

GAO

Report to the Ranking Minority Member,
Committee on Veterans' Affairs, U.S.
Senate

April 2000

VA HEALTH CARE

Changes in Medical Residency Slots Reflect Shift to Primary Care



GAO

Accountability * Integrity * Reliability

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Abbreviations

CBOC	community-based outpatient clinic
UCLA	University of California at Los Angeles
VA	Department of Veterans Affairs
VISN	Veterans Integrated Service Network



United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-283989

April 12, 2000

The Honorable John D. Rockefeller IV
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Rockefeller:

Many changes under way in the Department of Veterans Affairs (VA) have the potential to affect the relationship between VA medical facilities and their affiliated medical schools. For example, VA has been reorganizing its health care delivery system by moving more care from inpatient to outpatient settings. It is also integrating facilities and consolidating programs and services at health care facilities to improve efficiency, which could potentially affect its graduate medical education program. Also, over the last 3 years, VA has been realigning its graduate medical education program, which involves reducing specialty residency slots while increasing the number of primary care slots—such as those in family practice and internal medicine.

You expressed concern that limited information is available explaining the rationale for changes in the numbers and types of medical residency slots and describing the effect these changes have had on the resident training environment.¹ In this context, you asked us to address the following questions: (1) What were VA's goals in realigning its residency program, and did VA accomplish its goals? (2) Who initiated the changes in the number of graduate medical education residency slots, and why? (3) What are the views of VA facility and medical school officials on the effect of the changes on resident training and on the potential to train residents at VA community-based outpatient clinics? To assess residency realignment, we met with officials from VA's Office of Academic Affiliations, reviewed VA's residency realignment goals, and compared the goals with data from the last 3 academic years. For the other questions, we visited six VA facilities that experienced among the largest net changes in their number of residency slots. At each facility, we met with senior management officials,

¹Residents have graduated from medical school and are undergoing clinical training to prepare them to practice medicine independently.

clinical service chiefs, and representatives from the affiliated medical school(s) to determine their rationale for changes in the number of residency slots and to obtain views about the effect the changes have had on the training environment and on the opportunities for training at VA community clinics. We did our work from May 1999 through January 2000 in accordance with generally accepted government auditing standards. Additional information on our scope and methodology is included as appendix I.

Results in Brief

The changing health care environment has resulted in less demand for specialty physicians and more demand for primary care physicians. This shift, in turn, influenced the changes in residency slots at VA. Over the last three academic years,² VA realigned its graduate medical education program and achieved its goal to train 48 percent of its residents in primary care. VA's strategy eliminated 251 residency slots in specialty care and converted 714 specialty residency slots to primary care slots. These changes reduced the number of residency slots from 8,910 to 8,659.

The major reasons for the changes in residency slots were (1) VA's decision to increase primary care residency slots and decrease specialty slots and (2) medical school decisions to restructure their programs to meet changing demands for physicians or accreditation requirements. VA initiated the majority of changes in the residency slots at the six facilities we visited, but these changes were consistent with the medical schools' own initiatives to meet changing demands. VA and medical school officials characterized the changes as generally mutually beneficial because they were consistent with current health care practices nationally.

Changes in residency slots have not been disruptive to training, according to VA and medical school officials at the six facilities we visited. When VA reduced the number of residency slots, for the most part those residency slots reappeared at other hospitals affiliated with the medical schools. In addition, VA and medical school officials said that some training opportunities exist at VA's community-based outpatient clinics. However, VA is not pursuing establishment of such slots because (1) sufficient opportunities exist for primary care training in outpatient clinics located at VA hospitals; (2) remote community-based clinics present a commuting

²The academic year runs from July to June.

problem for the residents; and (3) the physicians who would be required to supervise and train residents at the remote clinics might not be able to obtain faculty status at the medical schools.

Background

The U.S. health care system is undergoing profound changes. Rapid technological advances, changing economic and demographic factors, and an emphasis on cost containment have resulted in a dramatic decrease in inpatient care and a corresponding increase in ambulatory services. Recognizing the need to adapt to changes occurring in the health care environment, VA is reorganizing its health care delivery system. VA replaced its four health care regions with 22 Veterans Integrated Service Networks (VISN). VA's reorganization has increased veterans' access to ambulatory care, emphasized primary care, and decentralized decision-making. To attract and retain veterans who do not live close to VA medical facilities, VA has also established community-based outpatient clinics that emphasize primary care.

Each of VA's 22 networks oversees between 4 and 11 medical facilities. Some networks have integrated facilities, a critical piece of VA's overall strategy to enhance the efficiency and effectiveness of health care delivery to veterans. An integration involves restructuring clinical and administrative services within two or more medical facilities into one health care delivery system. Integrations are meant to allow VA to provide the same or higher quality services to veterans at a reduced cost. As of January 2000, networks had initiated 26 integrations involving 54 facilities.

Transforming VA's health care delivery system from an inpatient to an outpatient focus, increasing reliance on primary care, and consolidating services in two or more facilities could have direct implications for VA's education mission—one of its four core missions.³ For example, VA's initiatives will increasingly involve consolidating programs or possibly closing facilities to eliminate duplication among nearby VA facilities. Because VA is a major source of medical training opportunities, medical schools clearly have a vested interest in VA's transformation.

Since 1946, VA facilities have had affiliation agreements with medical schools. VA appoints medical school faculty as VA staff physicians so that

³VA's four core missions are patient care, education, research, and medical backup to the Department of Defense in the event of a national security emergency.

they can teach and supervise medical residents and students who are training at VA facilities. Of VA's 172 medical centers, 130 are affiliated with 107 medical schools. In fiscal year 1999, VA spent about \$356 million for residents' salaries. VA is supporting 8,659 residency slots during the 1999-2000 academic year. Annually, 33,000 residents rotate through these slots—almost one-third of all residents trained in the United States.

These affiliations are beneficial to both VA and medical schools. Residents provide a portion of the care to veterans at VA facilities. According to VA, when residency slots cannot be filled, the cost of replacement by nonphysician practitioners or fully trained physicians is greater. Residents are taught and supervised by VA physicians who hold academic faculty appointments, provide direct patient care, and conduct research. This combination of patient care, education, and research makes VA positions attractive for the recruitment and retention of highly qualified physicians. An additional advantage is that some VA-trained residents become career employees.

VA Residency Realignment Goals Have Been Met

For academic year 1999-2000, VA met its goal of increasing to 48 percent the portion of its residents training in primary care. In 1997, VA began reducing the number of specialty residents trained by eliminating some slots and shifting some slots to primary care. This goal was established on the basis of the national need to reduce the total number of resident training slots and the number of residents trained in specialty care.

Recognizing the changing nature of health care, the Under Secretary for Health appointed a committee to develop a strategy that would ensure that VA's graduate medical education program was prepared to meet present and future health care needs.⁴ He asked the committee to include any issues that might improve VA's graduate medical education program, including the number and types of training opportunities.

In May 1996, the Residency Realignment Review Committee recommended that VA increase its proportion of primary care slots to 48 percent by

⁴The Residency Realignment Review Committee was convened in the fall of 1995 by the Under Secretary for Health. The Committee was made up of nationally acknowledged experts in graduate medical education representing both VA and the private sector. The Committee was charged with making recommendations for the possible realignment of the graduate medical education program.

eliminating 250 residency slots in disciplines other than primary care and shifting 750 slots from specialty care to primary care. The Committee defined primary care slots as internal medicine, family practice, geriatric medicine, preventive medicine, obstetrics, and gynecology. Specialty care was defined as those slots that provide support to VA primary care and includes psychiatry, general and other types of surgery, cardiology and other subspecialties of internal medicine, pathology, and radiology (see app. II for a list of primary care and other specialties). The Committee suggested that its recommendations be implemented over a 3-year period ending with academic year 1999-2000. VA accepted the Committee's recommendations.

Table 1 shows the changes VA made to attain its goal of having 48 percent of its residency slots in primary care. This reduced the number of residency slots to 8,659 systemwide. See appendix III for a list of changes by network.

Table 1: Changes in the Number of Residency Slots Supported by VA

	Baseline academic year 1995-96	Academic year			Change from baseline year
		1997-98	1998-99	1999-2000	
Total VA-supported residency slots	8,910	8,848	8,721	8,659	-251
Total VA-supported residency slots in primary care	3,442	3,655	3,813	4,156	+714
Total VA-supported residency slots in specialty care	5,468	5,193	4,908	4,503	-965
Percentage of VA- supported residents in primary care	39	41	44	48	+9

Note: Fifty-eight VA facilities designated 281 medical subspecialty and psychiatry residency slots as primary care because residents spent a portion of their rotations providing primary care. This accounted for 3 percent of the total 8,659 slots.

Changing Health Care Environment Influenced Shifts and Reductions in VA Residency Slots

The changing health care environment, such as the increased emphasis placed on primary care, was the main reason for the shifts and reductions in the 207 residency slots at the six facilities we visited. VA's residency realignment effort increased residency slots in primary care and reduced the number of specialty slots, and in the meantime, the affiliated medical schools decided to restructure their programs to meet changing demands for physicians or accreditation requirements.

To understand the reasons for the changes in the number of residency slots, we visited six VA facilities that had experienced among the largest net changes in the number of slots—Albany, New York; Albuquerque, New Mexico; Gainesville, Florida; Muskogee, Oklahoma; Philadelphia, Pennsylvania; and West Los Angeles, California. During our facility visits, we obtained information on the specific reasons for each change and whether VA or the medical school initiated the change.

As shown in table 2, the six VA facilities initiated more changes that added residency slots than the medical schools did because of VA's desire to increase the number of primary care residents trained. On the other hand, the medical schools initiated changes that reduced residency slots more often than VA did.

Table 2: Changes in Residency Slots at the Six Facilities Visited

	Residency slots added	Residency slots decreased	Total residency slots affected	Percentage of total change
VA-initiated change	58	62	120	58%
Medical school-initiated change	14	73	87	42%
Total changes for six facilities	72	135	207	100%

Of the 120 changes in residency slots that VA initiated, 24 increased the number of primary care resident slots and 49 decreased the number of specialty residency slots. Various reasons accounted for the other 47 slots affected. For example, the VA facility in Albuquerque obtained 12 residency slots in general internal medicine from another VA facility within the same network. This change was made because an affiliated medical school, the Texas Tech University Medical School, decided to reduce the size of its

general internal medicine program at the VA facility in Amarillo, Texas. VA changed the remaining 35 residency slots for various reasons, including adding new residency programs, reducing existing residency programs, and the changing patient workload demands.

When medical schools initiated changes in residency slots, the vast majority of the changes resulted in decreases in the number of residency slots. Seventy-three of the 87 changes in residency slots shown in table 2 resulted in such reductions. Medical schools decided to reduce residency slots mainly because of restructuring decisions or accreditation requirements. While medical schools did not usually initiate large changes in the number of residency slots, this was the case at two of the locations that we visited.

- In the first case, one of the two medical schools affiliated with the VA facility in Philadelphia, MCP Hahnemann University School of Medicine, discontinued its affiliation with VA after a merger with another school and subsequent assessment of its patient workload and the number of residents it could support. This resulted in a decrease of 24 residency slots at VA in four different resident training programs.
- In the second case, the University of Oklahoma College of Medicine-Tulsa, which is affiliated with the VA facility in Muskogee, was experiencing accreditation problems with some of its residency programs. Because the medical school was affiliated with four hospitals, it decided to consolidate its residency programs so that it could deal with fewer hospitals. Since the Muskogee facility was located 45 miles away from the school, the school pulled back 17 residency slots—13 slots in general internal medicine and family practice and 4 general surgery slots.

The remaining 46 changes in residency slots initiated by the medical schools resulted for a variety of reasons. For example, the medical schools made changes because of difficulty in utilizing and filling residency slots in certain specialties or decisions to downsize certain specialties. Two medical schools, for example, reduced 10 residency slots in anesthesiology because of difficulty recruiting residents. Other reasons included changes in patient workload and adding new resident training programs. For example, a medical school relocated a training slot in rheumatology to another affiliate because the workload at VA was not adequate to support the number of residents assigned. Another medical school increased the number of slots in cardiology to build its program in that specialty.

VA's Resident Training Has Not Been Impaired

The shifting of residency slots from specialty to primary care and the elimination of specialty slots have not been disruptive to training, according to VA and medical school officials at the locations we visited. When VA initiated changes in residency slots, it was generally done in collaboration with the medical schools because the medical schools have been under pressures similar to those VA has experienced to meet changing health care demands.

Most VA and medical school officials we interviewed said that while the elimination of some slots and the shifting of others had sometimes been difficult to implement, the realignment did not adversely affect training of the remaining residents or the accreditation of residency programs. In most cases, when VA reduced slots, the medical schools relocated them to their other affiliates. Therefore, the medical schools' residency programs generally maintained their size (see app. IV for a comparison of the number of medical schools' residency slots before and after VA's residency realignment initiative).

Medical schools were under similar pressures to change residency programs while VA was realigning residency slots. For example, some medical schools reduced specialty residency programs because of state legislation to increase the number of residents trained in primary care. According to the National Conference of State Legislatures, 11 states passed legislation in the early 1990s to have medical schools increase their training of primary care physicians. Seven of those state laws required the schools to direct at least 50 percent of their graduates into primary care.⁵ The University of California at Los Angeles (UCLA) School of Medicine, which is affiliated with the VA facility in Los Angeles, was affected by such legislation. In 1992, the California legislature passed a bill that required medical schools to increase their primary care residency slots to 50 percent of the total number or lose up to \$8 million in state funding. Although this legislation was subsequently vetoed, in a 1994 memorandum of understanding with the state of California, UCLA agreed to increase its percentage of residents in primary care to 60 percent over a 10-year period. Thus, when the VA facility in Los Angeles initiated increases in primary care residency slots and decreases in specialty care slots, it actually helped

⁵See Carol S. Weissert, Ph.D, and Susan Silberman, *Holding Medical Schools Accountable: A Study of State Legislative Action and Implementation*, report submitted to the Robert Wood Johnson Foundation (Feb. 28, 1998).

UCLA meet its goal. Similar legislation affected schools elsewhere, such as the Albany Medical College, which is affiliated with the Albany VA facility in New York.

According to medical school and VA facility officials, most residents have remained satisfied with their education experience. Medical school officials told us that on the basis of surveys and interviews regarding VA rotations, there has been no change in residents' satisfaction levels. Residents like their VA rotations and, in some cases, consider them their best experiences. In addition, medical schools value the opportunities VA rotations afford their residents. VA provides education opportunities that residents are not always able to get at other affiliates, such as working with a larger population of patients who are older and have multiple and advanced diseases. Furthermore, VA officials told us that some residents prefer VA rotations because they (1) have more independence and greater responsibility, (2) believe the teaching atmosphere is better at VA facilities because VA physicians spend more time with the residents, and (3) spend more time with patients.

While most VA and medical school officials did not believe that the training environment had been impaired by VA's residency realignment, some cited examples of how the environment had been affected. For example, the decrease in subspecialty residency programs has resulted in some loss of interaction between specialists and primary care residents. In addition, VA and medical school officials told us that reductions in slots will mean that some residents will miss the opportunity to treat patients who are older and have multiple and advanced diseases.

Opportunities for Training at Community-Based Outpatient Clinics

VA and medical school officials agreed that some training opportunities are available at VA's community-based outpatient clinics (CBOC). CBOCs differ from traditional freestanding VA outpatient facilities in that they provide primary care to veterans and frequently use private providers who contract with VA. The type of care veterans receive at these clinics is comparable to that available at a private physician's general practice office. The CBOCs associated with VA facilities we visited are located from 5 to 240 miles away.

Residents were not being trained at any of the 32 CBOCs associated with the six facilities we visited. (See app. V for specific information regarding the CBOCs at these facilities.) Moreover, VA has no plans to train residents at these locations. VA officials told us they are not using CBOCs for

resident training because (1) sufficient opportunities for primary care training exist in outpatient clinics located at VA hospitals; (2) CBOCs located far from the hospital present a commuting problem for the residents; (3) physicians who would be required to supervise and train residents at the remote clinics might not be able to obtain faculty status at the medical schools; and (4) the variety of education experiences residents would receive at CBOCs is limited, so residents would need to train at additional locations.

Agency Comments

In commenting on a draft of this report, VA concurred with its content. We made minor revisions on the basis of VA technical comments, as appropriate. VA's comments are included in appendix VI.

We are sending copies of this report to the Honorable Togo West, Secretary of Veterans Affairs, and other congressional committees with an interest in this issue. We will also make copies available to others on request.

If you have any questions about this report, please call me at (202) 512-7101 or Walter Gembacz at (202) 512-6982. Other major contributors to this report are listed in appendix VII.

Sincerely yours,



Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Objectives, Scope, and Methodology

The Ranking Minority Member of the Senate Committee on Veterans' Affairs expressed concern that there was limited information available explaining the rationale for changes in the numbers and types of residency slots or describing the effect these changes have had on the resident training environment. In this context, he asked us to address the following questions: (1) What were VA's goals in realigning its residency program, and did VA accomplish its goals? (2) Who initiated the changes in the number of graduate medical education residency slots, and why? (3) What are the views of VA facility and medical school officials on the effect of the changes on resident training and on the potential to train residents at VA community-based outpatient clinics?

To determine whether VA's realignment of its residency program accomplished its goals, we met with officials from the Veterans Health Administration's Office of Academic Affiliations, reviewed VA's residency realignment goals, and compared the goals with the latest available data on residency slots. We examined numbers of residency positions for academic years 1995-96 through 1999-00, the period during which VA implemented its residency realignment.

To address who initiated the changes and why, we visited six VA facilities that experienced among the largest net changes in the number of residency slots. In selecting the facilities, we considered the number of residency slots supported by VA. We selected facilities from six different Veterans Integrated Service Networks (VISN) and, among them, selected two integrated facilities. The six facilities selected were located in Albany, New York (VISN 2); Albuquerque, New Mexico (VISN 18); Gainesville, Florida (VISN 8);¹ Muskogee, Oklahoma (VISN 16); Philadelphia, Pennsylvania (VISN 4); and West Los Angeles, California (VISN 22).²

At each facility, we interviewed senior management officials and clinical service chiefs at VA medical centers and representatives from the affiliated medical schools to determine the reasons for increases or decreases in the number of residents trained in a specific specialty. For facilities where the residency positions were decreased, we determined whether the medical schools relocated the slots to affiliates or eliminated the slots.

¹This facility, which is part of the VA North Florida/South Georgia Health Care System and also includes the Lake City VA Medical Center, was integrated in 1997.

²This facility, which is part of the Greater Los Angeles Health Care System and also includes the Sepulveda and Los Angeles Outpatient Clinics, was integrated in 1998.

Appendix I
Objectives, Scope, and Methodology

To obtain views about the effect of changes in residency slots on the graduate medical education training, including opportunities for training residents at VA community-based outpatient clinics, we interviewed senior management officials and clinical service chiefs at VA facilities and representatives from the affiliated medical school(s).

Number of VA Medical Resident Primary Care and Specialty Slots in Academic Year 1999-2000

Type of slot	Number of slots
Primary care	
Family practice	147
Geriatric medicine	170
General internal medicine	3,476
Gynecology	21
Obstetrics/gynecology	7
Preventive medicine	38
Specialty care	
Addiction psychiatry	1
Allergy and immunology	9
Anesthesiology	187
Colon and rectal surgery	1
Cardiovascular disease	266
Critical care	7
Dermatology	140
Diagnostic radiology	262
Emergency medicine	6
Endocrinology and metabolism	64
Geriatric psychiatry	28
Gastroenterology	180
Hematology	16
Hematology/oncology	107
Infectious diseases	81
Nephrology	89
Neurology	255
Neurological surgery	57
Nuclear medicine	29
Occupational medicine	17
Ophthalmology	237
Orthopedic surgery	216
Otolaryngology	162
Pathology	198
Pulmonary/critical care	159
Plastic surgery	47
Physical medicine and rehabilitation	189

Continued

**Appendix II
Number of VA Medical Resident Primary Care
and Specialty Slots in Academic Year 1999-
2000**

Type of slot	Number of slots
Psychiatry	778
Radiation oncology	24
Rheumatology	48
General surgery	706
Thoracic surgery	49
Urology	179
Vascular surgery	7
Total	8,660

Continued from Previous Page

Note: Because the numbers of residency slots for each specialty were rounded, the number of slots totals to 8,660 instead of 8,659; VA actually has a total of 8,659.2 slots.

Percentage of Residency Slots in Primary Care Training, by Network

Network	Academic year 1995-96		
	Percentage of primary care slots	Number of primary care slots	Total number of residency slots
1	36	192.7	530.4
2	35	91.4	261.9
3	35	220.0	621.0
4	48	157.5	330.7
5	43	102.5	236.5
6	42	153.0	368.3
7	39	177.0	452.0
8	34	191.0	558.5
9	42	232.5	553.5
10	37	97.0	259.0
11	40	130.5	323.5
12	38	256.0	679.5
13	42	91.0	214.7
14	41	82.7	200.0
15	39	134.0	347.1
16	35	242.0	696.3
17	36	124.0	340.0
18	49	148.4	303.3
19	39	89.3	226.3
20	45	118.3	261.3
21	35	135.0	388.5
22	36	276.0	757.6
National	39	3,442.0	8,910.0

**Appendix III
Percentage of Residency Slots in Primary
Care Training, by Network**

Academic year 1999-2000			1995-96 versus 1999-2000		
Percentage of primary care slots	Number of primary care resident slots	Total number of residency slots	Percentage change in primary care slots	Change in number of primary care slots	Change in total number of residency slots
45	230.8	515.4	9	38.1	-15.0
42	104.2	245.9	7	12.8	-16.0
46	270.8	587.5	11	50.8	-33.5
56	178.5	320.9	8	21.0	-9.8
54	131.7	246.0	11	29.2	+9.5
48	168.3	348.8	6	15.3	-19.5
49	213.1	438.4	10	36.1	-13.6
45	246.6	546.5	11	55.6	-12.0
50	262.9	528.3	8	30.4	-25.2
50	126.1	253.9	13	29.1	-5.1
50	161.0	319.0	10	30.5	-4.5
47	310.2	656.8	9	54.2	-22.7
48	93.9	197.6	6	2.9	-17.1
52	100.7	194.5	11	18.0	-5.5
48	162.0	339.0	9	28.0	-8.1
45	309.9	682.1	10	67.9	-14.2
46	154.6	333.0	10	30.6	-7.0
58	176.0	304.7	9	27.6	+1.4
50	117.6	233.9	11	28.3	+7.6
55	148.4	268.8	10	30.1	+7.5
44	166.5	379.7	9	31.5	-8.8
45	322.6	718.5	9	46.6	-39.1
48	4,156.0	8,659.0	9	714.0	-251.0

Selected VA Facility and Affiliated Medical School Residency Slots Before and After VA Residency Realignment

VA facility/affiliated medical school	Percentage of residents in primary care slots		VA residency slots		Total number of residency slots associated with medical school	
	1995-96	1999-2000	1995-96	1999-2000	1995-96	1999-2000
Albany/Albany Medical College	37	43	81.4	66.9	419	381
Albuquerque/University of New Mexico	36	54	99.8	112.9	424	439
Gainesville/University of Florida ^a	27	37	122.0	110.0	591	547
West Los Angeles ^b	35	46	328.6	322.0		
University of California LA					1,900	1,900
University of Southern California					1,000	1,000
Muskogee/University of Oklahoma	81	100	21.0	4.0	159	144
Philadelphia	42	43	123.0	92.2		
University of Pennsylvania					783	938
MCP Hahnemann University					703	587

Notes: Although the number of residency slots at the Albany Medical College went down from academic year 1995-96 to 1999-2000, VA did not initiate any of the reductions.

Although the number of residency slots at the University of Florida went down from academic year 1995-96 to 1999-2000, VA initiated seven of these reductions and only one of these was due to VA's residency realignment effort.

^aIntegration of Gainesville facility with Lake City facility.

^bIntegration of West Los Angeles facility with Sepulveda and Los Angeles outpatient clinics.

Summary of Community-Based Outpatient Clinic Data for the Six VA Facilities Visited

Location of VA facility visited	Number of community-based outpatient clinics	Range of distance between clinics and VA facility (in miles)	Are community-based clinics utilized for training residents?
Albany	10	5 to 205	No
Albuquerque	5	139 to 240	No
Gainesville ^a	5	35 to 180	No
West Los Angeles ^b	8	5 to 192	No
Muskogee	2	50 to 65	No
Philadelphia	2	45 to 60	No

^aIntegration of Gainesville facility with Lake City facility.

^bIntegration of West Los Angeles facility with Sepulveda and Los Angeles outpatient clinics.

Comments From the Department of Veterans Affairs

Note: A GAO comment supplementing those in the report text appears at the end of this appendix.



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

MAR 13 2000

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

Dear Mr. Backhus,

We have reviewed your draft report, **VA HEALTH CARE: Changes in Residency Slots Reflect Shift to Primary Care** (GAO/HEHS-00-62) and agree with you that the changing health care environment has resulted in a shift in demand from specialty physicians to primary care physicians. Your report describes how VA has realigned its graduate medical education program to meet this shift in demand. While it is generally accurate, we believe GAO should clarify several points.

This report deals with medical residents only. Because VA has a number of other residency programs, it is important to make the distinction in this report.

On page 4, the report states that in FY 1999, VA spent about \$683 million for residents' salaries and associated costs. Please revise this statement to show \$356 million for residents' salaries only, since the associated costs include costs for other programs besides medical residents, and it is not possible to break out the resident only portion of these costs. The way the report is written could mislead readers about costs used to support medical residents. At our February 23, 2000, exit conference, we discussed this point with GAO officials who agreed to make this change.

Also, the Residency Realignment Review Committee (RRRC) is not mentioned until page 5 of the report. We believe this placement does not give the RRRC the weight it should have as a change agent in realigning the graduate medical education program to better serve VA's health care needs. By citing it in the "Results in Brief" section, GAO would afford the RRRC its deserved prominence.

We appreciate the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Duffy".

Dennis Duffy
Assistant Secretary for
Planning and Analysis

Now on p. 6.

See comment 1.

**Appendix VI
Comments From the Department of Veterans
Affairs**

The following is GAO's comment on the Department of Veterans Affairs' letter dated March 13, 2000.

GAO Comment

1. No revision. Although we did not mention the Residency Realignment Review Committee by name, we gave prominence to the realignment of the graduate medical education program in the opening paragraph and in the results in brief of this report.

GAO Contact and Staff Acknowledgments

GAO Contact

Walter Gembacz, (202) 512-6982

**Staff
Acknowledgments**

The following staff made key contributions to this report: John Borrelli, Marcia Mann, Sigrid McGinty, Maria P. Vargas, and Stefanie Weldon.

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