined. In addition, they do not know where to go for clarification of the data when needed. VA needs more uniform and timely reporting of changes in access to care, including the number and eligibility priority of patients served, waiting times for care, and patient satisfaction for specific services at the VISN and facility level.

Finally, VA has not followed through on VERA's promise of more equitably allocating resources. VA guidance to VISNs on allocating resources to facilities includes no criteria for VISNs to use to achieve equitable allocation, and VA does not review VISN allocations to assess the extent to which they improve equitable allocation of resources. The allocation methods of VISN 3 (Bronx) and VISN 4 (Pittsburgh) that we reviewed include no initiatives for improving equitable allocation of resources among their facilities. If VISNs do not equitably allocate the resources received under VERA to their respective facilities, historical inequities within VISNs may continue even if VERA improves equity among VISNs.

Acting to achieve an objective, such as implementing VERA to improve equitable access to health care services, does not ensure meeting the objective. Indicators and monitoring are required to gauge whether the action taken is having the desired effect. Because VA has not established measures to assess its progress in achieving equitable access, it does not know whether it has made such progress. It does not know whether additional changes in resource allocation, strategic planning, or management decisionmaking are needed to ensure more equitable access. Without information on changes in equitable access, VA does not know whether the increased number of veterans it has served has occurred at

the expense of reduced access to services for veterans who have been historically underserved.

Recommendations

We recommend that the Secretary for Veterans Affairs direct the Undersecretary for Health to

- develop uniform definitions and institute timely reporting of changes in access to care, including the number and eligibility priority of patients served, waiting times for care, and patient satisfaction for specific services at the VISN and facility level and
- develop criteria for equitably allocating resources to facilities and monitor any improvements in equity of access among and within VISNs.

Agency Comments and Our Evaluation

In an August 26, 1998, letter in response to a draft of this report (see app. I), VA said it is working to improve its information systems so that they will be more useful to VISN and headquarters management. VA expressed concern, however, that our recommendation to develop national criteria for equitably allocating resources to facilities is contrary to VHA's reengineering philosophy, which decentralizes authority and accountability for these allocations to the network directors.

Regarding information systems, VA's letter did not specify whether it intends to implement our recommendation. As our report notes, improvements are essential to allow VA managers to identify problems and take corrective action in a more timely way to help ensure that veterans' access to care does not deteriorate in the environment of a transformed VA health care system.

We disagree that our recommendation for VA to develop criteria for equitably allocating resources to facilities within VISNs is contrary to VA's philosophy of decentralizing authority and accountability. We believe VA can develop criteria for VISNs' use in equitably allocating resources to their respective facilities and review VISNs' performance in addressing these criteria without being so prescriptive that local authority and accountability are compromised. For example, VA has already used performance measures based on national criteria to hold VISN directors accountable for achieving national goals. Having criteria does not preclude VISNs from using different methods for allocating resources to address local circumstances and VA's national criteria. We still believe that if VISNs

do not improve equitable allocation of resources to their facilities, VERA's promise of more equitable access to care will not be achieved.

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
ASSISTANT SECRETARY FOR POLICY AND PLANNING
WASHINGTON DC 20420

AUG 26 1998

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military
Health Care Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

Thank you for your draft report, ***VA HEALTH CARE: More Veterans Are Being Served, But Better Oversight Is Needed*** (GAO/HEHS-98-226), which raises some significant issues. Your report is rather comprehensive in its criticisms of the Veterans Health Administration's (VHA) planning, resource allocation, information systems, performance measures, and VHA's linking or failure to link these various efforts to ensure effective Veterans Integrated Service Network (VISN) and facility management.

Although GAO's entire report gives cause for concern, we are particularly focused on the implications of GAO's conclusions regarding the ineffectiveness of our information systems in providing useful and timely data to the VISNs and headquarters for planning, performance review, and resource allocation. We are working to improve these systems so that they will be more useful to our VISN and headquarters managers in the environment of a transformed VA healthcare system that serves more satisfied veterans.

We are also concerned that the recommendation to develop national criteria for equitably allocating resources to facilities with national oversight is diametrically opposed to VHA's reengineering philosophy of decentralizing authority and accountability for these allocations to the network directors. We do not believe the report makes the case that this philosophy is ineffective in its implementation. Rather, we believe the report demonstrates what we expected from the VISN reengineering; i.e., each network's systems would evolve to meet the needs of veterans within that network's service area in the most effective way based on local conditions.

2. Mr. Stephen P. Backhus

Regrettably, the very limited time afforded the Department to comment precludes us from addressing these and other critical issues in greater detail and still have our comments printed in your report. However, we will provide you and the Congressional requestors with a more extensive response shortly.

Sincerely,

Dennis Duffy

GAO Contacts and Staff Acknowledgments

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Staff Acknowledgments

The following team members made important contributions: Donna M. Bulvin, Senior Evaluator; John R. Kirstein, Evaluator; Lawrence L. Moore, Evaluator; and Michael J. O'Dell, Senior Social Science Analyst.

Related GAO Products

VA Health Care: VA's Efforts to Maintain Services for Veterans With Special Disabilities (GAO/T-HEHS-98-220, July 23, 1998).

Veterans' Health Care: Challenges Facing VA's Evolving Role in Serving Veterans (GAO/T-HEHS-98-194, June 17, 1998).

VA Community Clinics: Networks' Efforts to Improve Veterans' Access to Primary Care Vary (GAO/HEHS-98-116, June 15, 1998).

Results Act: Observations on VA's Fiscal Year 1999 Performance Plan (GAO/HEHS-98-181R, June 10, 1998).

VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO-HEHS-98-64, Apr. 16, 1998).

VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

Managing for Results: Agencies' Annual Performance Plans Can Help Address Strategic Planning Challenges (GAO/GGD-98-44, Jan. 30, 1998).

VA Health Care: Resource Allocation Has Improved, but Better Oversight Is Needed (GAO/HEHS-97-178, Sept. 17, 1997).

VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997).

VA Health Care: Assessment of VA's Fiscal Year 1998 Budget Proposal (GAO/T-HEHS-97-121, May 1, 1997).

VA Health Care: Improving Veterans' Access Poses Financial and Mission-Related Challenges (GAO/HEHS-97-7, Oct. 25, 1996).

VA Health Care: Opportunities for Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996).

Veterans' Health Care: Facilities' Resource Allocations Could Be More Equitable (GAO/HEHS-96-48, Feb. 7, 1996).

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