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VA COMMUNITY CLINICS

Networks' Efforts to Improve Veterans' Access to Primary Care Vary

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The Honorable Christopher S. Bond
Chairman, Subcommittee on VA, HUD,
and Independent Agencies
Committee on Appropriations
United States Senate

The Honorable Cliff Stearns
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Veterans Health Administration (VHA) operates one of the nation's largest health care delivery systems at a cost of about $17 billion a year.[1] The system includes 172 hospitals and 419 free-standing outpatient facilities, which provide a wide range of primary and specialized care. Over a third of the 3.4 million veterans served by these facilities each year must travel long or time-consuming distances to receive care.

In 1995, VHA announced plans to transition from a hospital-based system of care to a health-care system rooted in primary and ambulatory care. VHA restructured its facilities into 22 service delivery networks and encouraged network directors to establish community-based outpatient clinics. These clinics differ from traditional free-standing VHA outpatient facilities in that they basically provide primary care to veterans and frequently use non-VHA providers. The type of care veterans receive at these new clinics is comparable to that available during visits to a private physician's general practice office.

In an April 1996 hearing, we discussed the networks' first 12 operating community-based clinics and planning efforts for additional clinics.[2] We concluded that community-based clinics could be a cost-effective way to enhance veterans' access to VHA primary care. We expressed concern, however, that it would be difficult, if not impossible, to assess VHA's progress because networks had not developed comprehensive plans to

[1]VHA, one of three organizational units within the Department of Veterans Affairs (VA), is responsible for providing medical care to eligible veterans.

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

guide the development of new clinics. In a subsequent report,[3] we recommended that VHA require networks to develop such plans and, in doing so, focus first on improving access for current users, with a goal of equalizing access systemwide on the basis of a consistent travel standard and in accordance with veterans' statutory priorities for care. In response, VHA agreed to improve the process that networks use when planning and operating new community-based clinics and to provide more detailed guidelines.

This report responds to your request for information on VHA's use of community-based clinics to improve veterans' access to primary care. Specifically, it describes (1) VHA's planning process for new community-based clinics, (2) networks' implementation of VHA's planning guidelines, and (3) VHA and network oversight of clinic operations.

In conducting this study, we reviewed VHA guidance and the 22 networks' plans and proposals for 178 clinics approved between our 1996 testimony and February 1998. We surveyed each network to obtain additional information about their planning and oversight activities. In addition, we interviewed VHA officials responsible for developing planning guidance for networks and for reviewing network activities. We also visited VHA's New York/New Jersey Network headquartered in Bronx, New York; Southwest Healthcare Network in Phoenix, Arizona; and Desert Pacific Healthcare Network in Long Beach, California. We selected these networks because they had widely varying service areas, financial resources, and experiences in operating community-based clinics. For example, the New York/New Jersey Network covers the smallest geographic area compared with the Southwest Healthcare Network, which covers one of the largest areas. At each network, we interviewed staff, reviewed planning documents and clinic evaluations, and toured hospitals and clinics. At the networks based in New York and California, we interviewed individual veterans and conducted group discussions with approximately 40 veterans who had received care from their respective networks' community-based clinics.[4] Our work was done between March 1997 and May 1998 in accordance with generally accepted government auditing standards.

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

[4]A map and a summary profile of the three networks we visited are in app. I. Selected characteristics of all networks' clinics approved since October 1996 are provided in app. II.

Results in Brief

VHA has strengthened the process that networks are to use when establishing new community-based clinics, thereby addressing several of our earlier recommendations. First, VHA provided more detailed guidance, including a 30-minute travel standard and an expectation that clinics be established primarily to benefit current users rather than attract new users. Second, VHA developed a more structured planning process, including the development of network business plans covering a 5-year period, and established a task force to help networks develop clinic proposals in accordance with VHA's guidelines.

VHA's long-range goal is to increase the number of community-based clinics. To that end, VHA has approved 198 clinics, and network business plans show that 402 additional clinics are to be established between 1998 and 2002.[5] The plans, however, do not address the percentage of current users who have reasonable access, as defined by VHA's 30-minute standard, or what percentage of those without reasonable access are targeted to receive enhanced access through the establishment of new clinics. As a result, VHA's network business plans cannot be used to determine on a systemwide basis how well networks are using clinics to equalize veterans' access to primary care.

On the basis of the limited information that networks can provide, it appears that the geographic accessibility of VHA primary care currently varies widely among networks and that while networks' efforts should reduce this variation, thousands of VHA's 3.4 million current users will likely continue to have inequitable access for many years. Moreover, it appears that networks are planning to improve access for thousands of lower priority new users over the next 2 years, while thousands of higher priority current users are waiting considerably longer periods of time for reasonable access.

Networks, which have primary responsibility for monitoring community-based clinic performance, have developed evaluation plans for proposed clinics, as VHA requires. To date, few clinics have operated for more than 12 months. As a result, most evaluation plans have not been implemented. Network evaluation plans, however, vary widely, with few containing a common set of criteria or indicators that appear necessary to effectively assess clinic performance. As a result, VHA may have difficulties using clinic evaluations to monitor performance within or among networks.

[5]Included in the 198 clinics are 20 community-based clinics approved by VHA prior to its 1996 proposal requirement. For a complete list of community-based outpatient clinics by network and their approval dates, see app. III.

Background

Since 1930—when there was virtually no public or private health insurance—VHA's health care system has evolved into a direct delivery system, with government ownership and operation of facilities. However, of the 26 million veterans who are eligible for care, about half live more than 25 miles from a VHA hospital and about one-third live more than 25 miles from a VHA clinic. Of the approximately 3.4 million veterans VHA currently serves, we estimate that about 1 million travel more than 25 miles to access VHA primary care from a VHA hospital or clinic. In addition, many eligible veterans who are not currently receiving care say that they do not use VHA primary care services because they live too far from a VHA facility.[6]

In the early 1990s, VHA began developing a strategy to expand its ability to provide primary care, especially for veterans who had to travel many miles to receive care from existing facilities. In January 1994, the VHA hospital in Amarillo, Texas—now a part of the Southwest Network—established what is commonly recognized as the first VHA community-based clinic.

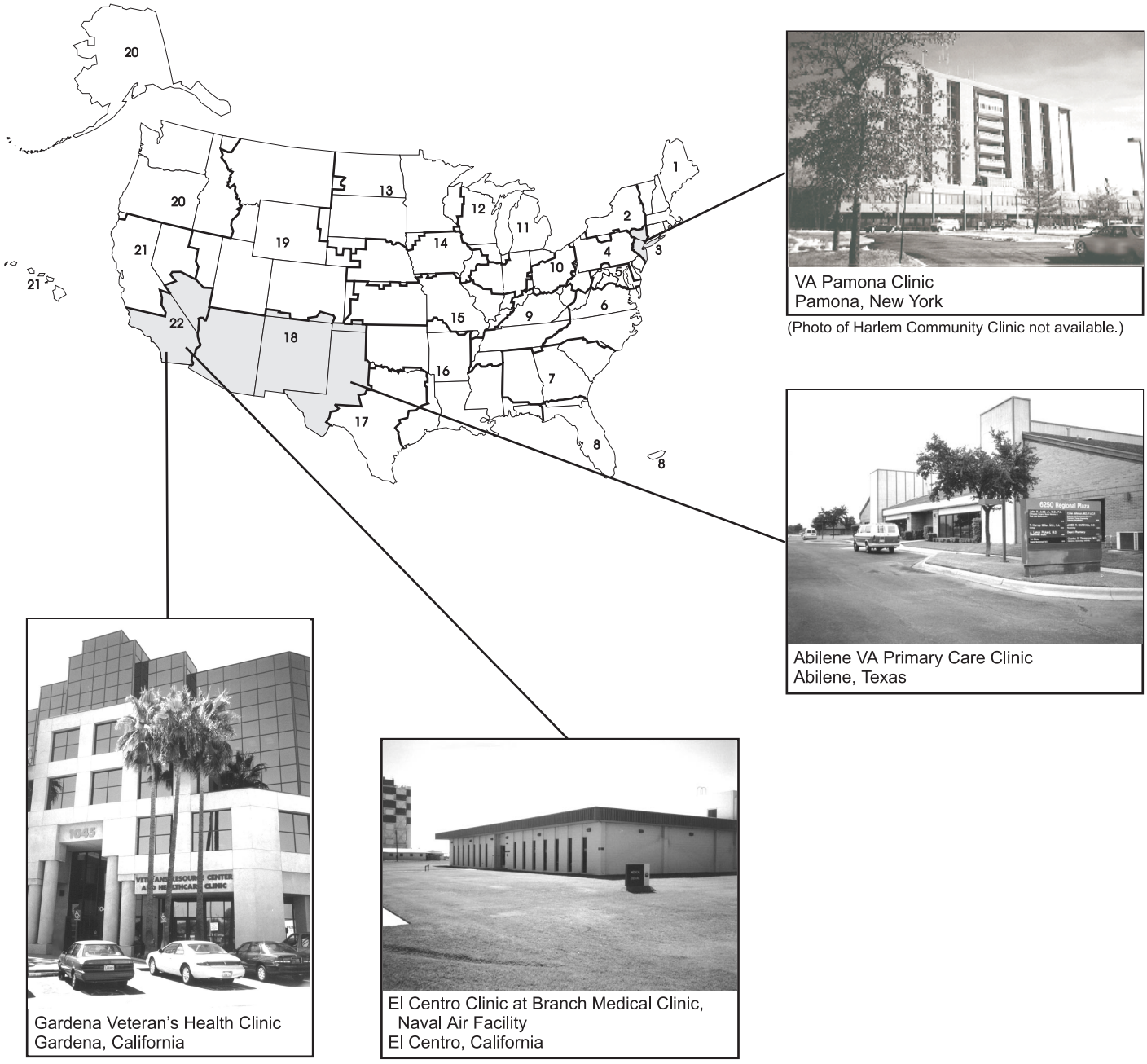
Until the establishment of the Amarillo clinic, VHA had required its hospitals to meet rigid criteria to establish separate outpatient facilities apart from hospitals. These criteria included that clinics had to serve a projected workload of 3,000 visits or more per year and be located at least 100 miles or 3 hours travel time away from the nearest VHA facility.

Subsequently, VHA encouraged its hospitals to consider establishing community-based clinics similar to Amarillo's. In doing this, VHA eliminated its restrictions concerning workload and location. It also encouraged hospitals to consider contracting with other providers when it was in the interest of the veteran and the hospital.

In late 1995, VHA reorganized its field operations into 22 Veterans Integrated Service Networks (VISN). (See fig. 1.) These networks are the basic budgetary and decisionmaking units of VHA's health care system. Networks have responsibility for making a wide range of decisions about care delivery options, including planning and establishing community-based outpatient clinics.

[6]See VA Health Care: How Distance From VA Facilities Affects Veterans' Use of Services (GAO/HEHS-96-31, Dec. 20, 1995) and VA Health Care: Exploring Options to Improve Veterans' Access to VA Facilities (GAO/HEHS-96-52, Feb. 6, 1996). See Related GAO Products at the end of this report.

Figure 1: Veterans Integrated Service Networks and Community-Based Clinics Visited by GAO in 1997



In January and February 1995, VHA approved 15 proposals for new community-based clinics. Although networks submitted many more proposals, VHA did not approve any additional clinics until October 1996. Since the first community-based outpatient clinic was established by VHA's Amarillo Medical Center in 1994, VHA has approved a total of 198 community-based clinics.

Networks' Planning Adheres to VHA's Improved Guidelines

VHA issued its initial set of guidelines for community-based clinics in February 1995.[7] In essence, these guidelines gave networks wide discretion to establish community-based clinics wherever they deemed appropriate to better serve veterans. Networks were required, however, to submit a brief summary, called a "white paper," for each planned clinic to VHA for review. These summaries were to describe certain key operational elements, such as target population, service availability, and cost.

VHA revised its guidelines in August 1996 to require networks to establish clinics primarily for current users who live more than 30 minutes from an existing VHA clinic. VHA separately required networks to develop annual business plans that, among other things, are to include information on the number of community-based clinics to be established and projected time frames. In addition, VHA provided guidance to networks for developing proposals—which were to provide more details than the original white papers—and implemented a process to help networks develop more consistent and thorough proposals, in accordance with VHA's guidelines.

Planning Criteria Clarify Target Veteran Population

In our 1996 testimony and report, we concluded that VHA had not adequately defined target veteran populations for new community-based clinics or reasonable travel goals for use in locating new clinics. Given VHA's limited resources, we expressed concern about the propriety of using clinics to provide convenient geographic access for new users while current users continue to experience inconvenient access. We recommended that VHA state which veterans were to be the primary group to be served by these new clinics and that they establish a travel time or distance standard when planning for new clinics.

In response, VHA instructed networks to establish clinics primarily to provide more convenient access to care for current users. Toward this end, VHA stated that it is desirable that a community-based clinic be

[7]Veterans Health Administration Interim Policy for Planning and Activating Department of Veterans Affairs Access Points (VHA Directive 10-95-017, Feb. 8, 1995).

located generally within 30 minutes' travel time from a veteran's home. VHA noted, however, that differences in veterans' medical conditions and other regional factors may affect veterans' access to VHA care. As a result, VHA also included several exceptions to the 30-minute travel standard, including traffic congestion, weather conditions, or overcrowding at existing VHA facilities.

Business Plans Document Time Frames for Establishing New Community-Based Clinics

In our prior work, we concluded that networks were not planning new community-based clinics on a strategic basis and that an overall plan was not available to permit an assessment of network activities from a systemwide perspective. Essentially, networks submitted proposals for individual clinics to headquarters on an ad hoc basis, and headquarters considered the proposals on their individual merit. We expressed concern that this approach would make it difficult, if not impossible, to assess networks' planning efforts individually or systemwide.

As part of its overall restructuring efforts, VHA requires networks to develop annual business plans that are to show how a network intends to spend its resources. In response to our concern, VHA instructed networks to include, as part of their business plans, the number of clinics to be established, time frames for establishing clinics, and locations of planned clinics. VHA stated its intent to consolidate the 22 network plans into a national business plan, which would permit an assessment of network activities from a systemwide perspective.

With the networks' 1997 and 1998 business plans completed—and their 1999 business plans to be completed over the next 3 months—the evolving nature of clinic planning activities can be seen. In their 1997 business plans, the 22 networks reported their intent to establish 211 clinics by the year 2001.[8] As networks gained experience in planning and operating clinics, the number of clinics to be established grew significantly. Networks' 1998 business plans show that 402 additional clinics are to be established by 2002, although a target year had not been selected for 93 of these clinics. (See table 1.) We surveyed networks about 2 months after their business plans were submitted and found that they had since decided to establish most of the 93 clinics in years 1999 through 2002.

[8]The plans do not discuss how many veterans will be served, which veteran populations are targeted, how clinics will be funded, or how they will operate. Rather, VHA requires networks to address these issues when new clinics are proposed.

Table 1: Aggregate Number of Clinics That Networks Plan to Establish, by Fiscal Year

Business plan term	Year expected to be established							
	1997	1998	1999	2000	2001	2002	Unspecified	Total
FY 1997	124	44	20	12	11	NA	0	**211**
FY 1998	NA	180	68	44	11	6	93	**402**

Note: NA = not applicable.

The 22 business plans are intended to provide estimates of the number of clinics networks plan to propose and projected time frames for when the clinics will become operational. Collectively, the estimates and projections have been fairly reliable. For example, of the 124 clinics total planned for in the networks' 1997 business plans, 122 were actually proposed. However, only four networks proposed the same number of clinics as they had indicated in their business plans. Of the remaining 18 networks, 10 proposed a total of 29 more clinics than they had planned and 8 proposed 31 fewer. Still, the majority of networks that proposed more or less than they had stated in their business plans were within three clinics of their estimates.

In April 1997, VHA consolidated the 22 network plans into its national business plan.[9] The consolidated plan summarizes the number of community-based clinics that networks have established and plan to establish. However, the plan does not provide sufficient information to assess the impact of community-based clinics on veterans' access to care on a systemwide basis. In July 1997, VHA was directed by the Senate Appropriations Committee to address the need for a national plan and to respond to the findings and recommendations in our October 1996 report.[10] In its report to the Committee, submitted in April 1998, VHA stated that its response to our October 1996 report remained essentially unchanged from its original comments summarized in our report. In other words, VHA believes that its April 1997 national plan—based on the total number of clinics contained in the 22 individual business plans—is responsive to our concerns.

At the time of our earlier report, we did agree that VHA's intended national business plan could provide a means to achieve the intent of our recommendations. However, it was not known at the time whether the plan would ultimately provide sufficient detail to afford the Congress

[9]Veterans Health Administration, Journey of Change (Washington, D.C.: Department of Veterans Affairs, Apr. 1997).

[10]Senate Committee on Appropriations, Report 105-33, July 17, 1997; to accompany S. 1034, p. 14.

enough information to determine the overall extent and cost of establishing community-based clinics. Now that we have had the opportunity to review networks' 1997 and 1998 business plans, VHA's national plan, and VHA's report to the Senate, our concerns remain.

In contradiction to VHA's contention that the sum of clinics contained in 22 individual network business plans can serve as an adequate national plan for establishing community-based clinics, we believe it contains less information than do the individual business plans upon which it is based. If it is impossible to determine equity of access issues from individual network business plans, it is, therefore, also impossible to make that same assessment with VHA's national business plan.

VHA Task Force Assists Networks in Developing Clinic Proposals

When planning a new clinic, networks must describe, as required by VHA's 1995 guidelines,

- justification for the clinic,
- service delivery options,
- the targeted veteran population and anticipated workload,
- services to be provided,
- funding sources,
- an implementation plan, and
- stakeholder comments.

While networks were required to involve stakeholders, such as veterans, in the development of clinic proposals, the guidelines afforded networks considerable discretion in deciding how to describe these elements and present their results in proposal documents. To obtain greater consistency among proposals for community-based clinics, VHA provided in August 1996 additional guidance on determining how key elements apply to the needs of the veterans who would be served by the proposed clinics and the network's ability to fund such clinics. The guidance also provided a standard format for presenting their planning assessment results.

Along with the new proposal guidelines, VHA also implemented a new management process to help ensure more thorough and consistent oversight of network proposals. VHA established a task force to assist networks in developing their proposals and to serve as a resource to both network and VHA management. The task force was responsible for ensuring that the information contained in the proposals was complete, accurate, and met VHA requirements. In doing its work, the task force also

trained and developed network staff in the skills of preparing clinic proposals. As part of its work, it prepared and distributed guidelines that contained a standardized proposal format with examples and sample wording network planners could use to develop their own proposals.

The task force reviewed proposals for 178 clinics and determined that each met VHA's guidelines. The task force was disbanded in February 1998 and its duties transferred to VHA's Network Office in headquarters.

Our assessment of the 133 proposals reviewed by the task force during fiscal years 1996 and 1997[11] shows they are designed to serve primarily current users, as VHA guidelines suggest. Of the 272,000 veterans expected to use the new clinics, about 17 percent are estimated to be new VHA users, ranging from 0 percent to 62 percent.

Clinics are to be operated in accordance with options contained in VHA's clinic guidance. Of the 133 proposed clinics we reviewed, 77 will be operated by VHA, 53 by contractual arrangement with other healthcare providers, 2 by combined VHA-contractor arrangement, and 1 by the Department of Defense. On average, VHA-operated clinics plan to serve more veterans than will non-VHA-operated clinics (2,400 versus 1,800).

The distance between community-based clinics and VHA hospitals range from 2 to 250 miles. Twenty-one community-based clinics are located 25 miles or less from a VHA hospital to reduce overcrowding in existing facilities or help veterans avoid traffic-congested areas, and 112 are located 25 miles or more from a VHA hospital. This geographic distribution of VHA health care facilities meets VHA standards.

Networks' Planning Does Not Address Access Inequities

In our April 1996 testimony and October 1996 report, we expressed long-standing concerns about inequities in veterans' access to VHA care. We concluded that given VHA's limited resources, networks should focus on improving geographic access for current users in a manner that ensures that a comparable percentage of users in each network has reasonable access as defined by VHA's travel standards. VHA agreed with the need to minimize inequities in access among networks but preferred to encourage such outcomes without mandating national standards for equity of access.

[11]Forty-five proposals were approved in February 1998 after our fieldwork was completed and are not included in our detailed review or analyses.

As stated in VA's fiscal year 1999 performance plan, VHA has established a goal of increasing the number of community-based clinics as part of its efforts to implement the Government Performance and Results Act of 1993 (GPRA).[12] This goal, however, focuses on outputs—the number of clinics—rather than on the desired outcome of increasing the percentage of current users having reasonable geographic access to primary care.

As a result, networks' planning efforts focus on the number of community-based clinics to be established and do not address the extent to which new clinics will achieve equity of access for current users among networks or enroll new users in accordance with statutory priorities. Moreover, VHA has not tried to measure networks' progress in planning community-based clinics to achieve these outcomes. Consequently, we remain concerned about how effectively these clinics are used to equalize veterans' access to VHA primary care within and among networks.

Equalizing Access for Current Users

Networks do not present information on how the 402 clinics included in business plans or the 198 approved clinic proposals will reduce access inequities for current users within networks or among networks. Moreover, network officials told us that they do not collect on a networkwide basis information needed to determine the number of current users who have reasonable access or the number who have unreasonable access. As a result, data are not available on the magnitude of access inequities or the impact of networks' planned clinics on reducing such inequities.

To demonstrate how access inequities could be measured and a results-oriented performance goal established, we asked networks to estimate the percentage of current users who

- had reasonable access in 1997 and met VHA's 30-minute travel standard and
- will have reasonable access by 2002 if new clinics are established as planned.

Of the 22 networks, 14 provided estimates to us.[13] These 14 networks account for nearly two-thirds of the clinics VHA has approved to date and

[12]GPRA (P.L. 103-62) 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.

[13]According to representatives from the remaining eight networks, they could not provide us with both estimates.

nearly three-quarters of the clinics planned to be established by 2002. Our analysis of the 14 networks' estimates shows that accessibility among networks currently varies widely and inequities are likely to remain for many years.

Networks' estimates suggest that their levels of access differed significantly when they started establishing community-based clinics, and these differences remain largely unchanged today. Our assessment of the networks' estimates shows that the 14 networks had averaged about 53 percent of their total users residing within 30 minutes of one of their primary care facilities in 1995. The 14 networks estimate that 63 percent of users resided within 30 minutes in 1997, with this increase attributable primarily to the new clinics. Despite these improvements, the variability in the percentage of veterans having reasonable access in the 14 networks remains large. (See table 2.)

Table 2: Percentage of Current Users in 14 Networks Estimated to Have Reasonable Access to VHA Primary Care, 1995 and 1997

Percentage of current users within 30 minutes of VHA primary care	Number of networks	
	1995	1997
90 or higher	0	0
80-89	0	1
70-79	1	1
60-69	1	8
50-59	8	2
Less than 50	4	2

Note: Eight networks were unable to provide estimates.

The 14 networks' estimates show that, on average, about 85 percent of current users are expected to have reasonable access by 2002. This is attributable primarily to the additional clinics that the networks plan to establish over the next 5 years. If established as planned, these clinics could significantly reduce access variabilities among networks, while greatly raising the accessibility levels within networks. (See table 3.)

Table 3: Percentage of Current Users in 14 Networks Estimated to Have Reasonable Access to VHA Primary Care, 1997 and 2002

Percentage of current users within 30 minutes of VHA primary care	Number of networks	
	1997	2002
90 or higher	0	5
80-89	1	5
70-79	1	4
60-69	8	0
50-59	2	0
Less than 50	2	0

Note: Eight networks were unable to provide estimates.

Overall, the 14 networks expect to provide reasonable access for 36 percent more current users in 2002. Most of these networks, however, are increasing access at widely varying rates. For example, four networks estimate that they will provide reasonable access to 50 percent more current users in 2002 than in 1997.

Networks' estimates, however, suggest that it will take several years beyond 2002 for the least accessible networks to achieve equity with the most accessible networks. For example, 5 of the 14 estimate that their accessibility level will be below the estimated network average of 85 percent in 2002. (See table 4.)

Table 4: Percentage of Current Users in 14 Networks Estimated to Have Reasonable Access to VHA Primary Care in 2002

Percentage of current users estimated to be within 30 minutes of VHA primary care by 2002	Number of networks
90-95	5
85-89	4
80-84	1
75-79	2
70-74	2

Note: Eight networks were unable to provide estimates.

We estimate that the five networks could provide reasonable access for 85 percent of users between 2003 and 2008 if they continue to establish clinics at their current 1997 to 2002 rates. To achieve 85-percent accessibility, these five networks would have to increase the number of new clinics established over the next 5 years from the 119 currently planned to 178—an average of approximately 12 additional clinics per network.

Nine of the 14 networks estimate that less than 90 percent of current users will have reasonable access by 2002. We estimate that these nine could achieve a 90-percent accessibility level between 2003 and 2011 if they continued establishing clinics at their current rates. To achieve 90-percent accessibility, these nine networks would have to increase the number of new clinics established over the next 5 years from the 199 currently planned to 312—an average of approximately 13 additional clinics per network.

Serving Users in Community-Based Clinics in Accordance With Statutory Priorities

By law and under VA regulations, veterans are accorded different priorities for enrollment and care based on several factors. Generally, veterans with service-connected disabilities have the highest priority, followed by lower income veterans, and then higher income veterans. While VHA has directed networks to establish new clinics to improve access for current users who have been "historically underserved," VHA does not specify who these veterans are or how priority applies to such veterans. Our assessment of network business plans and proposals for the 133 clinics suggests that the result of network planning will be to improve access for thousands of lower priority new users in 1998 and 1999, while thousands of higher priority current users may wait until 2000 or beyond for improved access.

To date, networks have generally defined historically underserved veterans to be those traveling greater than 30 minutes to a VHA primary facility, regardless of whether they currently receive care in a VHA facility. Because networks seldom consider the statutory priorities when they plan clinics, data are not available to show whether networks' plans will improve access for high-priority veterans first. Business plans provide no information on the target populations to be served and only 18 of the proposals for the 133 clinics we examined considered service-connected disabilities when differentiating among other current and future users to be served. This approach assumes that veterans with varying priorities and conditions are evenly distributed geographically and throughout each network.

Networks are establishing new clinics over a 5-year period, in large part because of the limited resources available. VHA requires networks to establish clinics with existing resources, and most networks are implementing efficiency initiatives as a primary means to generate the resources needed for new clinics. To date, networks have budgeted about $85 million to establish 178 clinics, or about $258 per veteran served.

Networks may spend $190 million to establish the 402 clinics planned for the next 5 years if their cost per veteran continues to average $258.

Network Oversight of Clinic Operations Varies Widely

Networks included a description of their evaluation plans in their clinic proposals, as VHA guidelines require. The actual evaluation plans vary widely, and some are still being developed. In addition, few have been implemented, primarily because most clinics have operated less than 6 months. VHA obtains information on clinic performance as needed rather than periodically receiving network evaluation results on a systematic basis.

Networks Describe Evaluation Plans in Proposals

All networks included a description of their plans to evaluate their clinics' performance in their clinic proposals, as VHA requires. Our analysis of the proposals for the 133 community-based clinics approved as of November 1997 shows that evaluation plans were broadly defined and items to be evaluated were described in general terms. Proposals rarely contained an explanation of exactly what would be measured, how it would be measured, the frequency of measure, who would conduct the evaluation, or how the results of an evaluation would be used and by whom.

VHA's August 1996 guidelines added a requirement that networks develop evaluation plans for each new clinic proposed. VHA gave networks wide discretion in how evaluations are to be conducted and results used. In essence, VHA directed networks to evaluate how clinics are achieving their purposes, overall goals, and objectives. Each network is to coordinate evaluation efforts among clinics to ensure that "the same minimal criteria" are evaluated throughout the network. Networks are to define "specific performance measures" for assessing their clinics' effectiveness.

Toward this end, VHA's guidance identified a number of key indicators that networks can use to measure their clinics' operational effectiveness. These include reduced beneficiary travel expenditures (by having patients travel to nearby clinics rather than compensating them for traveling greater distances to a medical center), shortened waiting times (by scheduling appointments with clinics that serve fewer clients), and reduced fee-basis care (by serving veterans at VHA-operated or VHA-funded clinics rather than sending them to a private provider).

VHA also issued guidance to help networks develop evaluations.[14] This guidance defines a program evaluation as a method used to provide specific information about a clinical or administrative initiative's activities, outcomes, costs, and effectiveness in meeting its goals. It further explains that new programs should build in monitoring systems for capturing near-term and long-term data to provide information about how well the program is meeting its goals and that a deliberately planned and executed program evaluation is most likely to be useful to managers. Evaluations should be ongoing in order to provide managers with information they can use to adjust or fundamentally change the structure and processes of a program to improve its outcomes. Policymakers, managers, and clinicians alike use program evaluation as a tool to assist them in making informed decisions on the objectives, implementation, and progress of their programs.

We included several questions in our network survey about their evaluation plans to understand how networks implemented the broadly described evaluation plans contained in their proposals. First, we asked if they were using a standard networkwide evaluation, a clinic-specific evaluation, or some other evaluation plan. Three indicated they were using a networkwide evaluation; 11 indicated they would use a clinic-specific evaluation; and 7 indicated they were still developing their evaluation plans, would use some other plan—such as a product-line approach—or would establish a task force to develop an evaluation plan. One network did not answer the question.

Second, we asked the 18 that said they would conduct either a clinic-specific evaluation or some other plan if there was a common set of minimal criteria that would be evaluated throughout the network for other community-based clinics, as required by VHA. Five networks reported that they did not have a common set of criteria. Of the five, two did not clarify further. Of the remaining three, one reported that it collected data—but not on a regular basis—and that it intended to develop a core set of data items. One reported that evaluations are the responsibility of the clinic's parent medical center, which can develop its own criteria. The fourth network reported that a clinical practice council would develop and perform community-based evaluations of its clinics.

[14]Veterans Health Administration, Program Evaluation for Managers, Primer (Washington, D.C.: Department of Veterans Affairs, 1997).

Networks Have Performed Few Clinic Evaluations

Our assessment of the evaluations performed to date shows that clinic evaluations do not adequately address VHA's intent that clinics be evaluated to show how they are achieving the network's purposes, goals, and objectives. Nor do the evaluations include specific performance measures that can be used to manage clinics or assess their effectiveness.

As of November 1997, only 6 of the 22 networks reported completing 20 clinic evaluations. This is because most clinics had either not yet opened or had operated for less than 6 months. Nine had operated 1 year or longer, and 11 operated less than 1 year. We asked networks to give us copies of the 20 completed evaluations; networks were able to provide us with 15.

Our assessment of the 15 shows considerable variability in terms of what had been described in the proposals and what was actually done. With the exception of one clinic, the evaluations were limited to processes and did not include results-oriented outcomes. For example, 6 of the 15 evaluations were memorandums documenting site visits where administrative and patient records were reviewed for legibility, physicians were checked for proper credentialing, and checks were performed to ensure that data entry was being performed correctly and in a timely fashion. In one instance, where the clinic had been operating for more than 1 year, the memorandum documenting the evaluation stated "This review was intuitive, not explicit. The goal was to obtain a general idea of how well Dr. [X] was doing [and an] ongoing review should probably be done at 6-month intervals."

In the instance of the one clinic that we considered to have been evaluated, the evaluation plan contained a list of indicators with measurable criteria that could be used to compare against actual performance. (See table 5.)

Table 5: Example of an Evaluation Plan Used by a Community-Based Clinic With Indicators and Criteria

Indicator	Criteria
Uniques (new)[a]	4% growth
Uniques (old)[b]	500 for 1.25 full-time employment equivalents
Visits	4,000 visits (8 visits per patient) in 1 year
Total Category A	95% of census
Total Category C	5% of census
Total tri-care (uniques)	One beneficiary per week
Total tri-care (visits)	Eight visits per year
Total referred for specialty care	Less than 5%
Operating budget (including staff, lease, utilities, and supplies)	Within budget
Exceeding current maximum workload	(See uniques (old) and visits, above)
Uniques hospitalized	One per month
Bed days of care	84/1,000
Number receiving travel	Less than 1%
Overbookings	Less than 5%
Number receiving fee-for-service care	Less than 1%
Number receiving home health services	Less than 5%
Number in community nursing homes	Less than 1%
Customer survey performed	Quarterly
Implemented prevention or health groups	One group per month
Number in halfway house	Less than 1%

[a]"Uniques (new)" is an unduplicated count of veterans, based on Social Security numbers, who have not received care from VHA within the past 3 years.

[b]"Uniques (old)" is an unduplicated count of veterans, based on Social Security numbers, who have received care from VHA within the past 3 years.

We believe that using indicators with measurable criteria such as these could be helpful in measuring the effectiveness of VHA's community-based clinics and is consistent with VHA's evaluation guidance and the intent of its clinic evaluation requirement.

VHA Obtains Limited Information on Clinic Performance

Since networks started establishing new community-based clinics in 1995, VHA has generally collected information on clinic operations as questions or concerns are raised by VA officials and others, such as in the following cases:

- VHA surveyed the 22 networks in July 1997 to gather selected information on the status of 90 approved clinics, including whether clinics had started operating, budget information, and the number of visits clinics had actually experienced compared with what had been estimated.
- VHA prepared a report for the Senate Appropriations Committee addressing the need for a national plan for community-based clinics and to respond to the findings and recommendations contained in our October 1996 report. The VHA report basically held that a national plan for such clinics is unnecessary and presented no information that had not already been presented or discussed.
- VA's Capital Budgeting and Oversight Service examined the operations of four clinics in one network in spring 1997. The report of that examination is still in draft form, but VHA officials told us that they looked at problems associated with contractors and monitoring clinics.

Our assessment of VHA's evaluation and community-based clinic guidance, evaluations conducted so far, and VHA's call for information on an as-needed basis suggests that VHA's guidance is not being implemented as it was intended and that VHA may not be aware that this is happening.

Conclusions

VHA continues to lack the information needed to help ensure that networks are establishing community-based clinics in a consistent and equitable manner. Neither VHA nor network officials are able to adequately answer basic questions such as the following:

- How many VHA primary care facilities in each network meet VHA's travel standard by providing veterans reasonable access to health care (within 30 minutes of their homes)?
- How many current users in each network do not have reasonable access to VHA primary care?
- Of those veterans, how many have service-connected disabilities (highest priority for care)?
- How many current users will obtain reasonable access through the establishment of new clinics in the next 5 years?
- Of those veterans, how many have service-connected disabilities?
- How many newly established clinics meet VHA's performance goals and objectives?

Network business plans, proposals, and responses to our surveys failed to provide adequate information to answer these key questions. Information available suggests considerable variation among networks, which raises

concerns about the equity of veterans' access to care even though networks have improved access for thousands of current users. This is because networks started at different access levels and have established clinics at widely varying rates. Moreover, networks appear to be planning without regard to the priorities. As a result, they will spend limited resources on lower priority new users in 1997 and 1998, while improved access for thousands of higher priority current users will not be available until 2000 and beyond.

In order to avoid such potential undesirable situations, and consistent with GPRA, VHA would need to establish results-oriented goals to ensure that each network

- affords reasonable access to VHA primary care for a minimum percentage of current users by 2002 with the intent of equalizing access systemwide to the maximum extent practical,
- establishes clinics so as to provide veterans improved access consistent with statutory priorities for care, and
- evaluates its clinics' performance using a consistent set of minimal criteria.

VHA appears to have a timely opportunity to improve network planning activities, given the networks plan to complete their 1999 business plans within the next 3 months. Additional VHA guidance and other VHA assistance in developing networks' 1999 business plans could result in a more consistent and thorough strategy for using clinics to equalize veterans' geographic access to VHA primary care systemwide.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following actions:

- Set a national target level of performance that focuses each network on a goal of providing reasonable geographic access to VHA primary care for the highest percentage of current users practical by 2002.
- Require networks to include in their business plans the percentage of (1) current users, by priority status, who have reasonable access; (2) the remaining current users (without reasonable access), by priority status, who are targeted to receive improved access through the establishment of community clinics by 2002; and (3) current users, by priority status, who will not have reasonable access by 2002.

- Require networks to plan and propose new community-based clinics in a manner that ensures that veterans with highest statutory priorities achieve reasonable access as quickly as possible, consistent with the requirements of the Veteran Health Care Reform Act of 1996 (P.L. 104-292).
- Establish minimum criteria that all networks are to use annually for evaluating new clinics' performance.
- Require networks to annually report their evaluation results to the Capital Budgeting and Oversight Service, a unit within VA, and to others for their use in reviewing proposals for new clinics and other purposes.

Agency Comments and Our Evaluation

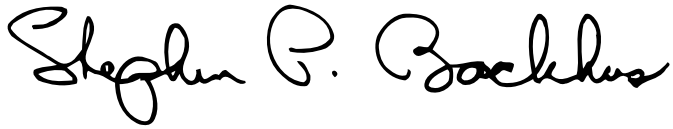
In commenting on our draft report, VHA officials generally agreed with our findings and recommendations. To improve planning, actions are being taken to incorporate in networks' business plans information on current users' access to care now and by 2002. While agreeing that there is variation in access, VHA pointed out that it was not clear that a national target for access is required to focus networks. VHA bases this response on its preliminary analysis of clinic data, which indicates that by 2002, 80 percent of high-priority veterans will, on average, have improved access to care. We agree that networks seem focused on improving access for current users by 2002, but we remain concerned about the potentially large variability among networks, which could be between 70 and 95 percent based on estimates provided to us. As such, we believe that establishment of a national target or goal could help ensure that networks remain focused on achieving reasonable access for the highest percentage of veterans practical, while reducing the variations among networks to the greatest extent practical.

VHA also agreed that minimum criteria should be established to evaluate clinic performance; VHA said it will identify a minimum criteria set for all networks that will focus on evaluation of outcomes. While noting that annual reporting seems excessive, VHA said it will perform annual evaluations until it can determine what a more reasonable time frame would be. VA also said it will report the results to the Capital Budgeting and Oversight Service, as recommended. Thereafter, VA suggested, and we agreed, that it seems reasonable to review and adjust clinic performance as part of the networks' planning processes.

VHA officials agreed with the spirit of our recommendation requiring networks to plan and propose clinics to ensure that the highest statutory priority veterans (those with service-connected disabilities) achieve access as quickly as possible. VHA explained, however, that the Veteran

Health Care Reform Act of 1996 will change veterans' eligibility for medical services beginning October 1, 1998, by requiring veterans to enroll for care. Service-connected veterans are in the higher enrollment priorities, but once veterans are enrolled, it will no longer differentiate among enrolled veterans by priority status. In other words, all enrolled veterans—not just those with the highest priorities—are to have equal access to needed services, and networks will necessarily need to address access for all enrolled veterans when planning community-based clinics. VHA suggested, and we agreed, that our recommendation require networks to plan clinics for veterans with the highest priorities in a manner consistent with the act.

Please call me at (202) 512-7101 if you have any questions or need additional assistance. Other major contributors to this report include Paul Reynolds, Assistant Director; Michael O'Dell, Senior Social Science Analyst; Carolina Morgan, Senior Evaluator; Lawrence Moore, Evaluator; Barry Bedrick, Associate General Counsel; and Joan Vogel, Senior Evaluator (Computer Science).



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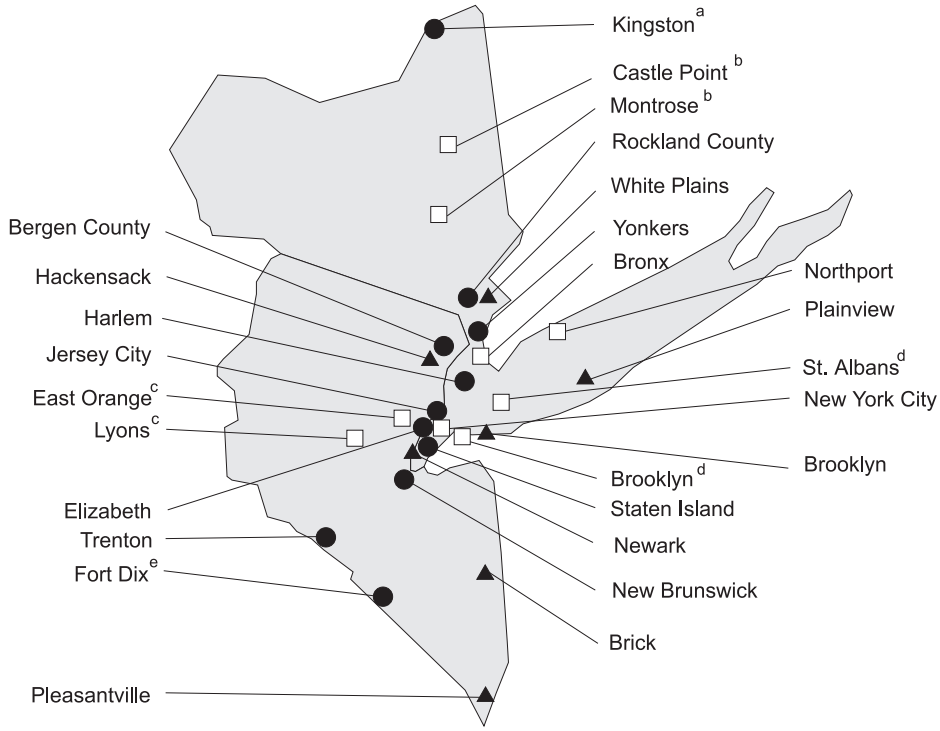
Abbreviations

GPRA	Government Performance and Results Act
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Profiles of Networks We Contacted

Figures I.1 through I.3 provide brief profiles—including the number of facilities, fiscal year budgets, total veteran population, and number of veteran patients served in the network area—for the three networks we visited.

Figure I.1: New York/New Jersey Network Profile



Legend

- ● Community-Based Outpatient Clinics
- □ Medical Centers
- ▲ Other VA Facilities Providing Primary Care

Profile

The New York/New Jersey Networks' service area is located in southern New York and parts of northern New Jersey and is comprised of six medical centers with nine geographically distinct facilities. A unique feature of this network is the geographic proximity of its medical centers; all are within a 60-mile radius.

The network's budget was $974 million for fiscal year 1998, $1.017 billion for fiscal year 1997, and $1.022 billion for fiscal year 1996. We visited two New York clinics in this network: Rockland County (Montrose/Castle Point VA Medical Center) and Harlem (New York VA Medical Center).

Veteran Population:	1,433,790

Patients Served (Fiscal Years 1995-97)	
Unique Category A	174,188
Unique Other	59,763
Total	**233,951**

Patients Served (Fiscal Years 1995-97)	
Unique Inpatient Visits	23,521
Unique Outpatient Visits	1,878,697

[a]Clinic shared with the VA Healthcare Network Upstate New York.

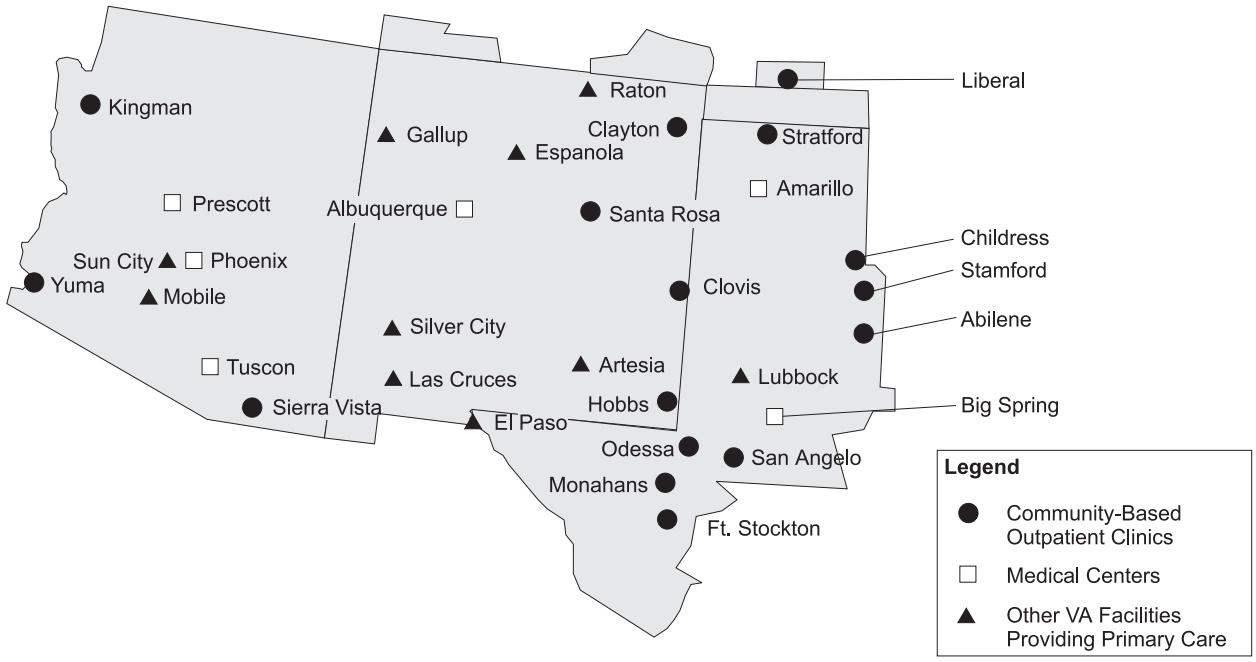
[b]Hudson Valley Healthcare System.

[c]New Jersey Healthcare System.

[d]Part of the multifacility Brooklyn Medical Center.

[e]Clinic shared with the VA Stars and Stripes Healthcare Network.

Figure I.2: Southwest Healthcare Network Profile



Profile

Geographically, the Southwest Healthcare Network is one of the largest networks, encompassing over 361,000 square miles in six states. The service area is comprised of the entire states of Arizona and New Mexico, the western portion of Texas, as well as bordering counties in Colorado, Kansas, and Oklahoma. Much of the service area is rural with low population density. In Arizona and New Mexico, 94 percent of the counties have been designated as being medically underserved.

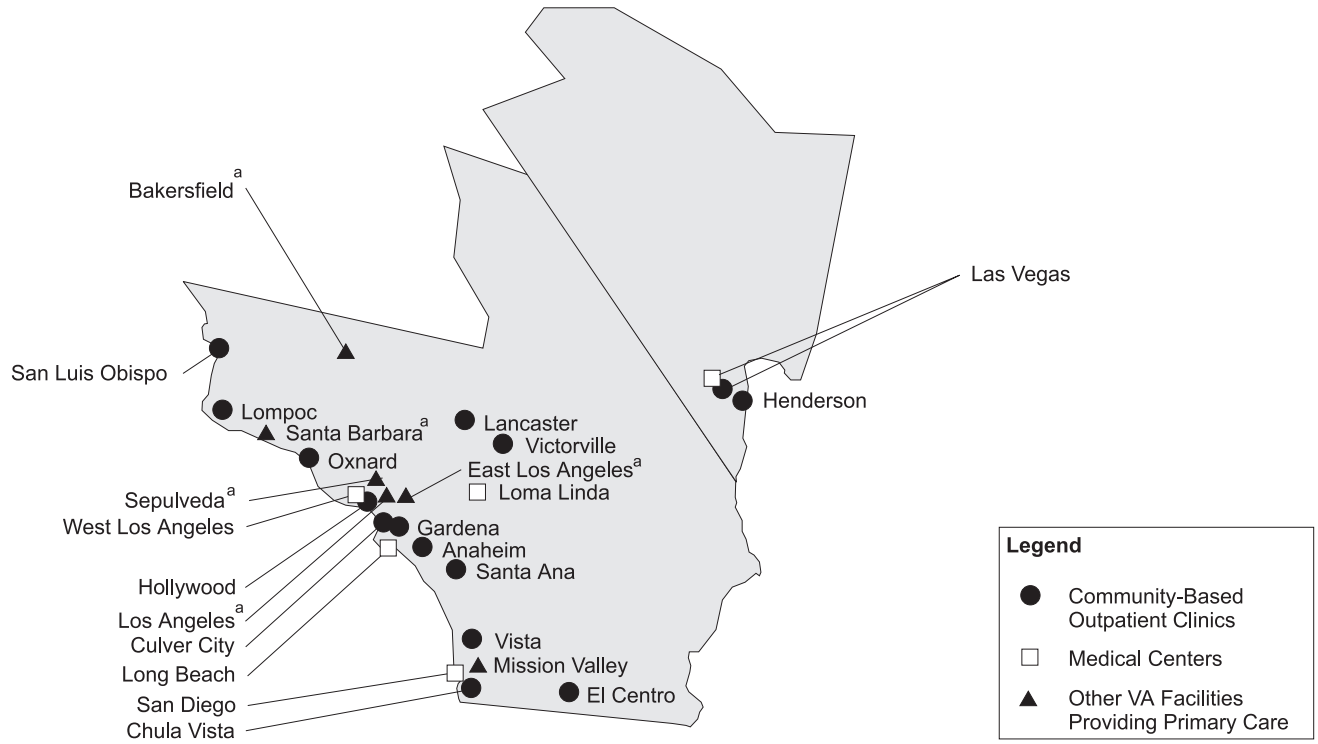
The Southwest Healthcare Network's budget has increased from $485.5 million in fiscal year 1996 to approximately $518.4 million in fiscal year 1997 and $545 million in fiscal year 1998. We visited one community-based clinic in Abilene, Texas (Big Spring Medical Center).

Veteran Population:	815,460

Patients Served (Fiscal Years 1995-97)	
Unique Category A	174,174
Unique Other	60,595
Total	**234,769**

Patients Served (Fiscal Years 1995-97)	
Unique Inpatient Visits	29,684
Unique Outpatient Visits	1,302,733

Figure I.3: Desert Pacific Healthcare Network Profile



Profile

The Desert Pacific Healthcare Network spans approximately 110,000 square miles of southern California and southern Nevada. It contains three of the nation's most heavily populated counties, yet many parts include uninhabited desert and mountain areas. Some of the greatest challenges for the network include lifestyle habits and social problems, which could possibly overwhelm local community infrastructure and services. For this reason, a unique community-based clinic was established in Las Vegas to serve as a social referral service, offering social advice to veterans in need.

The Desert Pacific Healthcare Network's budget was $943.3 million in fiscal year 1998, $918.5 million in fiscal year 1997, and $900 million in fiscal year 1996. We visited two clinics in California at El Centro (San Diego, VA Medical Center) and Gardena (West Los Angeles Medical Center).

Veteran Population:	1,714,550

Patients Served (Fiscal Years 1995-97)	
Unique Category A	227,077
Unique Other	48,266
Total	**275,343**

Patients Served (Fiscal Years 1995-97)	
Unique Inpatient Visits	27,318
Unique Outpatient Visits	1,903,773

[a]These clinics comprise the Southern California System of Clinics.

Summary of Selected Characteristics of Clinics Approved Since October 1996

Table II.1: Number of Community-Based Clinics and Veterans to Be Served, by Network

	Number of clinics			Veterans to be served		
Network	**VHA operated**	**Non-VHA operated**	**Total**	**New users**	**Current users**	**Total[a]**
1	9	0	9	3,048	6,185	22,440
2	1	6	7	3,285	9,968	13,253
3	7	0	7	5,273	10,009	18,282
4	15	5	20	3,375	20,355	35,154
5	3	0	3	3,452	3,392	6,844
6	1	2	3	260	4,593	4,853
7	1	5	6	1,833	12,625	17,033
8	10	1	11	7,406	19,978	28,584
9	3	5	8	2,029	12,971	17,137
10	10	1	11	908	25,005	28,513
11	0	2	2	0	3,500	3,500
12	3	6	9	1,180	9,372	11,102
13	2	6	8	0	2,858	2,858
14	1	1	2	1,790	5,252	7,042
15	8	4	12	911	7,593	17,488
16	2	5	7	1,296	5,120	10,016
17	2	14	16	0	3,391	7,448
18	5	0	5	86	3,636	6,932
19	7	2	9	2,867	10,893	21,209
20	2	4	6	752	10,076	12,405
21	2	1	3	2,160	3,632	9,642
22	10	4	14	2,930	24,056	28,986
Total	**104**	**74**	**178**	**44,841**	**214,460**	**330,721**

[a]Totals may exceed the sum of “new users” plus “current users” because some proposals only provided totals and did not indicate who they planned to serve.

VHA's Approved Community-Based Clinics

Table III.1: Community-Based Clinics' Locations and Approval Dates, by VISN

Clinic	Date approved
VISN 1: New England Healthcare System	
Bennington, Vt.	February 1998
Essex County/Lynn, Mass.	June 1997
Framingham, Mass.	November 1997
Haverhill, Mass.	February 1998
Hyannis, Mass.	June 1997
Portsmouth, N.H.	January 1997
Torrington, Conn.	February 1998
Waterbury, Conn.	February 1998
Windham, Conn.	February 1998
VISN 2: Healthcare Network Upstate New York	
Binghamton, N.Y.	October 1996
Glens Falls, N.Y.	January 1997
Kingston, N.Y. (with VISN 3)	November 1997
Niagara Falls, N.Y.	June 1997
Rensselaer County, N.Y.	November 1997
Schenectady County, N.Y.	November 1997
South Saratoga County, N.Y.	November 1997
VISN 3: New York/New Jersey Network	
Bergen County, N.J.	March 1995
Central Harlem, N.Y.	October 1996
Elizabeth, N.J.	June 1997
Ft. Dix, N.J. (with VISN 4)	January 1997
Jersey City, N.J.	November 1997
New Brunswick, N.J.	November 1997
Rockland County, N.Y.	January 1997
Staten Island, N.Y.	October 1996
Trenton, N.J.	November 1995
Yonkers, N.Y.	June 1997
VISN 4: Stars and Stripes Healthcare Network	
Aliquippa, Pa.	November 1997
Armstrong County, Pa.	February 1998
Ashtabula County, Ohio	November 1997
Bucks County, Pa.	February 1998
Cape May, N.J.	October 1996
Centre, Pa.	June 1997
Clarion, Pa.	February 1998
Clearfield, Pa.	June 1997

(continued)

Clinic	Date approved
Crawford County, Pa.	November 1997
Greensburg, Pa.	June 1997
Lancaster, Pa.	November 1997
Lawrence County, Pa.	February 1998
McKean County, Pa.	November 1997
Mercer County, Pa.	February 1998
Schuylkill, Pa.	June 1997
Seaford, Del.	November 1997
Tobyhanna, Pa.	June 1997
West Middlesex, Pa.	February 1998
Williamsport, Pa.	October 1996
VISN 5: Capitol Network	
Charlotte Hall, Md.	November 1997
Fairfax, Va. (Vet Center)	November 1997
Hagerstown, Md.	November 1997
VISN 6: Mid Atlantic Network	
Charlotte, N.C.	June 1997
Greenville, N.C.	November 1997
Tazewell, Va.	January 1997
VISN 7: Healthcare System of Atlanta	
Albany, Ga.	November 1997
Dothan, Ala.	October 1996
Florence, S.C.	November 1997
Macon, Ga.	November 1997
Myrtle Beach, S.C.	November 1997
Northeast Georgia	February 1998
Walker County, Ala.	March 1995
VISN 8: Florida/Puerto Rico Sunshine Healthcare Network	
Bartow, Fla.	June 1997
Brookville, Fla.	November 1997
Cecil Field, Fla.	February 1998
Ft. Pierce, Fla.	November 1997
Homestead, Fla.	October 1996
North Pinellas County, Fla.	November 1997
Ocala, Fla.	November 1997
Sarasota, Fla.	January 1997
South St. Petersburg, Fla.	November 1997
Southwest Broward County, Fla.	November 1997
Valdosta, Ga.	November 1997

(continued)

Clinic	Date approved
VISN 9: Mid South Healthcare Network	
Bowling Green, Ky.	January 1997
Charleston, W.V.	November 1997
Ft. Knox, Ky.	February 1998
Hopkinsville, Ky.	January 1997
Madison, Tenn.	June 1997
Smithville, Miss.	November 1997
Somerset, Ky.	November 1997
Southern Indiana	February 1998
VISN 10: Healthcare System of Ohio	
Akron, Ohio	November 1997
Athens, Ohio	January 1997
Lima, Ohio	November 1997
Lorain County, Ohio	January 1997
Mansfield, Ohio	November 1997
Middletown, Ohio	June 1997
Northern Kentucky	February 1998
Portsmouth, Ohio	November 1997
Sandusky, Ohio (with VISN 11)	June 1997
Springfield, Ohio	November 1997
Zanesville, Ohio	November 1997
VISN 11: Veterans Integrated Service Network	
South Bend, Ind.	June 1997
Yale, Mich.	June 1997
VISN 12: Great Lakes Healthcare System	
Aurora, Ill.	November 1997
Chicago Heights, Ill.	June 1997
Elgin, Ill.	November 1997
Hancock, Mich.	January 1997
LaSalle County, Ill.	November 1997
Menominee, Mich.	February 1998
Rhinelander, Wis.	November 1997
Union Grove, Wis.	June 1997
Wausau, Wis.	November 1997
Woodlawn, Ill.	March 1995
VISN 13: Upper Midwest Network	
Bismarck, N.D.	June 1997
Brainerd, Minn.	January 1997
Fergus Falls, Minn.	January 1997

(continued)

Clinic	Date approved
Hibbing, Minn.	January 1997
Mankato, Minn.	January 1997
Owatonna, Minn.	January 1997
Pierre, S.D.	November 1997
Worthington, Minn.	January 1997
VISN 14: Central Plains Network	
Norfolk, Nebr.	June 1997
Waterloo, Iowa	June 1997
VISN 15: Heartland Network	
Cape Girardeau, Mo.	June 1997
Carmi, Ill.	June 1997
Ft. Leonardwood, Mo.	February 1998
Garden City, Kans.	February 1998
Hays, Kans.	February 1998
Kirksville, Mo.	February 1998
Mt. Vernon, Ill.	January 1997
Paducah, Ky.	June 1997
Paragould, Ark.	June 1997
Richards-Gebaur/Belton, Mo.	February 1998
St. Joseph, Mo.	June 1997
West Plains, Mo.	June 1997
VISN 16: Veterans Integrated Service Network	
Durant, Miss.	January 1997
Greenville, Miss.	February 1998
McAlester, Okla.	February 1998
Meridian, Miss.	February 1998
Mountain Home, Ark.	November 1997
Panama City, Fla.	November 1997
Ponca City, Okla.	June 1997
VISN 17: Heart of Texas Healthcare	
Alice, Tex.	February 1998
Beeville, Tex.	February 1998
Bonham, Tex.	November 1997
Brownsville, Tex.	October 1996
Brownwood, Tex.	February 1998
Decatur, Tex.	February 1998
Del Rio, Tex.	October 1996
Denton, Tex.	February 1998
Eagle Pass, Tex.	October 1996

(continued)

Clinic	Date approved
Eastland, Tex.	February 1998
Ft. Worth, Tex.	November 1995
Hamilton, Tex.	March 1995
Kingsville, Tex.	February 1998
McKinney, Tex.	February 1998
Palestine, Tex.	November 1997
Pleasant Grove, Tex.	June 1997
Tyler, Tex.	January 1997
Uvalde, Tex.	February 1998
VISN 18: Southwest Healthcare Network	
Abilene, Tex.	March 1995
Casa Grande, Ariz.	February 1998
Ft. Stockton, Tex.	March 1995
Hobbs, N.M.	November 1995
Kingman, Ariz.	November 1997
Liberal, Kans.	August 1996
Monahans, Tex.	November 1995
Odessa, Tex.	November 1995
Safford, Ariz.	February 1998
San Angelo, Tex.	November 1995
Santa Rosa, N.M.	March 1995
Sierra Vista, Ariz.	January 1997
Stamford, Tex.	November 1995
Yuma, Ariz.	January 1997
VISN 19: Rocky Mountain Network	
Aurora, Colo.	November 1997
Casper, Wyo.	January 1997
Gallatin Valley, Mont.	February 1998
Great Falls, Mont.	June 1997
Greeley, Colo.	February 1998
Missoula, Mont.	June 1997
Montrose County, Colo.	February 1998
Riverton, Wyo.	February 1998
Weber-Davis County/Ogden, Utah	February 1998
VISN 20: Northwest Network	
Bend, Oreg.	November 1997
Brookings, Oreg.; Cresent City, Calif.	February 1998
Salem, Oreg.	November 1997
Seattle/Puget Sound, Wash.	November 1997

(continued)

Clinic	Date approved
Tri-Cities Area, Wash.	November 1997
Twin Falls, Idaho	February 1998
VISN 21: Sierra Pacific Network	
Auburn, Calif.	November 1997
Merced, Calif.	November 1997
Vallejo, Calif.	October 1996
VISN 22: Desert Pacific Healthcare Network	
Anaheim, Calif.	June 1997
Chula Vista, Calif.	June 1997
Culver City, Calif.	February 1998
El Centro, Calif.	November 1995
Gardena, Calif.	January 1997
Henderson, Nev.	June 1997
Hollywood, Calif.	February 1998
Lancaster, Calif.	June 1997
Las Vegas, Nev.	June 1997
Lompoc, Calif.	November 1997
Oxnard, Calif.	November 1997
San Louis Obispo, Calif.	November 1997
Santa Ana, Calif.	June 1997
Victorville, Calif.	January 1997
Vista, Calif.	June 1997

Related GAO Products

VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 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: Opportunities for Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996).

Veterans' Health Care: Challenges for the Future (GAO/T-HEHS-96-172, June 27, 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).

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