United States General Accounting Office

GAO

Testimony

Before the Subcommittee on VA, HUD and Independent Agencies, Committee on Appropriations, U.S. Senate

For Release on Delivery
Expected at 10 a.m.
Wednesday, May 2, 2001

VA HEALTH CARE

Community-Based Clinics Improve Primary Care Access

Statement for the record by Cynthia Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

Chairman Bond, Ranking Member Mikulski, and Members of the Subcommittee:

We are pleased to contribute this statement for the record of the Subcommittee's deliberations on the President's fiscal year 2002 budget request for the Department of Veterans Affairs (VA). This budget proposes $22.3 billion for health care system expenditures by the Veterans Health Administration (VHA) to serve an estimated 4.1 million veterans and other beneficiaries.[1] This system comprises 22 health care networks, which operate over 700 medical facilities, most of which are community-based outpatient clinics (CBOC).

As you know, VHA launched a major initiative in February 1995 to expand its network of CBOCs. Before 1995, VHA operated about 175 community-based clinics, as well as 172 hospitals, which also offered outpatient services. Since VHA launched its initiative, about 400 CBOCs have opened and another 145 CBOCs are currently planned. These newly opened and planned clinics, hereafter referred to as Initiative CBOCs, were to operate essentially as physicians' offices focusing on primary care and were to be located in close proximity to VHA's patients.

VHA's stated goals for its Initiative CBOCs emphasized making access to care more convenient for its existing users, especially those with compensable service-connected disabilities or incomes below established thresholds.[2] For these high priority veterans—VHA's traditional population—Initiative CBOCs were expected to improve access, for example, by reducing the need to travel long distances or to travel in congested urban traffic.

My comments focus on (1) the accessibility of VHA primary care for patients who used VHA health care in the past, including the potential improvements that would result from opening planned Initiative CBOCs, and (2) the characteristics of Initiative CBOC users. To conduct our work, we surveyed VHA's 22 networks concerning their existing and planned CBOCs, analyzed VHA's outpatient care database for use patterns and

[1]About 9 percent of VHA's patients nationwide are nonveterans, for example, dependents of veterans who died of service-connected disabilities, patients provided humanitarian care, employees given preventive immunizations, and beneficiaries seen through sharing agreements with the Department of Defense.

[2]VHA uses a sliding scale of income thresholds, depending on number of dependents.

demographic information, and analyzed information in a VHA database that identifies the geographic location of VHA's patients to determine the effect of recently opened and planned CBOCs on their proximity to VHA's health care facilities.

In summary, Initiative CBOCs have contributed to improved accessibility of VHA primary care for patients who used VHA facilities in the past; however, access remains unevenly distributed across the networks. Planned CBOCs should help to further improve access, although network variation is not likely to be diminished much. While 87 percent of VHA's patients systemwide live in reasonable proximity to primary care clinics,[3] 13 percent—about 432,000 patients concentrated in 6 networks—still live more than 30 miles from a VHA primary care clinic. VHA's currently planned CBOCs could provide reasonable proximity to primary care for an additional 68,000 patients, but the majority of those who live more than 30 miles from a primary care clinic would still reside in 6 of the 22 networks. The difficulties in providing cost-effective VHA-staffed CBOCs or contract care in areas with few patients make it hard to improve accessibility, according to network managers.

Although Initiative CBOCs largely serve patients who have received VHA health care in the past, they have also facilitated access for new patients. [4] In fiscal year 2000, for example, about 135,000 Initiative CBOC users were new patients, including 56,000 higher-income veterans. During the same year, 158,000 new higher-income patients used other VHA outpatient facilities, but not Initiative CBOCs. Although their numbers are growing, new higher-income patients remain a relatively small segment of both patients using Initiative CBOCs and patients using any VHA outpatient health care.

Background

Regional directors of VHA's 22 health care networks (known as Veterans Integrated Service Networks, or VISNs)[5] were given responsibility for

[3]VHA's primary care clinics include Initiative CBOCs, hospital-based clinics, and pre-existing community outpatient clinics.

[4]New patients are defined as those who did not obtain health care through VA for 3 fiscal years before a visit. Past patients, in contrast, are those who did receive VA health care at any time during the 3 preceding fiscal years.

[5]In 1995, VHA created 22 VISNs, a new management structure to coordinate the activities of and allocate funds to VHA medical facilities in each region. See appendix I for a list of these networks.

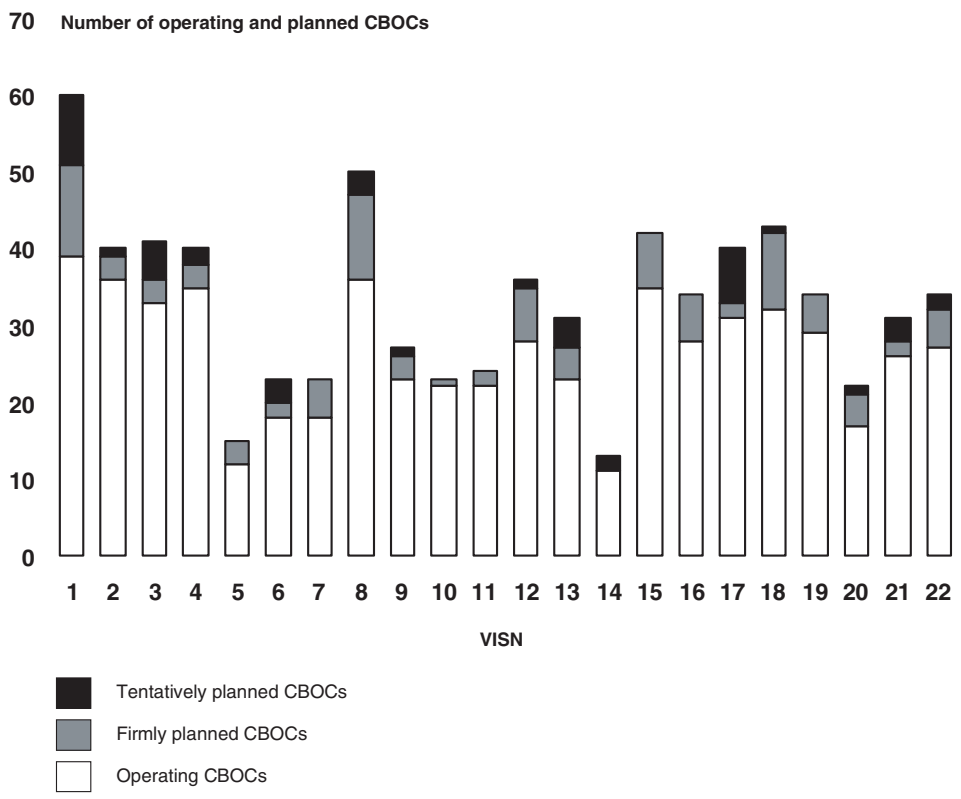
CBOC planning. VHA guidance stated that attracting new patients should not be the sole or primary goal of a new CBOC. This guidance instead noted that planners should exercise caution because any new patients attracted to CBOCs must be accommodated within existing resource constraints.

Since VHA's CBOC initiative was launched in February 1995, the number of CBOCs has more than tripled. As of February 28, 2001, VHA had 573 operating CBOCs, including nearly 400 Initiative CBOCs. According to network officials, firm plans for another 100 CBOCs have already been authorized by the Congress or have been submitted to VHA headquarters or the Congress for consideration.[6] Tentative plans for 45 CBOCs are in the development phase.[7] Network managers expect most of these plans to be implemented within the next 3 years. Networks vary in their numbers of existing and planned CBOCs, as figure 1 shows.

[6]Of these planned CBOCs, 12 have already opened. Because they opened after our reference date of February 28, 2001, we counted them among the firmly planned CBOCs.

[7]Network managers also indicated that an additional 70 locations are being considered. Because the plan development phase has not begun, we excluded them from our analyses.

Figure 1: Number of Existing and Planned CBOCs in Each Network as of February 28, 2001



[a]Appendix I identifies networks by location.

Source: Managers within VHA's 22 networks

Although new CBOCs continue to open, the peak of expansion seems to have passed. From March 1998 through February 1999, 124 Initiative CBOCs opened. Fewer have opened each year since. If networks implement all planned CBOCs within the next 3 years, then new openings will average about 50 CBOCs annually.

Existing CBOCs (including both Initiative and pre-existing CBOCs) differ somewhat in the services they provide. The vast majority—more than 90

percent—offer primary care, and about half offer mental health services.[8] In addition, one-third offer other services as well.[9]

Systemwide, VHA staff operate about 75 percent of VHA's current CBOCs using VA-owned or leased space. Contract arrangements are, however, becoming increasingly common. Contractors operated only about 1 in 25 CBOCs opened before February 1995. In contrast, one in three Initiative CBOCs are contract-run, and one in two of VHA's planned CBOCs are expected to involve contracted staff and space.

VHA's initiative to expand CBOCs was one component of a broader set of changes intended to improve veterans' access to health care. Notably, the Veterans Health Care Eligibility Reform Act of 1996 authorized a uniform package of health care benefits for all veterans. As a result, VHA's traditional veteran patients became eligible for a broader array of services (including preventive care) than was previously available. In addition, veterans with incomes higher than established thresholds could also receive the same uniform benefit package if VHA determines that it has more resources than it needs to serve traditional patients.

Over the last 6 years, VHA's patient base has increased dramatically. For example, VHA served 2.8 million patients in fiscal year 1995 compared to 3.8 million in fiscal year 2000, a 36 percent increase. VHA's fiscal year 2002 budget projects that about 4.1 million patients will be served, representing an increase of almost 50 percent since 1995.

[8]The Veterans Health Care Eligibility Reform Act (P.L. 104-262) authorized VHA to provide preventive care. Consistent with this, more than 97 percent of Initiative and planned CBOCs offer primary care, compared to 82 percent of pre-existing CBOCs. In contrast, more than 80 percent of pre-existing CBOCs offer mental health services, compared to 45 percent of Initiative CBOCs.

[9]These other services typically include ancillary or preventive services (such as laboratory testing or nutritional counseling), although some CBOCs offer limited specialty care as well.

CBOCs Are Improving Primary Care Access, but Results Vary Among Networks

As the number of Initiative CBOCs has increased, the percentage of VHA's patients who live in reasonable proximity to a VHA primary care facility has increased to 87 percent. In 1995, we found that about two-thirds of VHA patients had reasonable proximity to VHA health care facilities, which we then measured as living within 25 miles of an outpatient clinic.[10] After we recommended that VHA establish a time or distance standard for CBOCs,[11] VHA began to report the number of patients who lived within 30 miles of its facilities.

VHA's most recent report[12] showed that about 86 percent of its total fiscal year 1999 patient population, 3.4 million patients, lived within 30 miles of a VHA outpatient facility. Since that time, VHA has opened about 100 additional Initiative CBOCs, and we estimate that the percentage of those patients living within 30 miles of a VHA primary care clinic has increased to 87 percent.[13]

However, the percentage of the patients who live 30 miles or less from a primary care clinic is not evenly distributed among VHA's networks. As figure 2 shows, the percentage of patients who are within 30 miles of VHA primary care ranges from less than 70 percent in some largely rural networks, such as the VHA Upper Midwest Health Care Network (VISN 13), to nearly 100 percent in largely urban networks, such as the Veterans Integrated Service Network—Bronx (VISN 3).

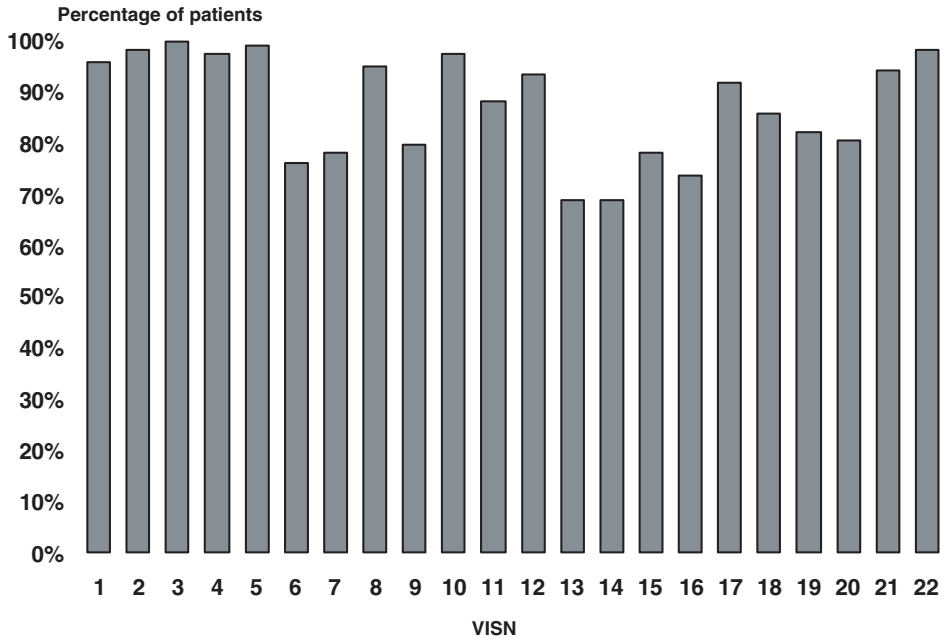
[10] *VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services* (GAO/HEHS-96-31, Dec. 20, 1995).

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

[12] *Geographic Access to Veterans Health Administration (VHA) Services in Fiscal Year 1999: A National and Network Perspective*, report by the planning systems support group, a field unit of the VHA Office of Policy & Planning (April 2000).

[13] Overall, 88 percent of VHA's patients live within 30 miles of a VHA outpatient facility, but not all of these facilities offer primary care.

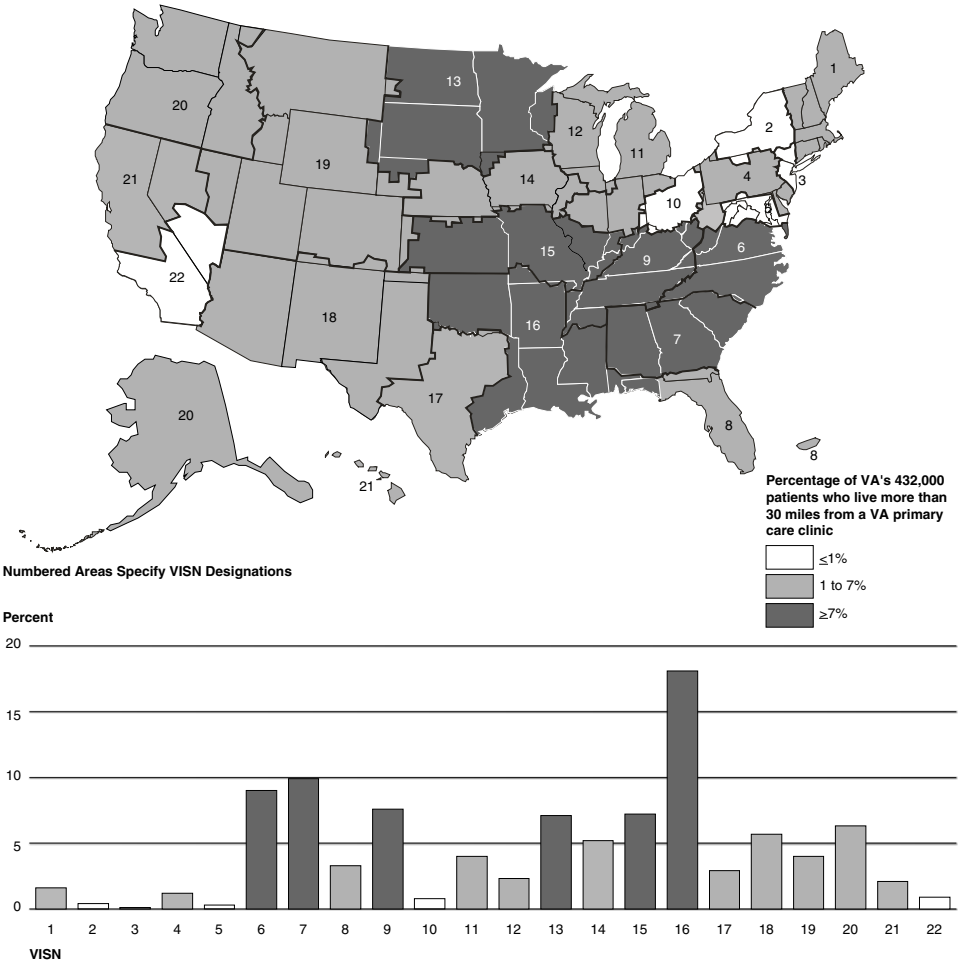
Figure 2: Percentage of Each Network's Patients Who Live Within 30 Miles of a VHA Primary Care Clinic Given CBOCs Operating on February 28, 2001



Source: GAO analysis of information provided by VHA and network managers.

Moreover, approximately 432,000 patients—or about 13 percent of VHA's patient population—live more than 30 miles from a VHA primary care clinic. As figure 3 shows, almost 60 percent of these 432,000 patients live in six networks.

Figure 3: Percentage of the 432,000 Patients Who Live More Than 30 Miles From a VHA Primary Care Clinic Given CBOCs Operating on February 28, 2001



Source: GAO analysis of information provided by VHA and network managers.

If networks implement all firm plans for 100 new CBOCs, then more than 50,000 additional patients will be within reasonable proximity to VHA primary care. In addition, another 18,000 patients will have reasonable

proximity to primary care if the tentative plans for 45 more CBOCs are also implemented.[14]

However, opening all planned CBOCs would not eliminate uneven access across the networks. Specifically, we estimate that 364,000 patients would remain more than 30 miles from VHA primary care, and the same six networks would still account for the majority (60 percent) of these patients. Moreover, more than 68,000 patients (19 percent) live in one network—the Veterans Integrated Service Network—Jackson (VISN 16)—and more than 148,000 patients (41 percent) live in the other five networks.

Managers in these networks noted challenges to improving the proximity of VHA primary care to their patients. In some areas, there are not enough VHA patients to support a cost-effective VHA-run CBOC. Even where there are enough patients, network managers reported that there can be difficulties recruiting VHA medical personnel to staff CBOCs or obtaining appropriate, affordable space. They also noted obstacles to arranging contract care. For example, some network managers mentioned difficulties in finding local providers who were willing to enter into contracts to provide primary care to veterans at reasonable costs.

Network managers nationwide noted that reducing the number of patients who live more than 30 miles from a VHA health care facility is not their only goal when planning CBOCs. Many, for example, mentioned reducing veterans' travel time to 30 minutes or less—whether because of distance, congested urban traffic, or other factors. VHA is in the process of estimating the time its patients must spend traveling to VHA health care facilities, an endeavor made possible by recent advances in computer mapping software. Because many patients who are within a 30-mile radius of a health care facility may need to travel more than 30 minutes to reach it, switching to a time-based measure of access will likely reduce the number of patients considered to have reasonable access. As a result, the uneven accessibility across networks portrayed in figure 2 is likely to change once VHA begins measuring access in terms of travel time rather than distance.

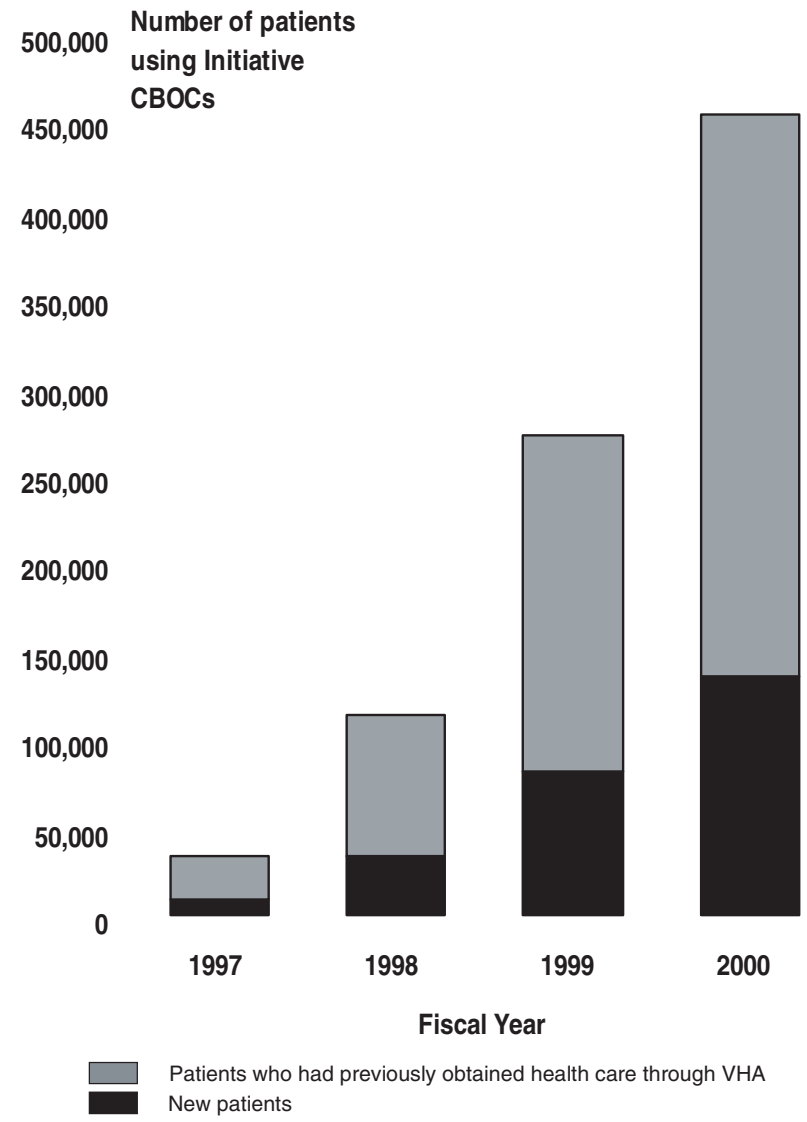
[14]If all plans for CBOCs were implemented, about 89 percent of VA's patients would live within 30 miles of a VA primary care clinic, an increase of about 2 percentage points over current levels.

CBOCs and Other Outpatient Facilities Serving A Relatively Small, but Growing Number of New, Higher-Income Veterans

New VHA patients have represented about 30 percent of Initiative CBOC users in each of the last 4 years, although their numbers are growing. In fiscal year 2000, for example, 454,000 patients used Initiative CBOCs,[15] including 135,000 who were new patients to the VHA system. In contrast, less than 10,000 new VHA patients were Initiative CBOCs users in fiscal year 1997. As figure 4 shows, each year since 1998 VHA has experienced significant increases in the use of Initiative CBOCs by both new patients and patients who had previously used other VHA outpatient facilities.

[15]Most patients who used Initiative CBOCs also used VHA's other facilities to obtain health care services.

Figure 4: Number of New and Past Patients Who Used Initiative CBOCs in Fiscal Years 1997–2000



Note: The number of patients who used Initiative CBOCs in fiscal years 1995 and 1996 cannot be counted accurately because outpatient visits to CBOCs during those years were often counted as visits to the medical centers that had administrative responsibility for their operations. Almost all CBOCs now report their workloads separately from those of medical centers.

Source: GAO analysis of information provided by VHA.

The percentage of Initiative CBOC patients who were new to VHA varied across networks. In fiscal year 2000, for example, new VHA patients who used CBOCs ranged from 16 to 42 percent, as table 1 shows.[16]

Table 1: Percentage of Initiative CBOC Patients Who Were New VHA Patients in Fiscal Year 2000

Percent	Number of networks
16 - 20	3
21 - 25	4
26 - 30	8
31 - 35	3
36 - 40	2
40 - 42	2

Note: These analyses are based on the network in which patients reside, rather than the location of the Initiative CBOC used.

Source: GAO analysis of information provided by VHA.

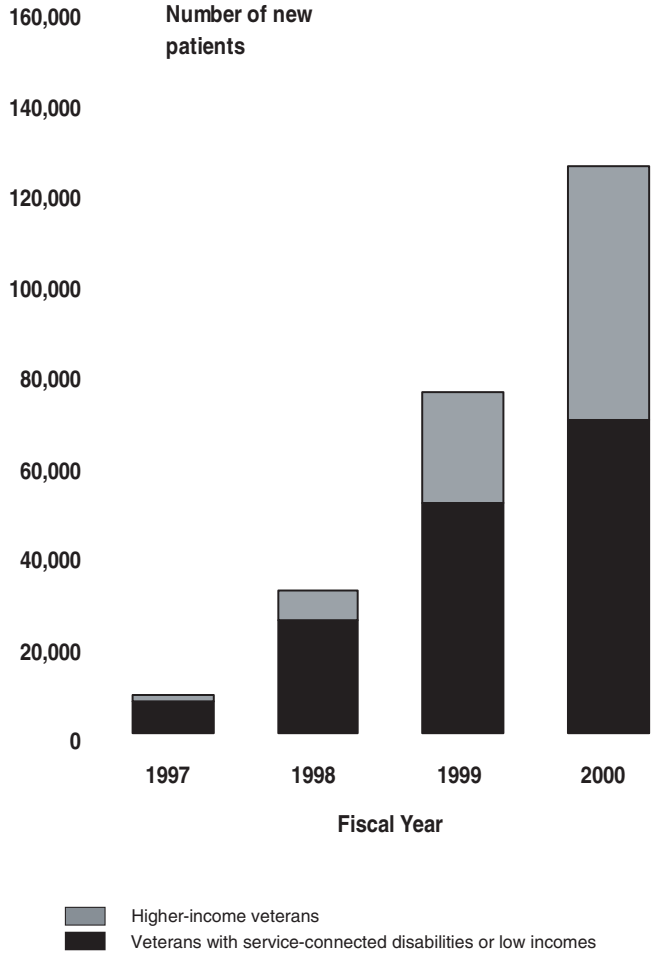
Of the 135,000 new VHA patients using Initiative CBOCs in fiscal year 2000, about 56,000 were higher-income veterans, up from 1,300 in fiscal year 1997.[17] Moreover, higher-income veterans as a share of new patients who use Initiative CBOCs have risen from 14 to 41 percent from fiscal year 1997 through fiscal year 2000 (see figure 5).[18]

[16]These analyses are based on the network in which patients reside, rather than the location of the Initiative CBOC used. That is, our numbers describe patients who live within a network, rather than patients who use the facilities within that network. For example, patients who live in VISN 6 may have used Initiative CBOCs in a neighboring network, such as VISN 5. Such patients would be included only in the data reported for VISN 6.

[17]In fiscal year 2000, a total of about 100,000 higher-income veterans used Initiative CBOCs; however, 44,000 had previously obtained outpatient health care from VHA.

[18]A small percentage of Initiative CBOC patients do not fall into either the traditional veteran population (those with compensable service-connected disabilities or low income) or the higher-income veteran population. These patients include nonveterans, veterans whose eligibility for benefits was being assessed, and veterans whose disability and income status were not identified in the outpatient database. They accounted for about 5 percent of Initiative CBOC patients in fiscal year 1997, but less than 4 percent of Initiative CBOC patients in fiscal years 1998 through 2000.

Figure 5: Number of New Patients Who Used Initiative CBOCs in Fiscal Years 1997–2000



Source: GAO analysis of information provided by VHA.

Like the percentage of new patients, the percentage of new higher-income patients using Initiative CBOCs varied across networks. In fiscal year 2000, for example, new higher-income veterans who used Initiative CBOCs ranged from 15 to 62 percent, as table 2 shows.

Table 2: Percentage of New Initiative CBOC Patients Who Were Higher-Income Veterans in Fiscal Year 2000

Percent	Number of networks
15 - 24	2
25 - 34	7
35 - 44	5
45 - 54	6
55 - 62	2

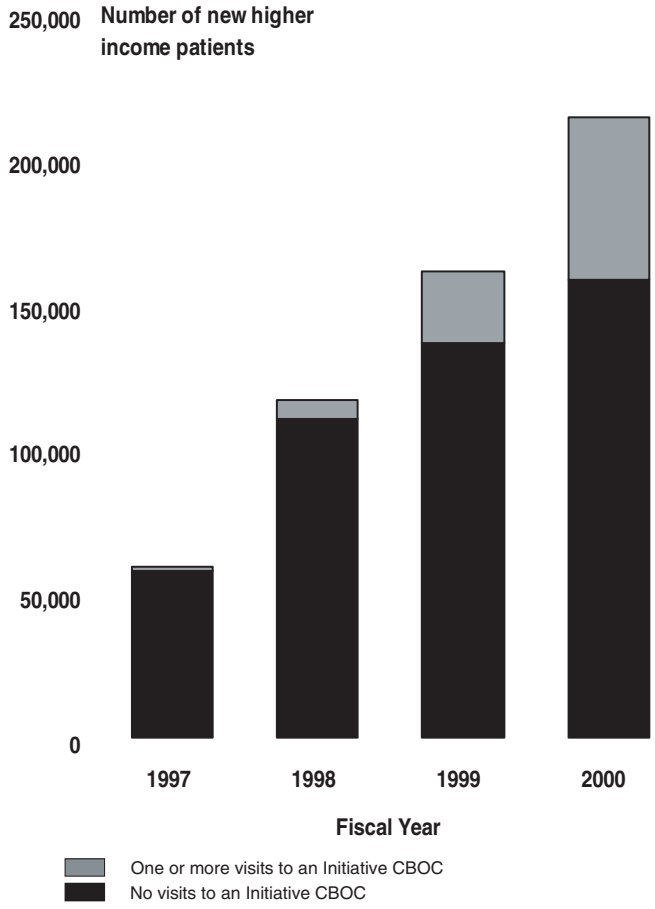
Note: These analyses are based on the network in which patients reside, rather than the location of the Initiative CBOC used.

Source: GAO analysis of information provided by VHA.

Systemwide, most new higher-income veterans do not use Initiative CBOCs, but instead use only other VHA outpatient facilities. Nevertheless, the number and share of new higher-income patients using Initiative CBOCs have increased dramatically. The proportion of new higher-income veterans who use Initiative CBOCs has grown from 2 percent in fiscal year 1997 to 26 percent in fiscal year 2000.[19] As previously discussed, the number of these new higher-income patients has increased from 1,300 in fiscal year 1997 to 56,000 in fiscal year 2000. To put this in perspective, during the same period, the number of new higher-income veterans using other VHA outpatient facilities exclusively grew from 57,000 to 158,000, as shown in figure 6.

[19]This is consistent with CBOCs growing share of total higher-income veterans (new and past users) using Initiative CBOCs; from fiscal year 1997 through fiscal year 2000, the percentage of higher-income veterans using CBOCs grew from 2 percent to 21 percent.

Figure 6: Number of New Higher-Income Patients Using Initiative CBOCs and Other VHA Outpatient Facilities in Fiscal Years 1997–2000



Source: GAO analysis of information provided by VHA.

Nonetheless, new higher-income veterans remained a small segment—about 6 percent—of all patients using VHA's outpatient facilities in fiscal year 2000, up from 2 percent in fiscal year 1997.

Concluding Observations

Overall, through its Initiative CBOCs, VHA is steadily making primary care more available within reasonable proximity of patients who have used VHA's system in the past. However, the uneven distribution of patients living more than 30 miles from a VHA primary care facility suggests that access inequities across networks may exist. Also, the improvements likely to result from VHA's planned CBOCs indicate that achieving equity

of access may be difficult. Nonetheless, we believe VHA's effort to assess the time it takes patients to reach a VHA outpatient clinic could provide a better measure and, therefore, a clearer understanding of access differences among networks.

In addition, our assessment suggests that new CBOCs may have contributed to, but are not primarily responsible for, the marked increase in the number of higher-income patients who have sought health care through VHA over the past few years. While Initiative CBOCs have undoubtedly attracted some new patients to VHA, our analysis suggests that new patients would have sought care at other VHA facilities in the absence of Initiative CBOCs. In that regard, enhanced benefits and access improvements afforded by eligibility reform may have attracted more new patients, including those with higher incomes, than VHA's Initiative CBOCs.

GAO Contacts and Staff Acknowledgments

For more information about this statement, please call Cynthia A. Bascetta, Director, Health Care—Veterans' Health and Benefits Issues, at (202) 512-7101, or Paul Reynolds, Assistant Director, at (202) 512-7109. Key contributors to this statement include Kristen Joan Anderson, Deborah Edwards, Michael O'Dell, Peter Schmidt, Thomas Walke, and Connie Wilson.

Appendix I:

Veterans Integrated Service Networks

VISN 1: VA New England Health care System (Boston)
VISN 2: VA Health care Network Upstate New York (Albany)
VISN 3: Veterans Integrated Service Network (Bronx)
VISN 4: VA Stars & Stripes Health care Network (Pittsburgh)
VISN 5: VA Capitol Health Care Network (Baltimore)
VISN 6: The Mid-Atlantic Network (Durham)
VISN 7: The Atlanta Network (Atlanta)
VISN 8: VA Sunshine Health care Network (Bay Pines)
VISN 9: Mid South Veterans Health care Network (Nashville)
VISN 10: VA Health care System of Ohio (Cincinnati)
VISN 11: Veterans Integrated Service Network (Ann Arbor)
VISN 12: The Great Lakes Health Care System (Chicago)
VISN 13: VA Upper Midwest Health Care Network 13 (Minneapolis)
VISN 14: Central Plains Health Network (Omaha)
VISN 15: VA Heartland Network (Kansas City)
VISN 16: Veterans Integrated Service Network (Jackson)
VISN 17: VA Heart of Texas Health Care Network (Dallas)
VISN 18: VA Southwest Health Care Network (Phoenix)
VISN 19: Rocky Mountain Network (Denver)
VISN 20: Northwest Network (Portland)
VISN 21: Sierra Pacific Network (San Francisco)
VISN 22: Desert Pacific Health care Network (Long Beach)

Related GAO Products

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

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

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

VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996).

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

VA Health Care: Exploring Options to Improve Veterans' Access to VA Facilities (GAO/HEHS-96-52, Feb. 6, 1996).

VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995).

VA Clinic Funding (GAO/HEHS-95-273R, Sept. 19, 1995).