

Journey of Change

April 1997



SPECIAL NOTE
from the Under Secretary for Health

While any organization can change or reduce its costs, it is much more difficult to change systematically in a way that produces clear, measurable, improved performance that readily translates into improved services and products at a reduced cost. This is an even more compelling challenge when the service provided is health care, the organization is a large government agency, and the customers are veterans of military service.

This strategic plan, *Journey of Change*, continues the story of VHA's transformation to meet the objectives articulated in the *Vision for Change* and *Prescription for Change*. The latter document represented the first strategic plan of the new VHA, defining broad goals and objectives. This new document takes the next step and describes in detail the systematic approach being taken to meet quantified strategic and annual targets that have been set for the twenty-two integrated service networks that currently comprise the veterans healthcare system.

As we begin our next planning cycle, it is important that we improve this plan for all concerned parties. To help us accomplish this, we ask that you fill out the evaluation form included in Appendix A. Your feedback is important in helping us produce the type of proactive, forward-thinking, responsive and innovative organization that we are striving to become. Thank you for your input.



Kenneth W. Kizer, M. D., M.P.H.
Under Secretary for Health

Journey of Change
Veterans Health Administration

TABLE OF CONTENTS

<i>Introduction</i>	1
<i>Chapter 1: Strategic Management Framework</i>	3
<i>Chapter 2: Mission, Goals, Strategy and Domains/Themes</i>	5
<i>Chapter 3: Targets and Actions</i>	8
<i>Chapter 4: Resource Management</i>	12
<i>Chapter 5: Managed Care</i>	21
<i>Chapter 6: Shift from Inpatient to Outpatient Care</i>	25
<i>Chapter 7: Improve Access to Care</i>	32
<i>Chapter 8: Eligibility Reform</i>	36
<i>Chapter 9: Enhance Information Systems</i>	39
<i>Chapter 10: Link Education and Research to Patient Care</i>	44
<i>Chapter 11: Empower Employees</i>	48
<i>Chapter 12: Special Programs</i>	50
<i>Plan Conclusions</i>	54
Appendix A: Strategic Plan Feedback Questionnaire	

INTRODUCTION

Healthcare in America is engaged in a dramatic transformation. Insistent demands for lower cost, greater accountability and higher quality have generated intense competition for greater market share in anticipation of diminishing revenue. Successful organizations have revamped the basic system of hospital-centered care and reformed the patterns of delivery toward managed, patient-centered primary care and necessary specialty care. In the wake of these dramatic management changes, healthcare providers everywhere are realigning, restructuring and reducing costs to improve their competitive posture.

The veterans healthcare system is experiencing similar pressures as well, although for somewhat different reasons. As a public system, there are increased demands for accountability, more readily demonstrable effectiveness and greater efficiency. In addition, VHA must continue to perform its mission of health professions education, research, and emergency preparedness. The new paradigm focuses on performance outcomes, such as actual costs, better access, higher levels of customer satisfaction and improved functional status of the patient. VHA's success will be compared with outcomes of other healthcare providers with comparable populations. How well VHA deals with these challenges and competitive comparisons will determine the future of VHA.

In response to these dynamic forces, VHA is continuing a course set in 1995, as articulated in the *Vision for Change*, a policy template for a more efficient and patient-centered veterans healthcare system. It envisioned a streamlined VHA headquarters providing governance to a decentralized system of integrated networks serving veterans as the future structure for a "new VHA." This vision has been implemented by an integrated process of goals, domains/themes, strategic targets, performance measures, and operational strategies/actions. (Figure 1)



Figure 1

Introduction

These goals were articulated by the Under Secretary for Health in 1996, in the *Prescription for Change*. Over the past year, the 22 newly configured integrated networks of care (Figure 2) have developed their strategic plans to respond to both the *Vision for Change* and the *Prescription for Change*. These 22 network plans are the implementation locus of this strategic plan.

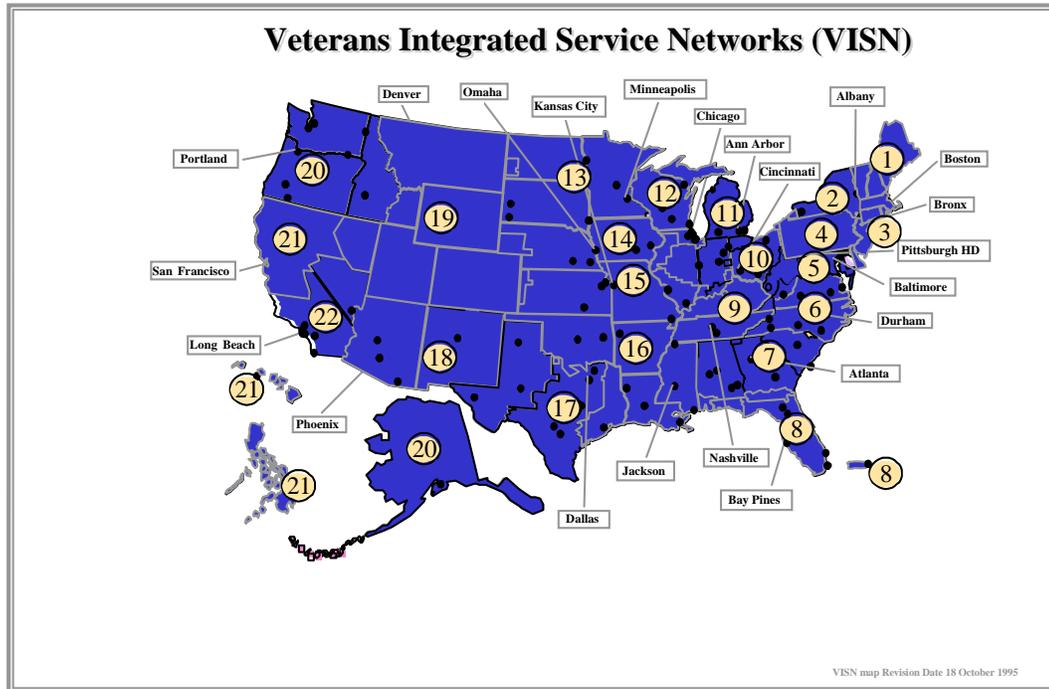


Figure 2

This national strategic plan, covering Fiscal Years 1997 through 2002, focuses on the key integrated goals, domains/themes, strategic targets, performance measures, and operational strategies/actions that will further propel VHA's transformation. It incorporates both field and headquarters perspectives in a set of new strategic and annual performance measures. It highlights the important addition of performance measurement to the VHA management system and it introduces the recently established "Ten for 2002" as strategic targets. In addition to the integration of the decentralized operational system of networks and the performance measurement system, the Veterans Equitable Resource Allocation (VERA) system supports and provides incentives for the reallocation of resources to the most appropriate level of care. Indeed, in the pages of this plan, we demonstrate integrated relationships that define a focused effort to continue the transformation of VHA.

CHAPTER 1: STRATEGIC MANAGEMENT FRAMEWORK

The strategic management framework for VHA was designed to assure that the implementation of corporate strategies will be effective and that there are mechanisms to communicate requirements and achieve organizational alignment. It also reflects the increasing level of specificity from broad system-wide mission goals to explicit operational actions, which will result in improved care to veterans. Of central importance to the framework is how alignment and consistency flow from goals and objectives to strategies and actions, as displayed in the pyramid below. This occurs by linkages between (1) **Mission Goals**, (2) **Domains of Value and Strategic Themes**, (3) **Strategic Targets**, (4) **Annual Performance Measures**, and (5) **Operational Strategies and Actions**. The achievement of VHA's mission goals depends largely upon the network and local implementation of aligned actions.

Communicating the strategic management framework (Figure 3) is critical to its implementation, not only for specific actions described in the plan, but for the daily activities of all VHA employees so that they can identify their connection to the mission goals of the organization. VAMCs, clinical and administrative service line managers, clinical teams and individuals will be able to link their activities to specific levels of the pyramid, fully aligning the organization to accomplish its Mission Goals and Strategic Targets.



Figure 3

Chapter 1: Strategic Management Framework

A general description of each layer of the strategic management framework is described below with a more detailed description in Chapters 2 and 3.



The *Prescription for Change* identified five corporate mission goals that provide unity of purpose throughout the organization and define VHA's strategy in operational terms. They are the focal point for aligning the activities of the organization.



The domains of value/strategic themes help define the organization in its environment and help in coordinating decisions and decision makers. They are the key drivers/critical success factors for their respective mission goals. (Detailed in Chapter 2)



VHA has established system-wide, national strategic targets -- "Ten for 2002." The strategic targets provide standards for assessing organizational performance at the national level. (Detailed in Chapter 3)



The key strategy for Headquarters to monitor organizational performance is the annual performance measures. Derived from the strategic targets, these measures reflect the interim performance steps necessary to reach the 2002 targets. (Detailed in Chapter 3) These performance measures are tailored at the network level. Accountability is measured by linking annual performance to the strategic targets.



In addition to the performance measurement system, the key headquarters strategy is the decentralized operational system (Networks) that places the locus of decision-making and accountability closer to the veterans served. The key VHA policy impacting network operational strategies is the Veterans Equitable Resource Allocation system implemented in the second half of FY 1997.

Successful achievement of the performance measurement targets requires network operational strategies and actions directed and supported by headquarters policy guidance. The following chapters cite specific network actions. (Detailed in Chapter 3)

CHAPTER 2: MISSION, GOALS, STRATEGY AND DOMAINS/THEMES

The planning process in VHA is designed to promote successful implementation of the *Vision for Change*, as succinctly defined in the mission and vision statement(s) in the *Prescription for Change*.

VHA Mission Statement

The mission of the Veterans Healthcare System is to serve the needs of America's veterans by providing primary care, specialized care and related medical and social support services. To accomplish this mission, VHA needs to be a comprehensive, integrated healthcare system that provides excellence in healthcare value, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability and by being an employer of choice.

VHA Vision Statement

Healthcare Value begins with VA. The new veterans healthcare system supports innovation, empowerment, productivity, accountability and continuous improvement. Working together, we provide a continuum of high quality healthcare in a convenient, responsive, caring manner---and at a reasonable cost.

VHA Strategy Statement

VHA's strategy is to provide excellent healthcare value and customer satisfaction to veterans through the integration of performance measurement, strategic planning, and financial goals and targets to achieve a patient-oriented, ambulatory care-based, results-driven, organized system of coordinated healthcare delivery focused on continuous quality improvement.

In order to implement the VHA strategy, the *Prescription for Change* identified five Mission Goals that translates the Mission, Vision and Strategy into goals that are the organizing principles for aligning the activities in the strategic plan. The goals provide the basis for a long run plan that is unified, comprehensive, and integrated.



Provide Excellence in Health Care Value

The operative term for this goal is Value, and VHA has identified five Domains of Value that provide the framework for defining and measuring value. Value is important to all VHA Mission Goals and these five domains are embodied throughout the goals.

- Technical Quality
- Cost/Price
- Service Satisfaction
- Access
- Functional Status



Provide Excellence in Service as Defined by Customers

As a customer-focused organization, VHA established a National Customer Feedback Center (NCFC) whose primary mission is to learn through focus groups what our patients and other customers feel about the healthcare they receive. This information is provided to administrators and practitioners for the purpose of making improvements. VHA has used that information to generate standards of care in a number of areas, including the “One VA” areas of staff courtesy and timeliness, as follows:

- Staff courtesy
- Decisions
- Physical comfort
- Timeliness
- Emotional needs
- Coordination of care
- One provider
- Patient education
- Family involvement



Provide Excellence in Education and Research

VHA already has an excellent reputation for its education and research activities. This goal aims to focus education and research more intensely in areas that relate to VHA patient care priorities as well as defining performance value in these areas.



Be an Organization that is Characterized by Exceptional Accountability

Accountability is achieved through a system of performance measures, and this goal demands a comprehensive performance measurement system for VHA. There must be sufficient measures to ensure a balance among the Domains of Value but not so many as to unnecessarily burden the system with excessive data collection. To that end, VHA is continuously collecting and assessing data regarding measures that are valid and relevant to its mission and vision. This effort has involved the collective wisdom of a broad spectrum of VHA employees, consultants and experience from public and private sector benchmark systems. The measures selected form the basis for performance agreements for key staff within the VHA healthcare system.



Be an Employer of Choice

The selection of this goal stemmed from VHA’s conviction that its most significant resource is its people. The quality of our employees and our VAVS volunteers has a direct relationship to the quality of care that our veterans receive. As such, VHA is committed to establishing feedback mechanisms to ensure that the views of employees are known to help shape policies and practices, redesign work systems, and identify other necessary improvements that ensure that VHA is an employer of choice.



DOMAINS OF VALUE

Mission Goals I and II are accomplished through the domains of value.

Mission Goal I - Provide Excellence in Health Care Value

Mission Goal II - Provide Excellence in Service as Defined by Customers

The domains are the critical factors that drive healthcare value. They represent a balanced scorecard approach by recognizing that value has multiple dimensions. It is their dynamic interaction that determines value. The domains are as follows:

- **Technical Quality** represents the successful application and appropriateness of the techniques and technologies used to treat medical conditions and the outcomes of those interventions
- **Cost/Price** represents the efficient management of appropriated and other funds to operate the VA healthcare system
- **Service Satisfaction** represents the views of veterans and their families about their care
- **Access** represents the time, distance and ease of obtaining appropriate VA medical care and services
- **Functional Status** represents the ability of patients to perform usual and accustomed activities after medical interventions

STRATEGIC THEMES

Mission Goals III, IV and V are accomplished primarily through strategic themes. These themes are the critical success factors for these mission goals. The Domains of Value are also inherent in these mission goals.

Mission Goal III - Provide Excellence in Education and Research

Strategic Themes

- Capitalize on the Needs of and Special Opportunities Available in VHA
- Link Education and Research With Current and Future Needs of Veterans
- Increase External Awareness and Collaborative Efforts

Mission Goal IV - Be an Organization that is Characterized by Exceptional Accountability

Strategic Themes:

- Link Reward, Recognition and Promotion to Performance Measurement
- Build a Culture of Team-Based effort and Individual Ethics and Accountability

Mission Goal V - Be an Employer of Choice

Strategic Themes:

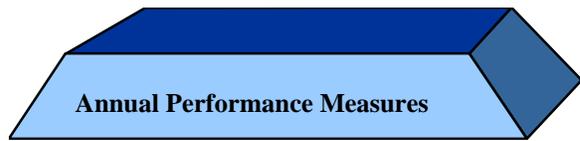
- Maintain a High level of Job Satisfaction
- Provide Equal Employment Opportunity
- Provide a Safe Work Environment
- Provide Tools for Continuous Quality Improvement as a Learning Organization

CHAPTER 3: TARGETS AND ACTIONS



VHA has established system-wide strategic targets—“**Ten for 2002.**” The strategic targets identify and quantify the results VHA desires to achieve at the national level by 2002. They link to the domains and strategic themes. The annual performance measures, linked to the strategic targets, reflect the interim steps necessary to reach the 2002 targets.

- Decrease the system-wide average cost (expenditure) per patient by 30 percent
- Increase the number of users of the veterans healthcare system by 20 percent
- Increase the percent of the operating budget obtained from non-appropriated sources to 10 percent of the total
- Exceed by 10 percent the proportion of patients of other large healthcare providers who achieve maximal functional potential
- Increase to 90 percent the proportion of patients reporting VA healthcare as very good or excellent
- Increase to 90 percent the proportion of patients who rate the quality of VHA healthcare as equivalent to or better than what they would receive from others
- Increase to 99 percent the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of the Department of Veterans Affairs
- When asked, 95% of physician house staff and other trainees would rate their VA educational experience as good or superior to their other academic training
- Increase to 2 percent, or 40 hours per year, the amount of an employee’s paid time that is spent in continuing education to promote and support quality improvement or customer service
- Increase to 100 percent the number of employees who, when queried, are able to appropriately describe how their work helps meet the mission of the “new VHA”



The performance measurement system links annual performance to the strategic targets (“**Ten for 2002**”) at the network level.. They monitor the progress being made to reach the strategic targets. The FY 1997 categories for measures are listed below.

- Decrease Bed Days of Care per 1000 Unique Patients
- Decrease Total Operating Beds
- Expand Ambulatory Surgery
- Increase Category A Users
- Improve Customer Satisfaction Regarding Timeliness of Access
- Increase Primary Care Enrollment
- Improve Management of Compensation and Pension Requests
- Implement and Improve the Chronic Disease Index Score
- Implement and Improve the Prevention Index Score
- Expand Use of Clinical Practice Guidelines
- Document End of Life Planning
- Improve Customer Service Satisfaction
- Improve Spinal Cord Injury Patient Satisfaction
- Document Addiction Severity Index Use for all Substance Abuse Patients
- Increase Total Peer-Reviewed Research Funding
- Improve employee knowledge of the VHA mission



The network internal and external assessments identified numerous strengths as well as threats. These assessments, in combination with the mission goals, strategic targets, and the FY 1996 and 1997 performance measures, resulted in identifying operational strategies and actions. These strategies are being implemented system-wide by headquarters and in different combinations and focus by the 22 networks. Since the plan’s focus is on measurable outcomes as represented in the strategic targets and annual performance measures, a representative list of actions that are planned in headquarters and the networks is included.

Operational strategies described in the following chapters are:

RESOURCE MANAGEMENT

- Veterans Equitable Resource Allocation
- Medicare/MCCR/Alternative Revenue Sources
- Capital Program Resources
- Consolidating Services
- Human Resources

MANAGED CARE

- Primary Care
- Utilization Management
- Clinical Practice Guidelines
- Service Line Management

SHIFT FROM INPATIENT TO OUTPATIENT CARE

- Reallocations to Outpatient Care
- Decrease Bed Days of Care
- Decrease Operating Beds
- Increase Ambulatory Surgery

IMPROVE ACCESS TO CARE

- Community Based Outpatient Clinics
- Timeliness of Care

ELIGIBILITY REFORM

- HQ develops implementation policies
- Pilot test an Enrollment Process
- Develop Educational Programs
- Develop Information Systems

ENHANCE INFORMATION SYSTEMS

- Decision Support System
- Telemedicine
- Computerized Patient Record System

LINK EDUCATION AND RESEARCH TO PATIENT CARE

- Resident Education and Academic Affiliations
- Research

EMPOWER EMPLOYEES

- Creating a high level of job satisfaction
- Be a learning organization
- Being committed to EEO principles
- Ensuring a safe work environment
- Ensure the availability of necessary tools

Figure 4 lists the major elements in the Strategic Management Framework and how its key components relate to one another.

Strategic Management Framework

- Excellence in Healthcare Value
- Excellence in Service as Defined by Customers
- Excellence in Education and Research

Mission Goals



- Be an Organization Characterized by Exceptional Accountability
- Be an Employer of Choice

- Technical Quality
- Cost/Price
- Service Satisfaction
- Access
- Functional Status

Domains / Themes



- Capitalize on Needs & Opportunities in VHA
- Link Education & Research with Patient Needs
- Increase External Awareness & Collaboration
- Link Reward, Recognition & Promotion to Performance Measurement
- Culture of Team Effort & Individual Ethics & Accountability
- Job Satisfaction
- Equal Opportunity Employer
- Safe Work Environment
- Promote Learning through QI

2002 Strategic Targets

- Decrease System-wide Cost/Patient by 30%
- Increase Healthcare Users by 20%
- Increase Revenues from Non-Appropriated Sources to 10% of Total Operations
- Exceed by 10% Proportion of Patients of Other Providers Who Achieve Maximal Functional Potential
- 90% of Patients Rate VA as Very Good or Excellent

- 90% of Patients Rate VA Better Than Others
- 99% of Research Relates to VA Patient Care
- 95% of Trainees Rate VA Experience as Good
- Increase Employee Education for QI or Customer Service to 40 Hours/Year
- 100% of Employees can Relate their Work to the "New VHA" Mission



Annual Performance Measures

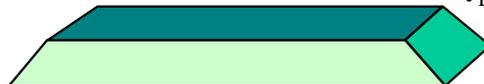
- Bed Days of Care/1000 Unique Users
- Total Operating Beds
- Ambulatory Surgery
- Category A Users
- Timeliness of Access
- Primary Care Enrollment
- Compensation and Pension Requests
- Chronic Disease Index



- Prevention Index
- Network-wide Clinical Practice Guidelines
- End of Life Planning
- Customer Service Standards
- Spinal Cord Injury Patient Satisfaction
- Addiction Severity Index
- Total Peer-Reviewed Research Funding
- Understand Mission and Role in Meeting Mission

Operational Strategies

- Resource Management
- Managed Care
- Shift from Inpatient to Outpatient Care
- Improve Access

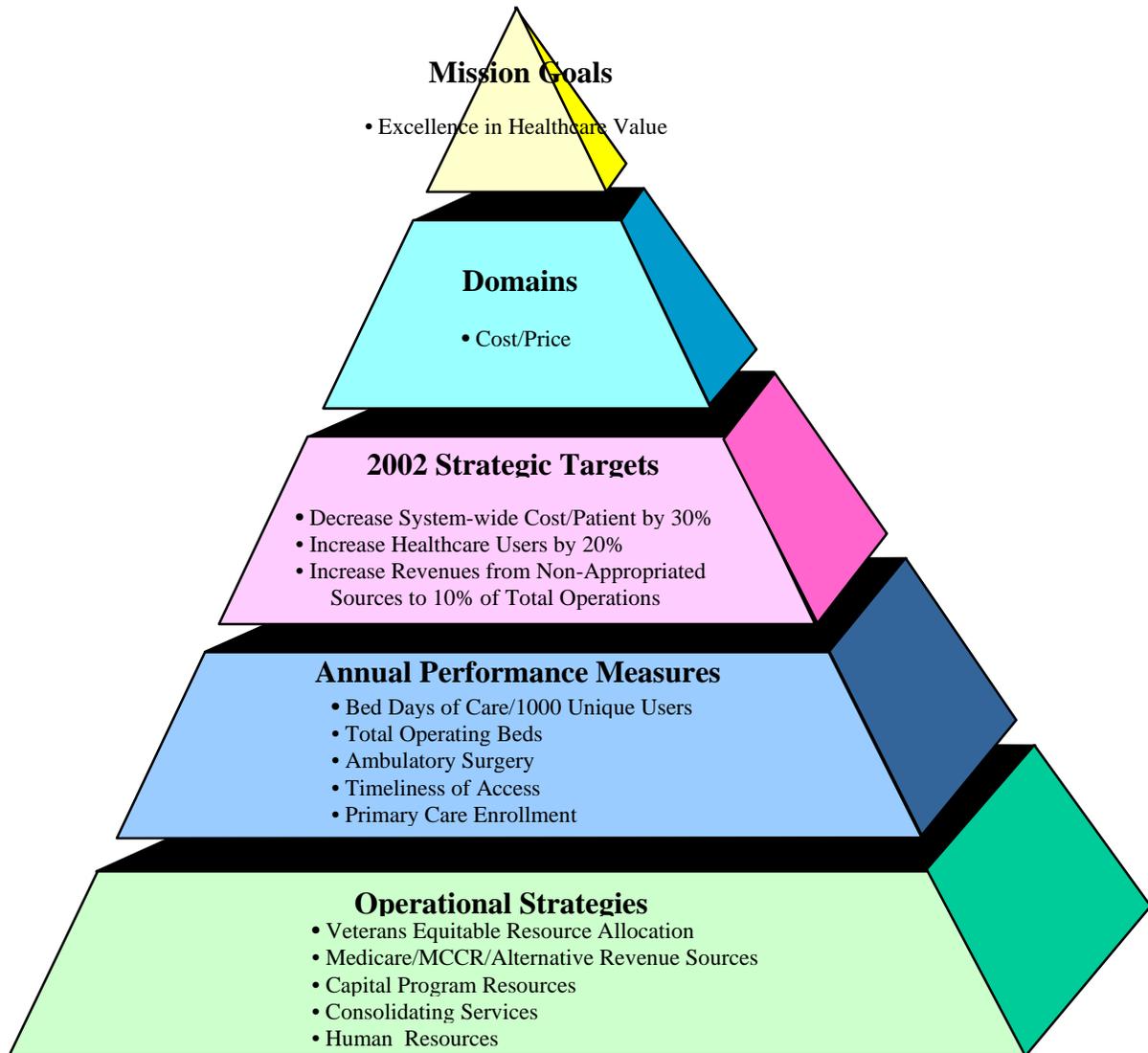


- Implement Eligibility Reform
- Enhance Information Systems
- Link Education and Research to Patient Care
- Empower Employees

Figure 4

CHAPTER 4: RESOURCE MANAGEMENT

Resource Management



To achieve the mission goals and strategic targets set for the healthcare delivery system, efficient resource utilization, reallocation and development are of paramount importance. Strategically, process changes and improvements, as well as measuring the achievement of critical performance objectives over time, demonstrate the planned judicious use of monetary, capital, and human resources.



VETERANS EQUITABLE RESOURCE ALLOCATION

The Veterans Health Administration (VHA) developed a new system to allocate its \$17 billion Congressionally appropriated healthcare budget to the 22 networks. This new methodology is called the Veterans Equitable Resource Allocation (VERA) system.

VERA was created to improve the resource allocation system and address previously documented problems. In particular, it was created to support VHA's goal to provide excellence in healthcare value by:

- Treating the greatest number of veterans having the highest priority for healthcare
- Allocating funds fairly according to the number of veterans having the highest priority for healthcare
- Recognizing the special healthcare needs of veterans
- Creating an understandable funding allocation system that results in having a reasonably predictable budget
- Aligning resource allocation policies to the best practices in healthcare
- Improving the accountability in expenditures for research and education support
- Complying with Congressional mandate

The VERA methodology achieves these objectives and, at the same time, strikes a balance between simplifying resource allocation and recognizing the complexities of the veterans healthcare system. For example, the VERA methodology:

- Recognizes that VHA treats two general sets of patients – those with “routine” healthcare needs (Basic Care) and those with complex and typically chronic healthcare needs (Special Care)
- Recognizes that national prices do not account for geographic differences in the cost of providing healthcare that are not under the control of VA management
- Adjusts network budgets depending on the wages the network must pay its employees in their part of the country
- Accounts for veterans who receive care in more than one network during the year by adjusting budgets based on the historical usage patterns and costs for these veterans
- In addition to the Basic and Special Care price differences, VERA adjusts for four other factors: research, education, equipment, and non-recurring maintenance

Under the VERA methodology, funds will shift among the networks, as shown in Figure 5. The model indicates that resource shifts range from a loss of 15 percent to a gain of 16 percent, as compared to the FY 1996 budget allocations. It is important to note, however, VHA does not believe that such funding shifts can realistically occur in a single fiscal year, so the funding shift resulting from VERA will be implemented incrementally. Most networks will see a budget increase under VERA (Figure 5).

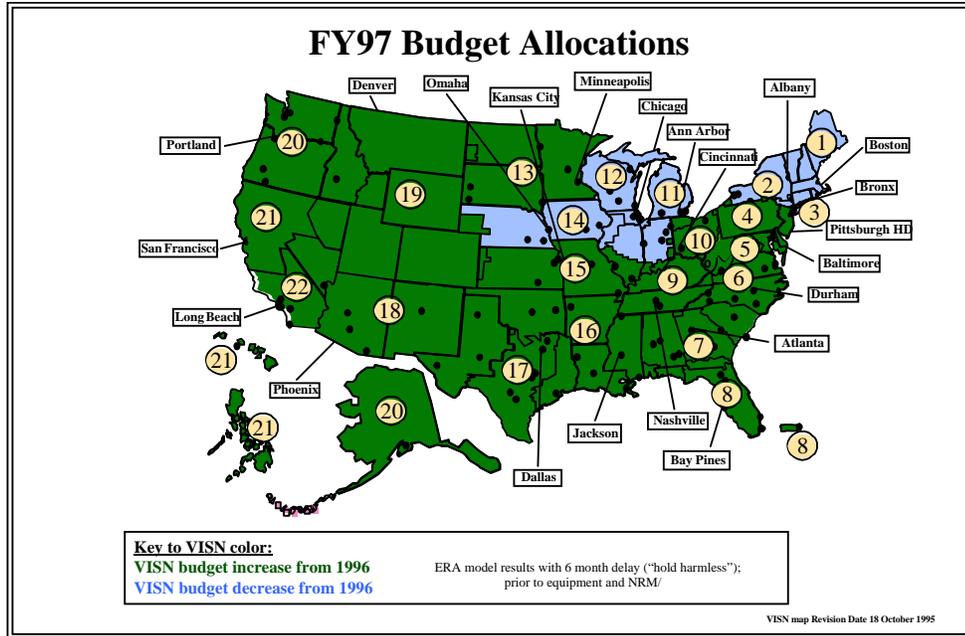


Figure 5

In FY 1997:

- No network will be reduced below 1.26 percent of their FY 1996 funding level
- 16 networks will receive more funding than in FY 1996
- Fifty-five percent of the networks will see funding increases that are greater than the total rate of increase in the system's funding from FY 1996 to FY 1997 (2.75%) (See Table 1 below.)

Table 1: Change in Network Budgets 1996 and 1997 with Phase-in Implementation (\$ in Millions)					
	Network	FY 96	FY 97	\$ Difference	% Difference
1	Boston	822	811	-10	-1.26
2	Albany NY	421	416	-5	-1.17
3	Bronx	988	976	-11	-1.16
4	Pittsburgh	744	746	2	0.22
5	Baltimore	408	425	17	4.07
6	Durham	656	681	25	3.76
7	Atlanta	748	785	37	4.93
8	Bay Pines	928	985	57	6.15
9	Nashville	662	671	10	1.46
10	Cincinnati	489	508	19	3.84
11	Ann Arbor	633	631	-1	-0.23
12	Chicago	801	793	-8	-1.05
13	Minneapolis	400	406	6	1.51
14	Omaha	277	276	-1	-0.42
15	Kansas City	560	590	30	5.31
16	Jackson	1032	1090	58	5.58
17	Dallas	566	601	35	6.14
18	Phoenix	466	498	32	6.90
19	Denver	353	369	17	4.70
20	Portland	561	595	34	6.09
21	San Francisco	665	696	31	4.71
22	Long Beach	868	884	17	1.91
VHA	National Data	\$14,048	\$14,434	\$386	2.75

Table 1

Under the VERA funding methodology, networks that were previously under-funded will now be able to operate closer to the national average cost per patient because the variance among networks is taken into consideration with regard to mix of patients, labor costs, research, and education activities. This should translate into increased access to care and it should allow for enhancements to the quality and timeliness of service in those networks. It will ensure that there are resources for each network to provide comparable services and care so that veterans may receive the same services no matter where they live.

Under the assumption that each passing year would result in more movement of resources, the equitable shift of resources across the country will be completed in FY 1999. In 4 of the 6 networks that are receiving less funding, the change will be completed in FY 1997-98. The progress made to date in the networks facing the greatest challenge in the amount of dollars shifted gives reason for optimism that results will be achieved earlier than projected.

Networks In Action

In FY 1998- 99:

- Implement a capitated system of VISN-wide resource allocation (Networks 4, 7)
- Refine distribution methodology based on workload at network level (Networks 2, 14)
- Construct a model for VISN budgeting by population (Network 15)



MEDICARE, MEDICAL CARE COST RECOVERY (MCCR) AND ALTERNATIVE REVENUE SOURCES

Future success of the VHA healthcare system may depend as much on diversifying VHA's funding base as on any other strategy. VHA has developed an important proposal to open the Medical Care Cost Recovery and Medicare programs as new funding streams. A number of networks are depending heavily on Medicare and other new revenue sources for at least a part of their future viability. VA Voluntary Service organizational donations are also considered a current as well as a future revenue source.

Medicare

One of the central “**Ten for 2002**” strategic targets is to increase non-appropriated funding sources by 10%. A major initiative to support this target is a proposal that would allow VA to begin a demonstration program in 1998 to test the feasibility of “Medicare Subvention,” i.e., billing Medicare for healthcare provided to Medicare eligible Category C veterans. This was initially introduced in 1995 as a Reinventing Government initiative. Legislation was submitted in the second session of the 104th Congress and currently in the first session of the 105th Congress that would authorize such a demonstration project.

Extensive discussions have been carried out with the Health Care Financing Administration and the Office of Management and Budget to develop a detailed Memorandum of Agreement (MOA) that will support the legislation and deal with many issues such as conditions of participation, benefits, reimbursement and site selection. The MOA will also explain how mechanisms will be put into place to ensure that VA is not reimbursed by Medicare for services already covered by appropriations and that there will be no threat to the Medicare Trust Fund. There has been agreement in principle on all major items.

Networks In Action

- 14 networks have indicated interest in becoming a Medicare Pilot site
- All 22 networks include Medicare reimbursement in their strategic plans
- VHA is actively pursuing standardizing VA payment schedules for non-VA healthcare services using Medicare payment schedules. Implementation is expected to result in annual savings approximating \$32.8 million.

Medical Care Cost Recovery/CHAMPUS/TRICARE

As with Medicare, a number of networks want to pursue a stronger collection program from private insurers of current patients. To do this, the incentives must be shifted to permit more of the collections to be retained within VHA, rather than be deposited to the U.S. Treasury, as is current policy. VHA has proposed legislation that would retain medical collections and user fees in the VA medical care appropriation.

Chapter 4: Resource Management

TRICARE, an approach to meeting military retiree healthcare needs, is a program of interest to some networks. No legislation is necessary; rather, it is incumbent that providers who are interested in TRICARE workloads, whether private or public, be prepared to assume certain risks. TRICARE uses capitation contracts which by their nature are risk-based contracts. VHA is providing guidance and direction to interested networks in their negotiations with TRICARE fiscal intermediaries concerning these opportunities.

VHA is actively pursuing a self-sustaining initiative, “Meds by Mail” program, which would allow CHAMPVA beneficiaries to obtain needed maintenance medications from VA Consolidated Mail-Out Pharmacies (CMOPs). As a result, CMOPs and affiliated medical centers would be reimbursed for dispensed medications while VA would realize program savings and further supplemental operating revenues. It is projected that, after national implementation, net revenues are likely to approximate \$4 million.

Networks In Action

- Participate in TRICARE partnership (Networks 4, 17)
- Be a TRICARE provider (Networks 6, 14, 15)
- TRICARE agreement—Humana Military Health Care services in 1997 (Network 8)
- Three VAMCs in the network are currently billing CHAMPUS directly for services (Network 11)
- Continue to operate as a successful CHAMPUS pilot project to collect health care funds from DOD (Network 18)



CAPITAL PROGRAM RESOURCES

VHA’s capital program includes major and minor construction projects, non-recurring maintenance, equipment, and leasing.

- The Major Construction Program has historically been a centralized program and part of a construction appropriation separate from the medical care appropriation
- The Minor Construction Program is included in the construction appropriation but project selection and implementation has largely been decentralized over the past several years
- The non-recurring maintenance, equipment and leasing programs are included under the medical care appropriation and have been implemented in both centralized and decentralized programs in recent years
- In FY 1997, all funds for the minor construction program, non-recurring maintenance, equipment, and leases have been decentralized to the networks on a capitated basis

Capital strategic planning is being integrated with health services strategic and tactical planning, operations and finance at the network level to achieve a new, coordinated level of delivery system planning. It is important to emphasize that the capital programs are only one option to implement healthcare delivery. A coordinated delivery system planning approach includes assessing all viable acquisition options, both non-capital and capital, from both a benefit and cost viewpoint.

Networks In Action

The focus of the proposed projects is on meeting the Mission Goals described in the *Prescription for Change* in the areas of shifting the emphasis of healthcare delivery from an inpatient orientation to a primary care/managed care, outpatient based system as well as to upgrade reduced but needed inpatient bed space. Capital projects are proposed to:

- Expand outpatient facility capacity (Networks 3, 5, 6, 10, 12, 18, 20, 21))
- Correct existing parking deficiencies (Network 19)

Chapter 4: Resource Management

- Correct deficiencies in inpatient bed and support areas (Networks 1, 2, 4, 7, 9, 11, 13, 17)
- Correct building system deficiencies such as structural (seismic) and heating, ventilating and air conditioning (Networks 8, 22)
- Enhanced use project between Indianapolis and State of Indiana to share buildings and land and to establish a \$10.0 million trust for treatment of Indiana veterans (Network 11)
- Leasing facilities (Networks 19, 21, 22)
- Constructing new ambulatory space where alternative options are not cost effective or otherwise practical (Networks 18, 20)

CONSOLIDATING SERVICES

Consolidation and integration is expected when there is costly redundancy, economies of scale are available, or when service levels and/or workload measures fall below minimum levels to assure cost effectiveness and clinical quality. This will entail restructuring facilities and contracts to reduce administrative costs and to increase the proportion of resources devoted to direct patient care. Restructuring addresses consolidation, integration, and right-sizing of facilities and realignment of services and programs within facilities. VHA has witnessed a significant decrease in the number of operating beds nationwide as a result of these activities and plans to continue decreasing operating beds in the future.

Networks in Action

- Target service integrations which include laboratory management for Syracuse, Bath and Canandaigua; laundry services for Buffalo, Syracuse and Canandaigua; and the establishment of a Network level A&MM Service (Networks 2, 12)
- Study the feasibility of integrating clinical programs, support services, and management at Lake City and Gainesville and implementing consolidated contracts in home oxygen and durable medical equipment, computerized tomography, preventive maintenance, transcription services, artificial limbs, and reference laboratory (Network 8)
- Consolidate routine laboratory services into two VISN hub laboratories (Network 10)
- Implement selected service integrations at Montgomery and Tuskegee VAMCs and Lakeside and Westside VAMCs in FY 1997 (Networks 7,12)
- Integrate Castle Point/Montrose and Des Moines/Knoxville and Lincoln/Grand Island (Networks 3, 14)
- Implement the “Administrative Service Center” which will consolidate various administrative functions (purchasing, contracting, payroll, human resources) within the Network (Network 14)
- Implement a Consolidated Support Center (Network 15)
- Implement Virtual Consolidated Contracts (Network 18)
- Intra-network streamlining and support resulting in consolidations, integrations and reallocation of workloads (Networks 1, 2, 4, 7, 21)



HUMAN RESOURCES

Attention to human resource management, such as staffing levels, reallocation and mix of clinical skills, education, and VA Voluntary Service (VAVS) volunteers, is a key driver in meeting mission goals and strategic targets.

Staffing Levels

To operate a more cost-effective and efficient system, VHA must reduce its administrative and clinical cost structure. This will require workforce changes, education, pursuit of non-appropriated revenue sources, and identification of other opportunities for contracting or selling services.

Networks In Action

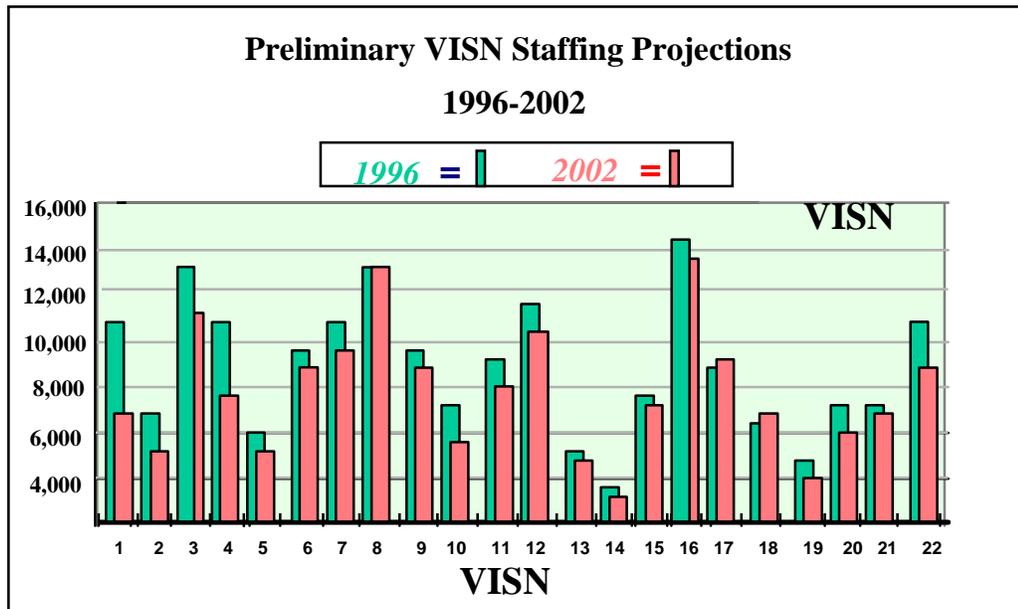


Figure 6

- Networks have made preliminary estimates of staffing projections between now and FY 2002 (Figure 6).
- Establish a network-wide administrative service center to consolidate purchasing contracting, human resources, etc. to reduce the cost of supplies and services (Networks 7, 14, 15, 18)

Staff Education

Aligning education to support the goals and objectives of the strategic plan is a critical component of its successful implementation. The strategic plan of the Headquarters Employee Education Service (EES) is directly linked to the strategic plans of the networks. The EES assessed in depth the 22 network plans to identify their educational implications and the status of educational planning in the networks. EES identified initial programming areas for which educational initiatives are being developed. Simultaneously, the EES plans to explore the partnering of educational efforts with the networks and medical centers. The EES has committed significant resources (human and financial) to focused efforts in the areas identified as high priority for the transition to the “New VHA”, such as: Ambulatory Care Data Collection/Utilization/Integrity, Human Resource Management Competencies, Eligibility Reform, Customer Service, Managed Care/Primary Care and National Clinical Guidelines.

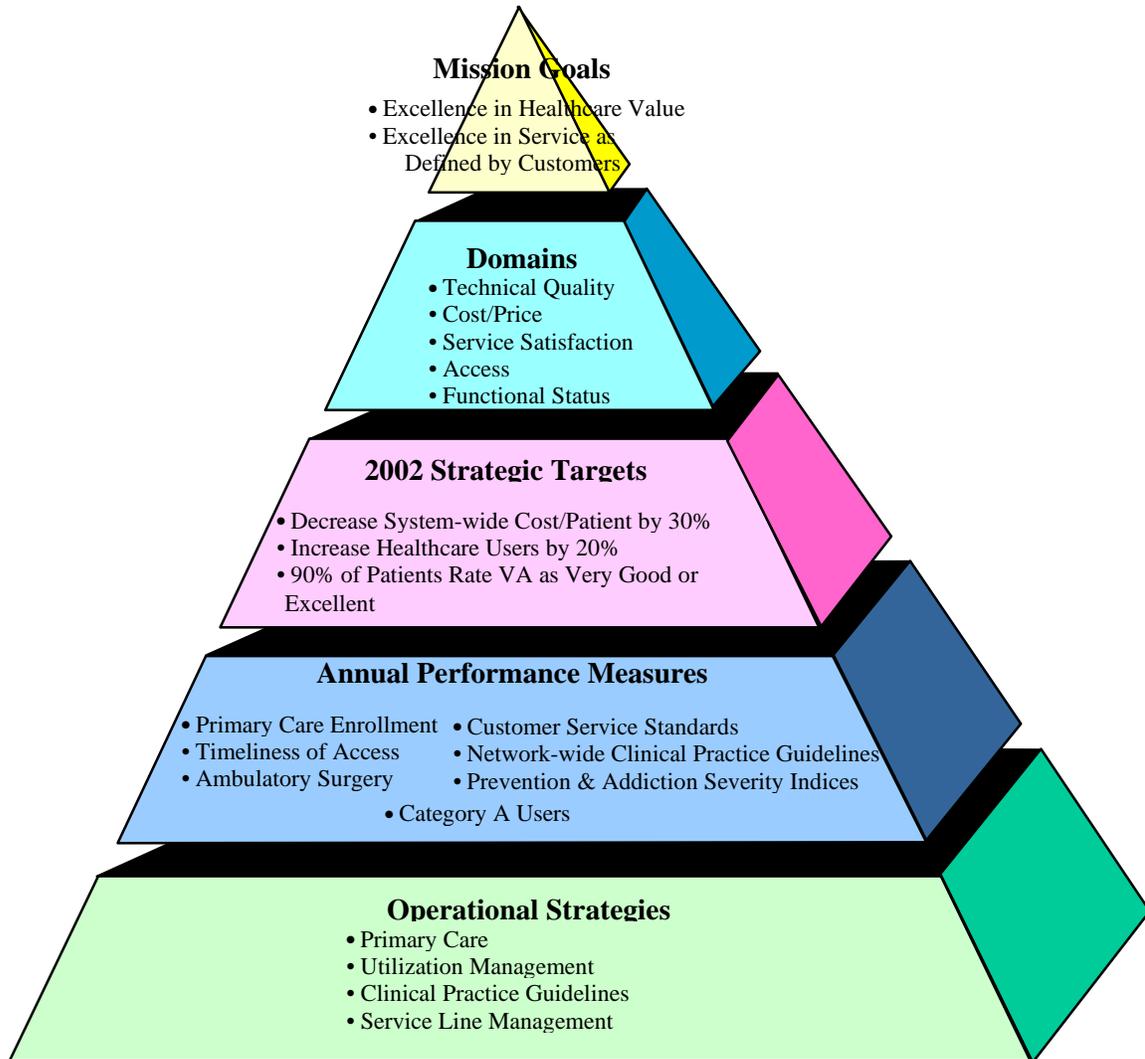
Networks in Action

VHA has a long-standing commitment to employee education and has promoted shared education and training activities for all employees. One of the “**Ten for 2002**” strategic targets calls for increasing staff education time nationwide to 2% or 40 hours per year in continuing education to support quality improvement and customer service. All networks are committed to meeting this requirement and to establishing a network-wide education and training program. Network plans demonstrate additional support for employee education:

- All networks have appointed Network Academic Affiliations Officers to coordinate educational issues
- 10 of the 22 networks have an Education Council or similar committee in place
- Network Education Council is charged to identify employee, professional and patient/customer education and training needs within the network and develop a comprehensive education plan (Networks 20, 22)
- Establish a Network University to link all education and training to the network goals, match educational needs with programs, and provide collaborative training opportunities (Network 14)
- Develop a Network Education Council plan for distribution of resources specifically targeted to Career Transition/Development, Information Resource Development, New Technology, Organizational Development and New Initiatives (Network 2)

CHAPTER 5: MANAGED CARE

Managed Care



VHA is reorganizing the way in which health services are delivered. Managed care is one of the major strategies that will transform the healthcare delivery system to treat patients in the most appropriate setting. The use of the primary care provider/team as the coordinator/manager will assure high quality cost-effective care.



PRIMARY CARE

The Headquarters Office of Patient Care Services has identified the shift to primary care as one of its key objectives. Primary Care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. All VHA facilities are now required to implement primary care programs. Consistent with this priority, networks are establishing primary care as the central focus of patient treatment.

- A survey conducted by Headquarters in October 1996 showed that 97% of facilities have developed primary care teams
- As of September 30, 1996, VHA had 53% of patients enrolled in primary care
- The 1996 performance measurement system results indicate that as a national average more than 70% of outpatients reported that one team or person was in charge of their care (Figure 7). In 1997, the expected level of performance is 85%

Primary Care Enrollment (1996)

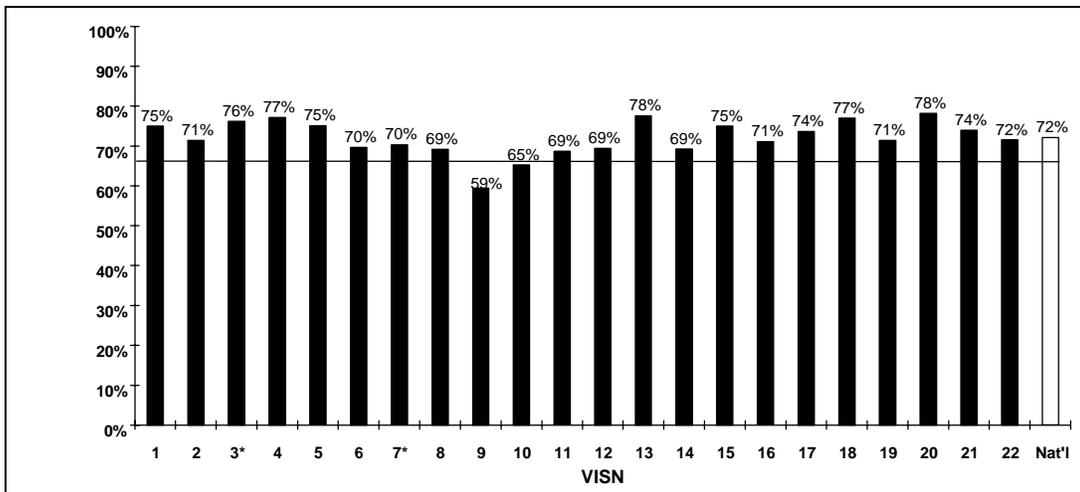


Figure 7

Networks In Action

- All extended care patients will be assigned a primary care provider (Network 8)
- VAMC Tucson currently uses the local Vet Center to conduct health screening (Network 18)
- Implement Home Based Primary Care at Bath and Canandaigua (Network 2)
- Considering a group practice model organized around front-line providers who have responsibility and accountability for patients; includes a capitation reimbursement strategy (Network 20)
- VISN-wide primary care model where primary care providers are accountable for patient care throughout the VAMCs (Network 15)
- Assignment of a primary practitioner/team for each patient (Network 2)



UTILIZATION MANAGEMENT

Utilization Management is a program to increase the efficiency and appropriateness with which services are provided and resources are utilized. It accomplishes this through activities such as monitoring length of stay, preadmission reviews, coordinating referrals, and ensuring that alternatives to hospitalization are available. All VHA facilities were required to implement Utilization Management Programs in FY 1996.

Networks In Action

- All 22 networks have implemented Utilization Management Programs
- UM program will provide the foundation for future report card development (Network 8)
- In FY 1997, networks are linking utilization management to performance measurement, by using clinical guidelines to manage patients through the continuum of care



CLINICAL PRACTICE GUIDELINES

Clinical practice guidelines are recommendations for the performance or exclusion of specific procedures or services, derived through a rigorous methodological approach and wherever possible are based on supporting literature review. In FY 1996, VHA developed five clinical guidelines which were implemented nationally. The five clinical guidelines are as follows: stroke, amputation, ischemic heart disease, major depressive disorder (MDD), and MDD with post traumatic stress disorder (PTSD).

In FY 1997, managed care will be facilitated by the implementation of 12 nationally developed clinical practice guidelines in addition to those adopted in FY 1996. Examples include: diabetes, depression and dementia assessment in primary care. Clinical management of patients using the guidelines and linked to the utilization management program is planned throughout the system in FY 1997. Networks plan to maintain and enhance Special Emphasis Program capabilities through practice guidelines and other tools.

Networks In Action

- Expand the application of clinical guidelines from the five nationally developed guidelines to guidelines based upon the 20 high volume DRGs and Special Emphasis Programs (Network 17)
- Fully implement the 13 recommendations of US Preventive Services Task Force on Wellness and Prevention (Network 14)
- Develop a monthly report card to monitor the implementation of clinical practice guidelines (Network 15)



SERVICE LINE MANAGEMENT

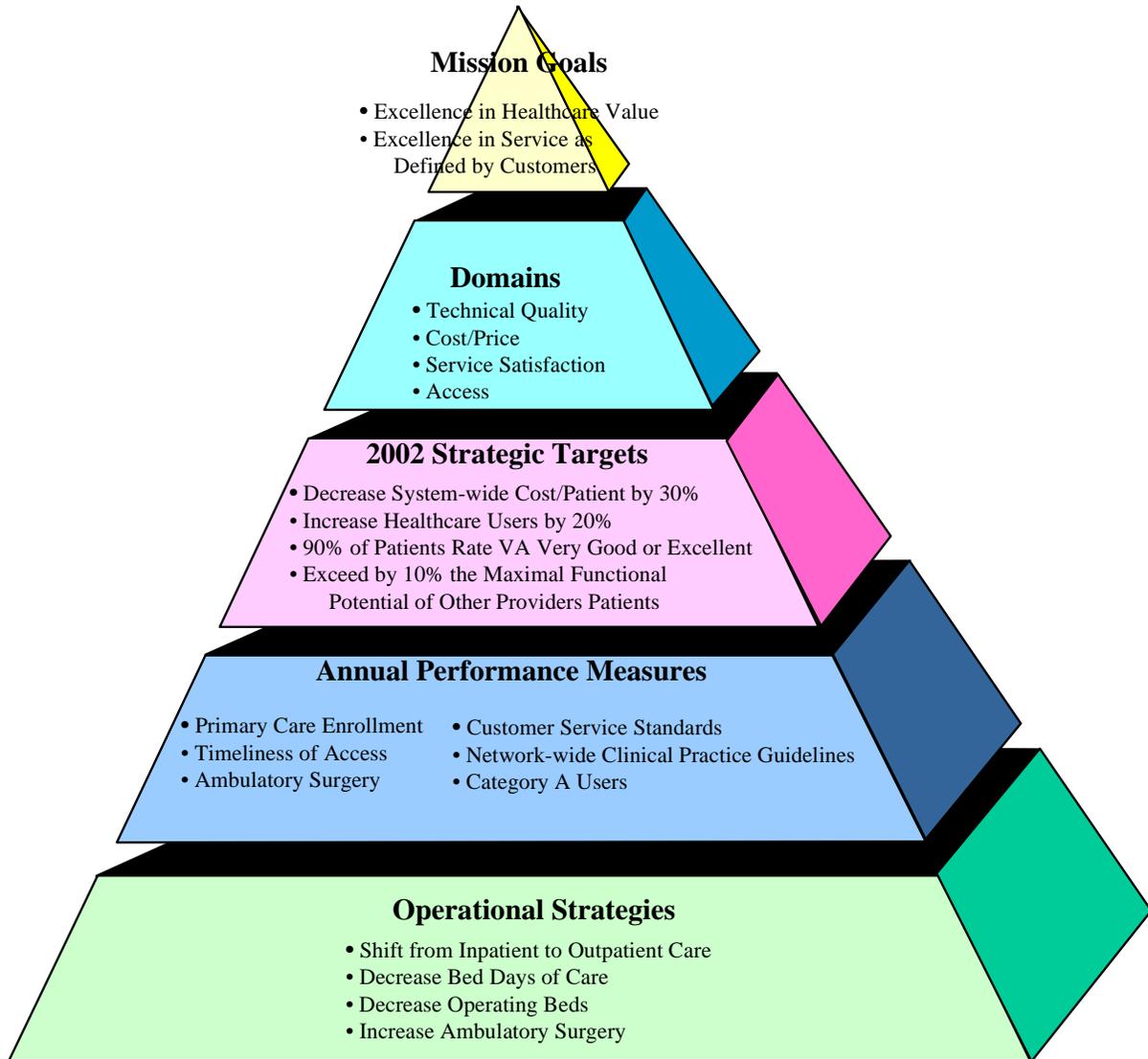
A service line (also known as a product line) is a strategy to consolidate delivery systems, budgeting and accountability within broad groupings of patients or functions rather than by traditional departments to treat patients in the most appropriate setting. Headquarters Patient Care Services has developed key service lines, including, but not limited to Critical Care, General Diagnostics Services, Seriously Mentally Ill, PTSD, and Women's Program Services. Service lines may also be administrative, such as Network Business Centers or Biomedical Engineering.

Networks In Action

- Develop and implement a product-line hub and spoke delivery system based upon the clinical inventory of patient needs (Networks 4, 17)
- The mental health programs and the domiciliary programs will be integrated into a service line (Network 3)
- VAMCs are pursuing their own level of reorganization into service lines to ensure more effective local control over programs and services (Network 18)
- Establish a Pathology & Laboratory Medicine Service product line (Network 12)

CHAPTER 6: SHIFT FROM INPATIENT TO OUTPATIENT CARE

Shift From Inpatient to Outpatient Care



The shift from inpatient to outpatient care is a critical success factor for meeting the strategic objectives. The shift impacts physical plant, clinical staff needs, and almost all aspects of the delivery system.

Chapter 6: Shift from Inpatient to Outpatient Care

The *Prescription for Change* states that ... “the hospital is no longer the center of the healthcare universe. Healthcare has become an ambulatory care-based activity.” Since VHA is making the transition from an inpatient bed-based system to an ambulatory care system, hospital utilization must be minimized whenever therapeutically possible, and inpatient services must be converted to outpatient services and extended into the community. As a result, a variety of strategies are being implemented to improve accessibility and to transition toward an ambulatory-based healthcare delivery system. This is reflected in the increase since FY 1994 in the total number of outpatient staff visits, as depicted in Figure 8.

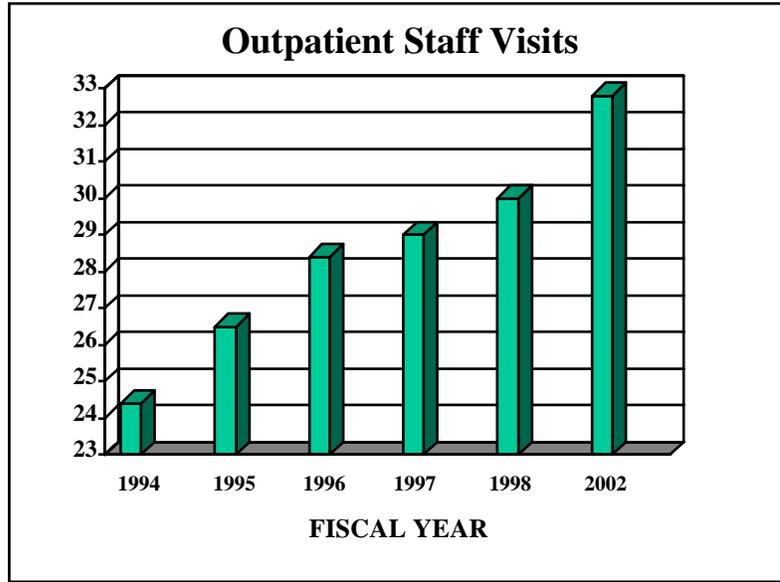
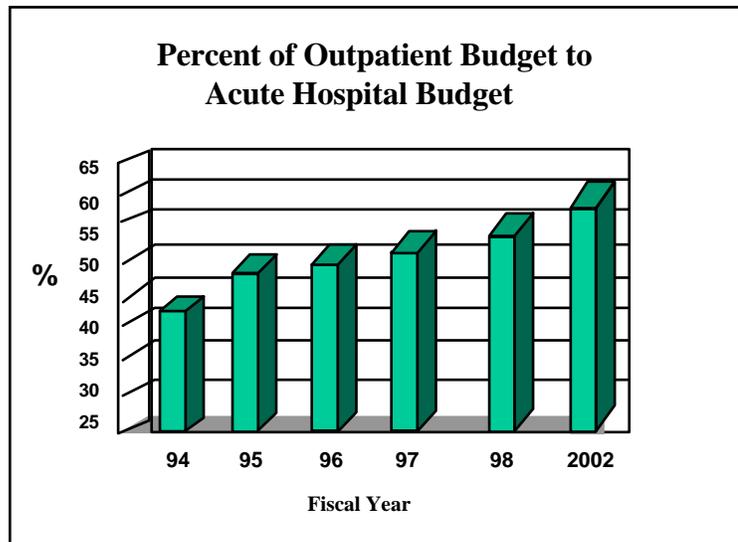


Figure 8



REALLOCATIONS TO OUTPATIENT CARE

VHA has made progress over the last several years in increasing the percentage of funding spent on outpatient care vs. acute hospital care, as shown in Figure 9. Also shown are an estimate for 1998 and a goal for 2002.

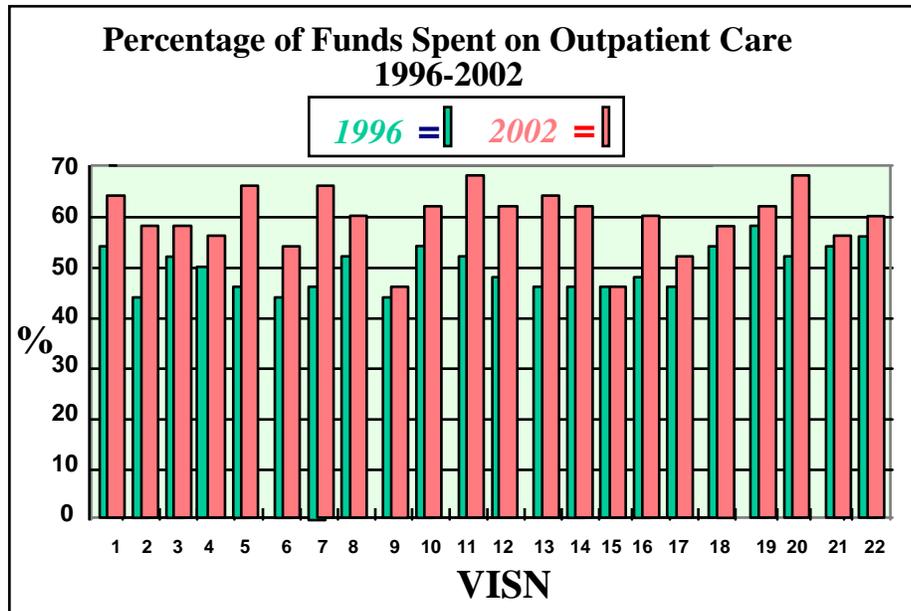


FY 1998 is an estimate. FY 2002 is a goal.

Figure 9

Networks In Action

- Figure 10 illustrates strategic projections (goals) by network which continues this progress.



FY 2002 is a goal.

Figure 10



DECREASE BED DAYS OF CARE

Until more refined unit cost measures are identified and developed, VHA is using this measure as a proxy for the efficiency of its healthcare delivery system. The strategic target of a 30% cost reduction is supported by the 1997 annual performance measure of decreasing bed days of care/1000 users. The actions taken to date to reduce costs and maintain services have been effective. For example, as noted in Figure 11, the acute days of care per 1000 users declined by 11% from FY 1994 to FY 1995 and the rate of decline accelerated to 21% from FY 1995 to FY 1996.

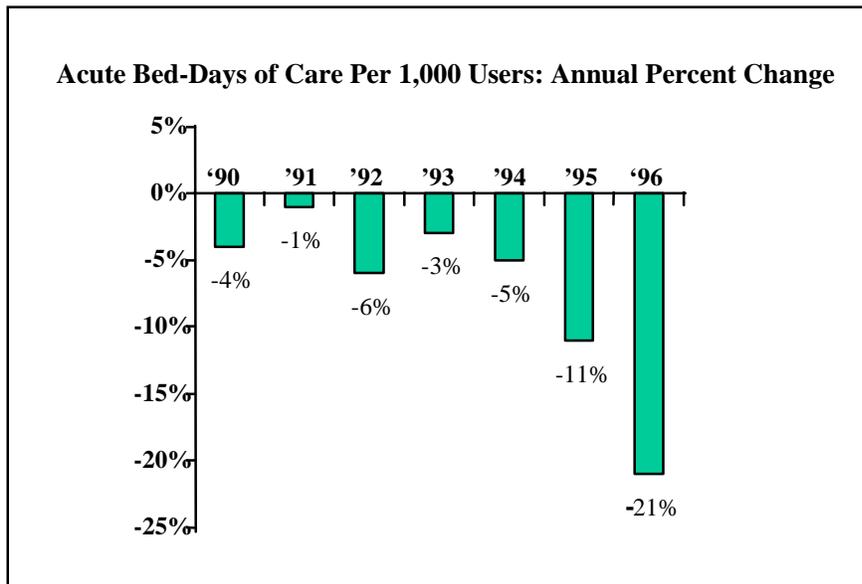
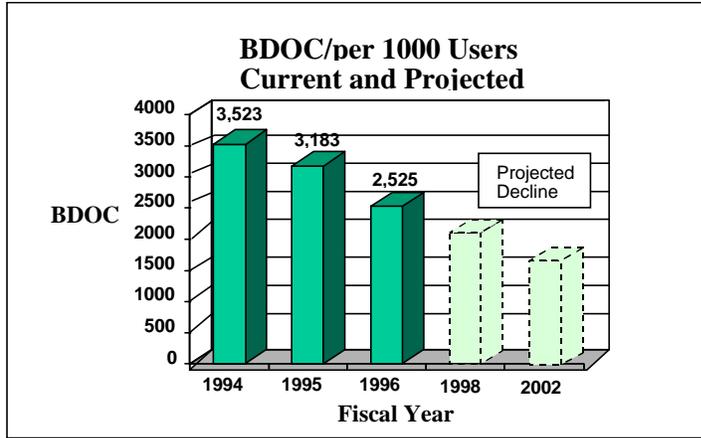


Figure 11

Nationally, the number of bed days of care per 1000 users of acute care facilities was 2,525 in FY 1996, 21% below the figure of 3,183 for the previous fiscal year. This proportionate change bettered the FY 1996 performance objective of a 20 percent decrease in this measure.

A concurrent increase in utilization of alternative settings such as ambulatory care is occurring (See Figure 8). Figure 12 illustrates the recent reduction in bed days of care per 1000 users and provides estimates for 1998 and strategic projections to 2002.



Source: FY 1998 Medical Care Appropriation Budget Request, FY 1994-1998
 Projected from Budget Request Data, FY 2002

Figure 12

Networks In Action

Plans by networks to reduce bed days of care can be seen in figure 13:

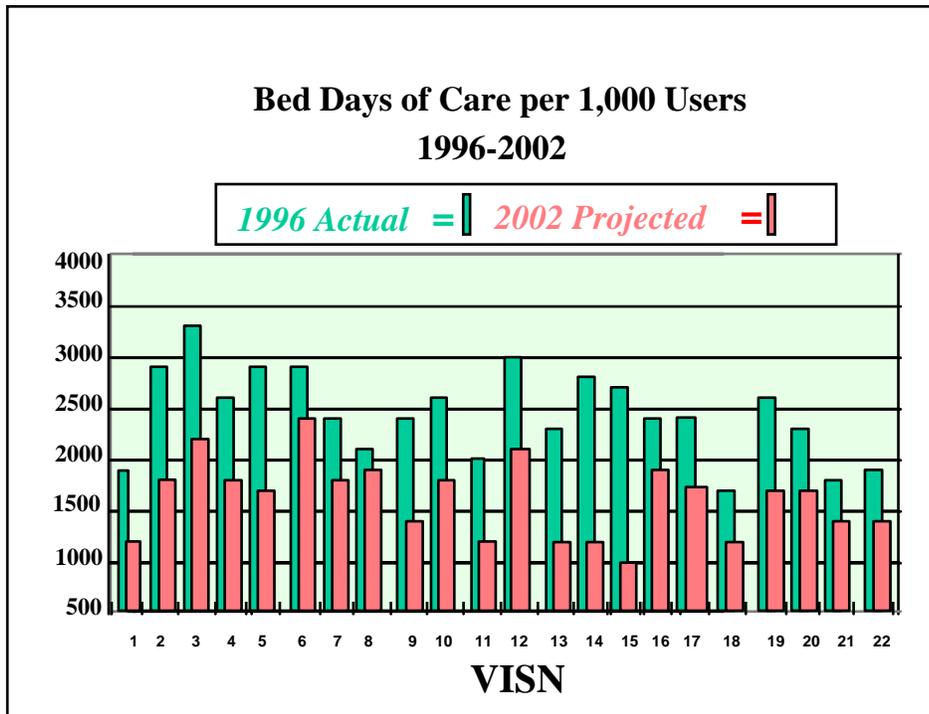
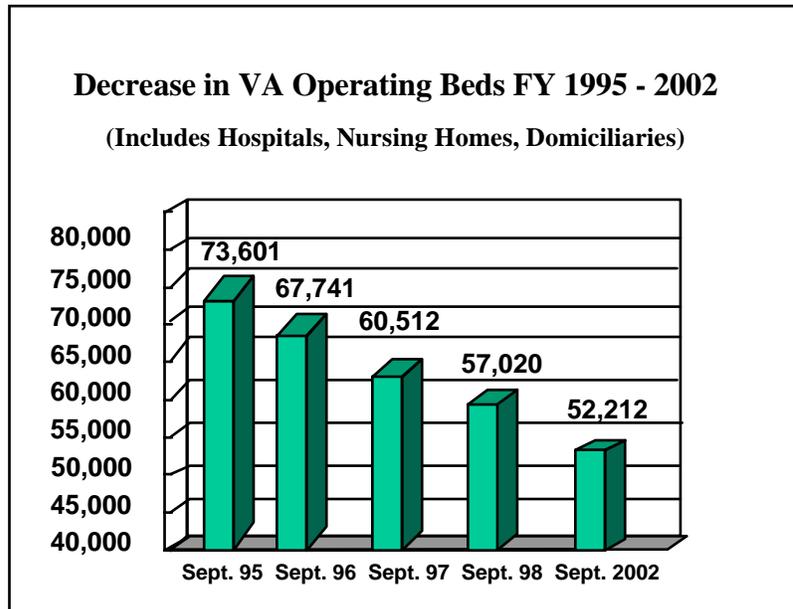


Figure 13



DECREASE OPERATING BEDS

A key strategy in moving toward a primary and ambulatory care focus is reducing the supply and utilization of beds. Since the end of FY 1995, VHA has eliminated 6,000 beds and has a goal to eliminate an additional 15,000 by FY 2002, resulting in an 18% decrease across the system. (see Figure 14).



Sept. 1998 is an estimate. Sept. 2002 is a goal.

Figure 14

Networks In Action

Examples by networks to decrease operating beds include:

- Geriatric programs will be combined into a separate service line and the network will emphasize non-hospital, community-based long term care (Network 3)
- Almost all Networks have shifted inpatient post-traumatic stress disorder programs (PTSD) and substance abuse programs to a less costly, but clinically effective, mode of care (i.e. residential care or short term inpatient settings)
- Implement home-based care at all facility locations within the network (Network 12)
- Indianapolis VAMC has implemented significant bed reductions (Network 11)
- Augment Geriatric Evaluation and Management Program (Network 2)



INCREASE AMBULATORY SURGERY

The common standard of practice is to perform appropriate surgical and invasive procedures in the ambulatory care setting. In 1994, VHA performed only 35% of surgeries in an outpatient setting. In 1995, this increased to 39%. In FY 1996, 52% of potential ambulatory surgeries and invasive procedures were done in ambulatory settings, reflecting a 33% improvement from the previous fiscal year, as shown in Figure 15.

Percent Surgeries and Invasive Procedures Done in 1996 in an Ambulatory Setting

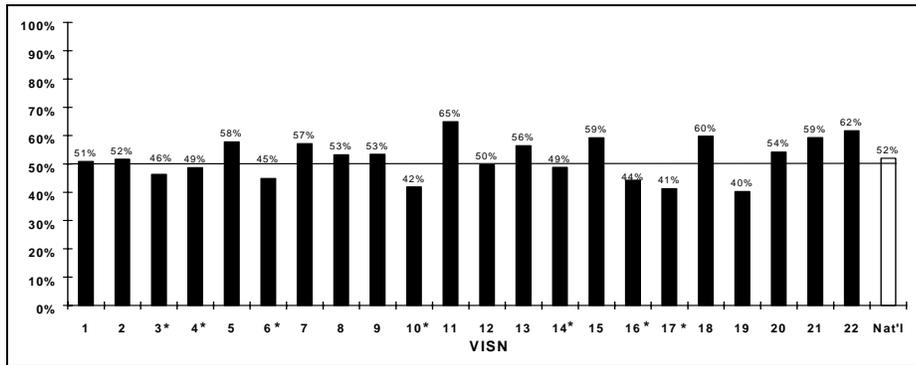


Figure 15

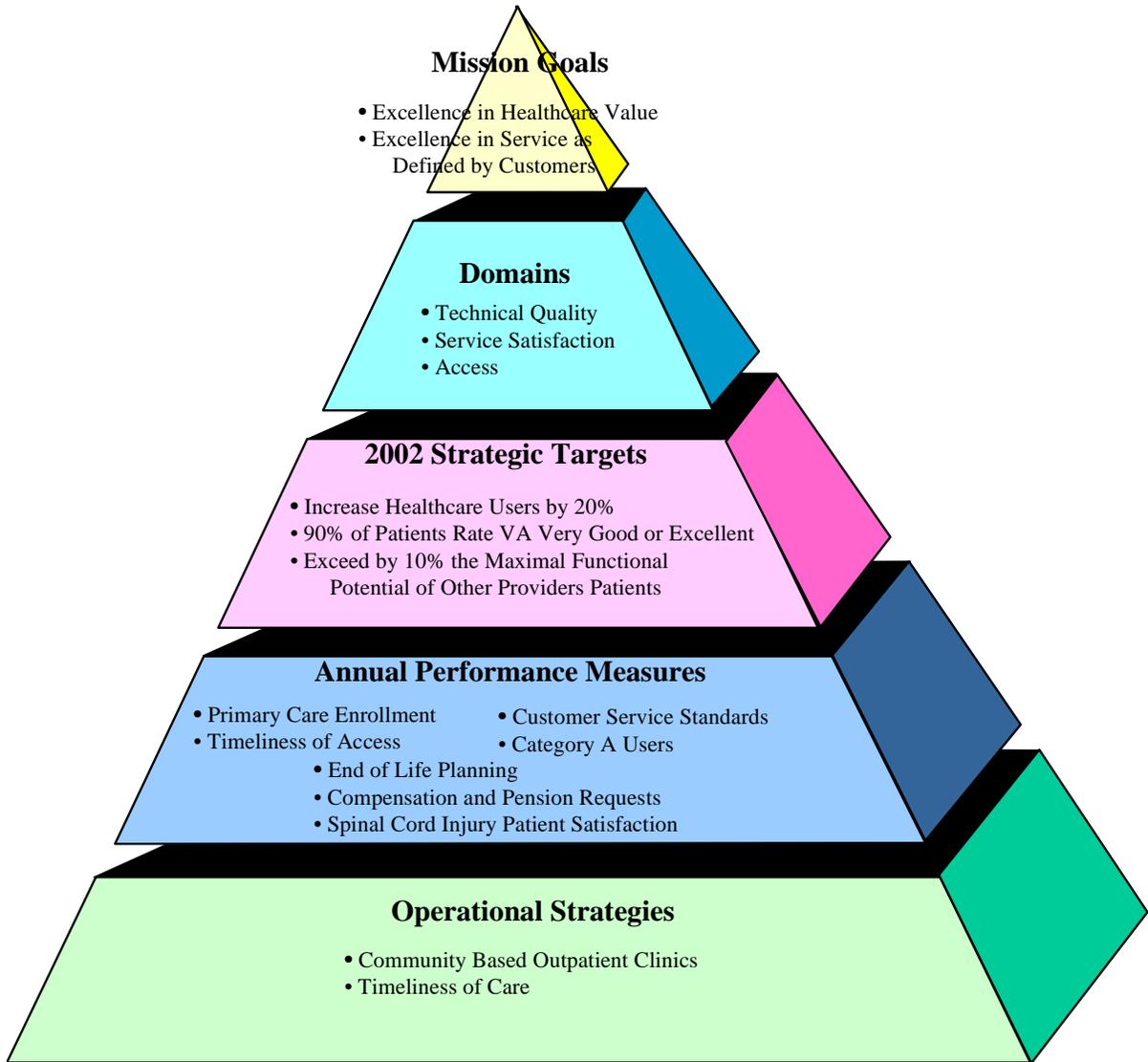
The FY 1997 target is to increase the level of ambulatory surgical and invasive diagnostic procedures to 65%.

Networks In Action

- Expand ambulatory surgery programs (Networks 15, 21)
- Performs 36% of cardiac catheterizations on an outpatient basis and targets 40% for FY 97 (Network 11)
- As of the end of FY 1996, 55% of procedures are being performed appropriately on an ambulatory basis (Network 6)

CHAPTER 7: IMPROVE ACCESS TO CARE

Improve Access to Care



The *Prescription for Change* states that an objective for VHA is to increase accessibility to services, especially for targeted at risk veteran groups. VHA has taken several important steps to improve access to VHA healthcare facilities and to upgrade the delivery of care within facilities. Access is an annual performance measure as well as a Domain of Value. One of the most important advancements was the Veterans Healthcare Eligibility Reform Act, PL-104-262, which provides significantly enhanced contracting and sharing authority that will enable VHA to bring services closer to the patient.



COMMUNITY BASED OUTPATIENT CLINICS (CBOC)

A Community Based Outpatient Clinic (CBOC) is a VA operated clinic (in a fixed location or mobile) or a VA funded or reimbursed health care facility or site that is geographically separate from a parent medical center. The passage of the Veterans Health Care Reform Act of 1996, PL-104-262, in October, 1996, expanded VA's authority to contract with community providers for the sharing of health-care services. Medical centers are no longer restricted to contracting only for specialized medical resources, but are now able to contract for primary care and/or for a CBOC.

CBOCs are a vehicle for serving eligible veterans more efficiently and effectively. Such clinics will facilitate the transition of VA from a hospital, bed based system of care to a more efficient health care system rooted in ambulatory and primary care. Some of the specific desirable outcomes and goals which might result and should be sought from establishing a CBOC are:

- Improve the access of current users of the VA healthcare system who find it difficult due to geographic location or medical condition to travel to a VA medical facility;
- Redirect patients currently served at medical centers and thereby shorten waiting times;
- Improve the quality of care by promoting more timely attention to medical problems;
- Reduce the operating cost of providing care: i.e., provide care to existing patients at a lower cost by providing it in a community ambulatory care setting rather than a hospital-based clinic.

Networks In Action

- VHA has authorized networks to set up CBOCs in their jurisdiction with an annual operating cost, including lease, of up to \$1 million. Networks have responded by stating that they plan to submit proposals for approximately 130 CBOCs nationwide in FY 1997. Establishment of CBOCs is subject to endorsement by Congress, the availability of funds within the Network, and applicable federal statutes and VA regulations.
- Since March of 1995, 51 CBOCs have been endorsed by the Congress and are currently in various stages of activation (Figure 16). An additional 38 CBOC proposals were submitted for Congressional review in March 1997. VHA will continue to support the efforts of the Networks to activate the remainder of the CBOCs requested in FY 1997 as well as those projected for FY 1998.

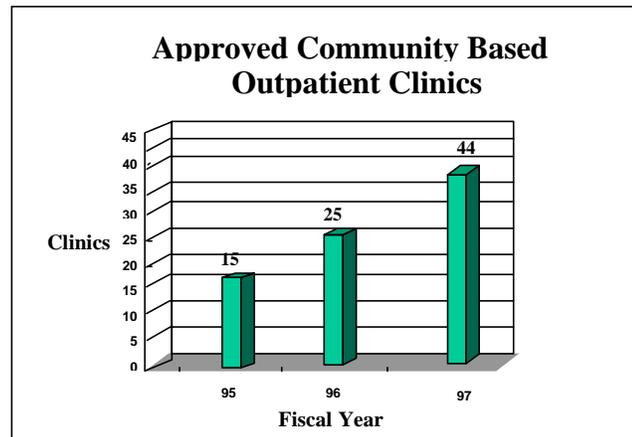


Figure 16

- Future demand for establishing CBOCs will continue to be determined in consultation with all concerned parties



TIMELINESS OF CARE

VHA has made a commitment to improve the timeliness of care provided to veterans in a variety of ways, such as:

- Establish a Telephone Liaison Program, whereby veterans can call medical centers to obtain advice and/or receive appropriate triage
- Ensure primary care clinic appointments within 7 days and specialty clinic appointments within 21 days
- Improve waiting times to see health care providers
- Decrease patient reported problems with access

Networks In Action

- Every network established Telephone Liaison programs in FY 1996
- Veterans received primary care appointments after an average median waiting time of 10 days and specialty clinic appointments within 5 days. Results by network are depicted in Figure 17

Median Number of Days Primary and Specialty Clinic Appointments in 1996

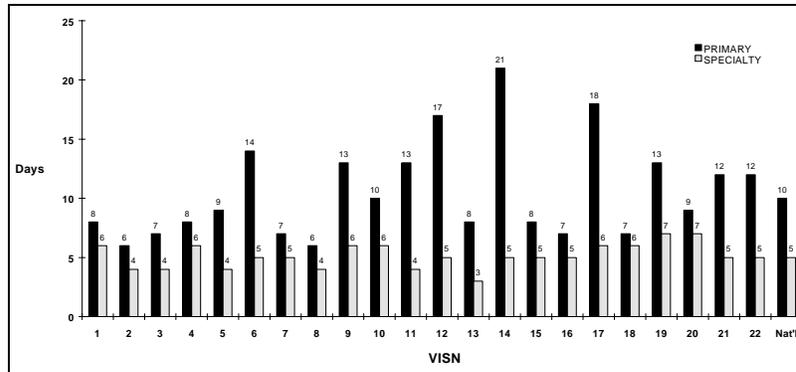
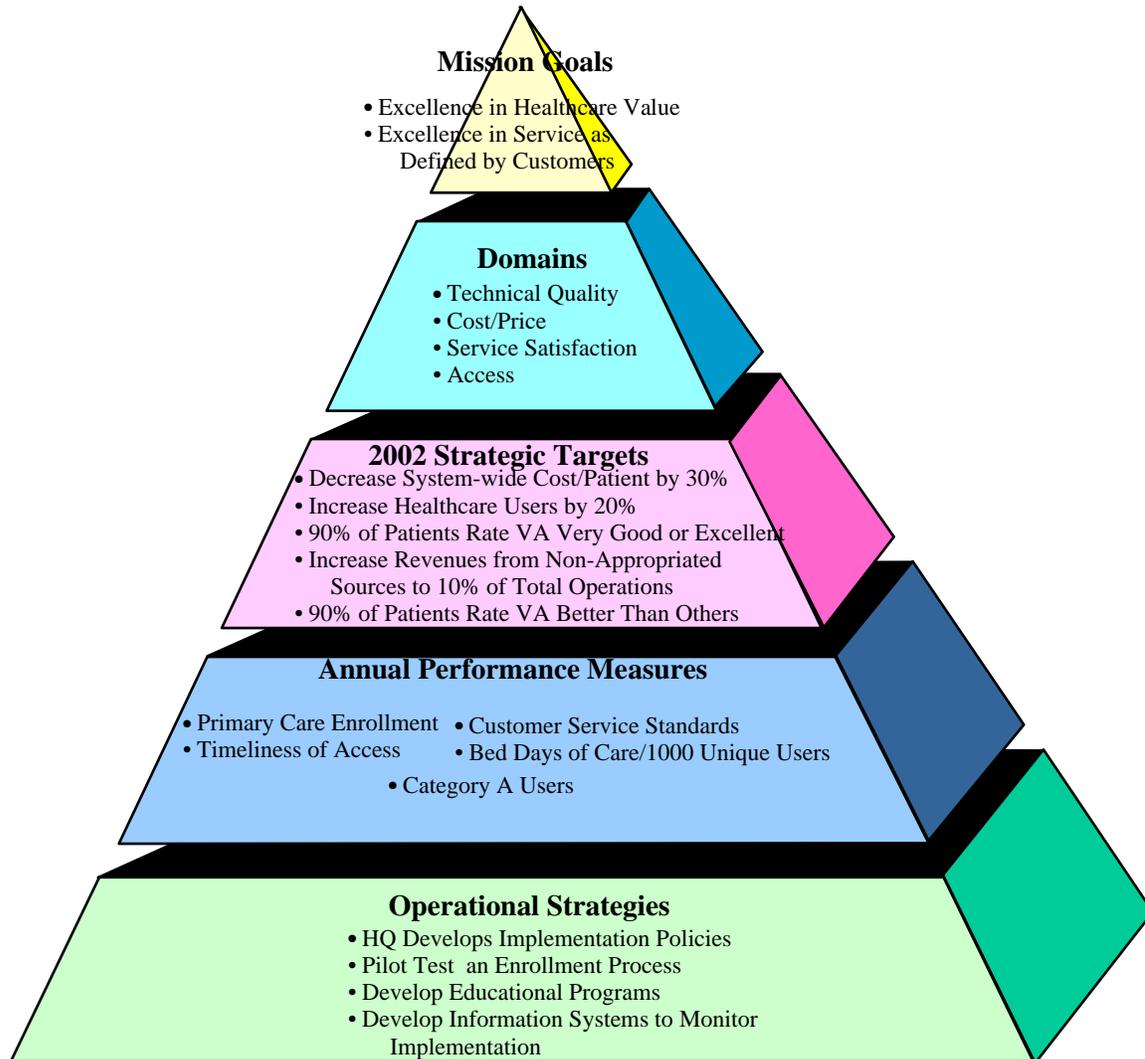


Figure 17

- Implement improvements in network transportation systems for patients, staff, and families to improve access to VHA facilities and planned community-based outpatient treatment in partnership, where applicable, with the Disabled American Veterans transportation network (Networks 1, 3)
- Implement a new and improved patient shuttle system in 1997 (Network 5)
- Establish Vet Center clinics and mobile clinic screening programs (Network 16)
- Expand mobile diagnostic services throughout the network (Network 2)
- Implement a DHCP program to consistently measure waiting times and implement CBOCs to ease appointment backlogs in hospital-based settings (Network 12)

CHAPTER 8: ELIGIBILITY REFORM

Eligibility Reform



VHA has advocated eligibility reform because existing eligibility rules were too complex and difficult to administer. The 104th Congress responded by passing Public Law 104-262, “**The Veterans Healthcare Eligibility Reform Act of 1996.**” The new authority reinforces our intent to restructure veterans’ healthcare by permitting VHA practitioners and managers not only to better organize patient care, but also to organize all VHA care more efficiently.

The law contains the following specific provisions:

- Makes the eligibility rules the same for both inpatients and outpatient
- Establishes two eligibility categories, to the extent appropriations are available: Veterans to whom:
 - First:** VA “shall” furnish needed care
 - Second:** VA “may” furnish care based on resource availability and copayment by the veterans
- The Law makes eligibility rules the same for both inpatient and outpatient. Thus VA will no longer have to needlessly admit patients and will be able to treat them sooner and closer to where they live in an efficient and cost effective manner.
- The law requires VA to manage the provision of VA hospital care and medical services through an annual patient enrollment process that is reflective of the priority system set forth in this law. Starting October 1, 1998, the veterans not enrolled can be denied care with few exceptions.
- The Act also directs VA to maintain its current capacity with reasonable access to care to treat disabled veterans requiring specialized treatment.
- Clarifies VA’s authority to provide preventive services to veterans not otherwise receiving care
- Eliminates certain restrictions on furnishing prosthetics for non-service connected disabilities to veterans receiving outpatient care
- Expands sharing authority to include any health care service, health care support or administrative service
- Expands potential sharing partners to include health care plans and insurers, organizations, institutions, entities or individuals involved in furnishing health care resources
- Allows VA to develop a simplified procurement process for sharing agreements

The following decisions have been made by the Under Secretary for Health regarding major requirements of Eligibility Reform. During FY 1997, headquarters will be issuing guidance, regulations and implementation instructions for the following:

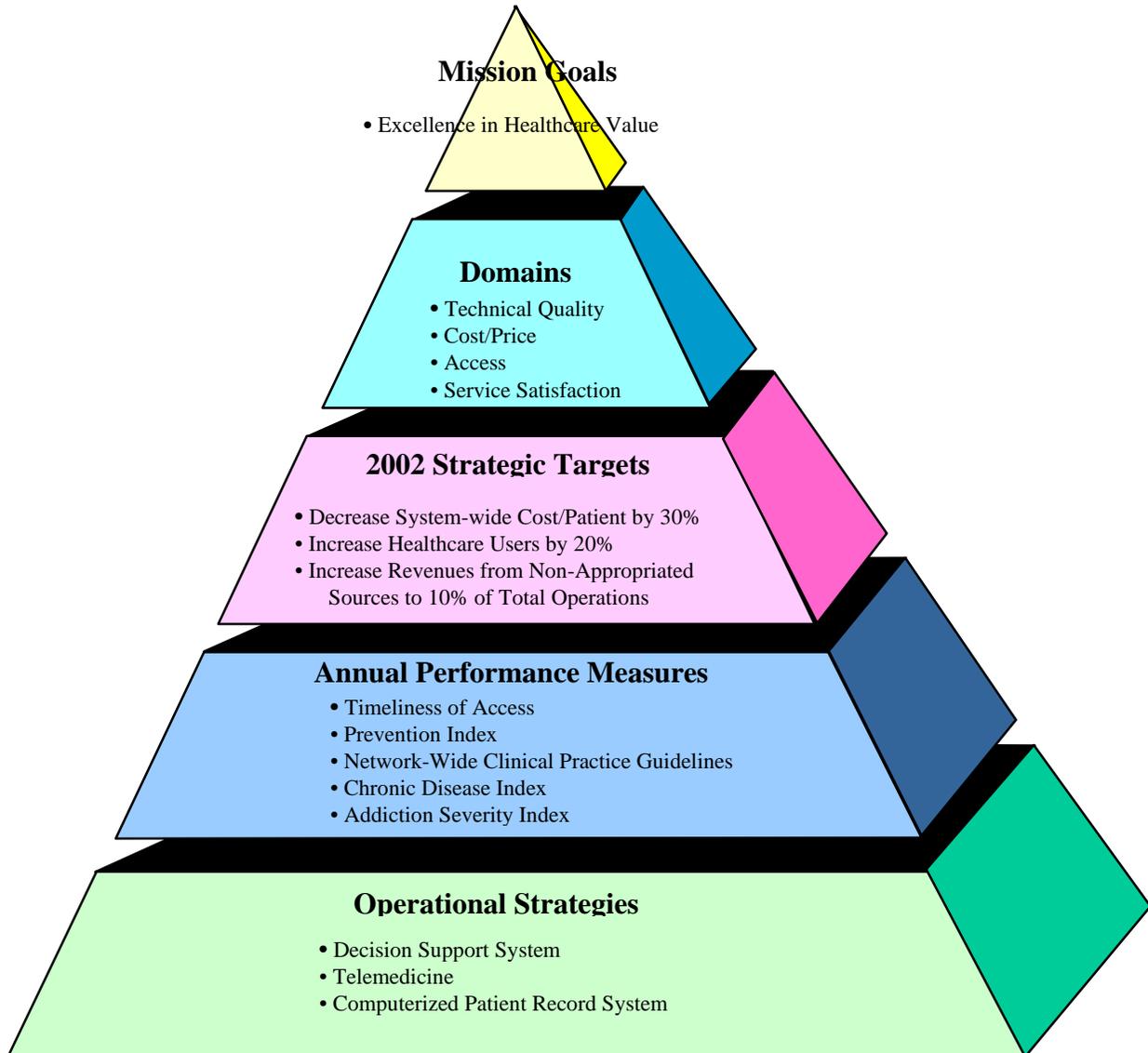
- VHA will adopt a uniform benefit package throughout VHA for all 22 networks. A uniform benefits package is intended to ensure all veterans cared for by VA will receive a consistent level of quality care and services regardless of the VISN providing the care. The benefits package will specify inclusions and exclusions of various health care benefits. The networks are expected to have services available by October 1, 1998 when the enrollment system must be in place.
- In order to prepare for enrollment starting October 1, 1998, a nationwide test will be conducted for one year starting October 1, 1997. Software specifications are being developed to support central data needs for implementing enrollment including assigning enrollment priorities centrally. An open ended, “rolling” enrollment system will be implemented to allow enrollment throughout the fiscal year. Veterans who received care during the previous 12 months will be enrolled automatically.
- VA has identified six special disability veteran groups, i.e., spinal cord dysfunction, amputations, blindness, mental illness, PTSD and TBI for which the current national capacity will be maintained. For next two years capacity will be measured in terms of workload (unique social security numbers) and resources i.e., dollars, beds, and FTEE. By October 1, 1998, functional outcomes and quality measures will be developed and implemented as a measure of capacity in lieu of workload and resources. Access will be measured as timeliness and use of market penetration and travel time will be investigated for the future.
- The policies to guide the implementation of new sharing authority, taking into account issues such as selling services, and the ability to collect from health plan sharing partners will be implemented in FY97.
- Employee Education service is developing educational programs and materials to provide the knowledge and skills required for implementation

Networks In Action

- Interest in eligibility reform has been very keen among the networks. Nearly every current network plan makes reference to the need to reconsider some network plan elements in the event that Congress acted, which subsequently occurred late in the session, by which time most network plans had been completed
- The FY 1998 network plans will fully incorporate Eligibility Reform

CHAPTER 9: ENHANCE INFORMATION SYSTEMS

Enhance Information Systems



Information systems are critical to restructuring the healthcare delivery system. Easy access to valid and reliable data for clinical and administrative decisions are key requirements. Effective telecommunication links clinical care, education and administrative systems so that specialized resources can be utilized throughout the system.

Chapter 9: Enhance Information Systems

A Telecommunications Strategic Plan (TSP) has been developed. The purpose of the TSP is to ensure that the telecommunications architectures, products, and services acquired and developed by VHA are responsive to VHA's validated business requirements. Three strategic goals have been identified for VHA telecommunications:

- Infrastructure Functionality: Ensure that VHA telecommunications systems are fully usable by, and accessible to, all customers authorized to use them
- Performance: Ensure that the performance of VHA's telecommunications infrastructure, in terms of both the availability and quality of the services that it provides, meets requirements
- Life-Cycle Cost-Effectiveness: Maximize the life-cycle cost-effectiveness of VHA's telecommunications infrastructure



DECISION SUPPORT SYSTEM

The Decision Support System (DSS) is a management information system that integrates cost, quality and clinical information into a patient-centered data base. It is used to improve strategic and operational decision making. It is the information infrastructure for data driven management decision making in the "new VHA." It enables accurate determination of the results of performance measurements.

DSS is a tool to analyze information on patterns of care and patient outcomes, which is linked to resource consumption and the costs associated with that care. This provides the potential to manage in ways not previously possible in VHA. Managers will now be able to readily perform functions such as:

- Accurately analyze efficiencies associated with moving resources from inpatient to outpatient services
- Determine product line costs and model increases or decreases in volume, changes in delivery methods, location of services and case mix changes
- Determine the marginal cost of services, which is critical in contract negotiations
- Track results of the use of clinical guidelines on cost and quality outcomes
- Accurately compare facilities and networks to determine best practices

The DSS program office strategy is moving from installation support to management training support. An educational program comprising four components, orientation, basic training, core training, and elective training, is being initiated in FY 1997.

Networks In Action

- Sixty-four medical centers have completed implementation of the DSS software. All sites will be fully implemented by July 1998
- In FY 1999, the DSS database will become the principal management tool for decision making on performance, budget and resource allocation
- Major planned efforts during 2000-2001 will focus on improving the system through offerings in curriculum, dissemination of case studies and information about best practices
- The first network that has fully implemented DSS is testing methods for rolling up facility data into a network database for use in network decision making (Network 13)
- All networks are attempting to speed up DSS implementation in order to utilize this tool



TELEMEDICINE

Telemedicine is a specific application which enables the practice of medicine in an environment that is independent of geographic or time boundaries. It accomplishes this by employing advanced data technology that permits the transmission of diagnostic and therapeutic imaging between facilities with no limitation on the geographic location of the patient or the practitioner. Telemedicine will facilitate interactions between VA physicians and other health care professionals dispersed across the networks. It will be particularly beneficial in communicating patient diagnostics from tertiary care VAMCs to rural clinics. Radiology, pathology, and dermatology are examples of medical specialties that will be provided away from existing medical centers via teleconferencing in order to increase access to patients and physicians. Medical consultations that occur will be of the following types: peer to peer, physician to patient, and physician to assistant.

Currently, several models exist for the practice of telemedicine and typically involve 1) a physician concentration of specialists in a single (campus) facility consulting via teleconferencing; and 2) specialists distributed throughout a region but logically concentrated around a telemedicine capability, i.e., physicians at one or more remote clinics running video-conferencing to a high resolution camera coupled to an ophthalmoscope.

Telemedicine is expected to provide the foundation for improvements in VHA's clinical practices, resulting in better care for veterans as summarized below:

- More timely and efficient access to patient care data at the point of care
- Improvements in patient satisfaction due to shorter turn-around times for test results, leading to faster diagnosis and treatment
- Capability for distributed imaging computing, allowing the medical staff access to patient imaging results from any location and increasing their ability to consult by providing simultaneous viewing
- Connectivity to other medical centers, educational networks, health care providers, and local governments, permitting VHA medical centers to provide real-time medical care to patients at remote locations, to share scarce medical specialties with other institutions, and to serve veterans better by providing ready access to information on available programs

Examples of Headquarters initiatives include:

- Dentistry has developed a model with designated hardware and software which totally support Teledentistry
- Guidelines for telepathology, telenuclear medicine and teleradiology are currently under development with a targeted completion in the fourth quarter of FY 1997
- Use of the Functional Independence Measure (FIM) will be available to all VAMCs effective April 1, 1997 (housed at Austin Automation Center)
- The Under Secretary for Health directed VHA to implement the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) in all VA Nursing Home Care Units (NHCUs) to facilitate comparisons of characteristics, outcomes and costs of care for VA NHCUs

Networks In Action

- All networks are reviewing/installing some form of telemedicine
- Network initiative to install Telepathology and Teleradiology (Network 22)

Chapter 9: Enhance Information Systems

- The network will further implement teleradiology, telepsychology, and teledermatology as soon as infrastructure improvements have been accomplished. A task force has been established to create a network-wide virtual imaging capability (Network 5)
- In conjunction with DOD and the Texas Technical University, telemedicine capabilities are being provided at three of the network's facilities (Network 18)
- In cooperation with Ohio State University and the PVA, the network is installing desktop video conferencing in all facilities (Network 10)
- Install telemedicine technology in support of reengineering laboratory services and pathology processes (Network 2)
- Install videoconferencing at all five medical centers (Network 2)
- Telepathology initiative between Iron Mountain and Milwaukee received a Hammer Award (Network 12)



COMPUTERIZED PATIENT RECORD SYSTEM

The Decentralized Hospital Computer Program (DHCP) is in use at every VHA medical center and is one of the largest and most comprehensive integrated health information systems in the country. VHA has been pursuing the automation of medical care for years and has made a commitment to this pursuit by developing software to improve the quality and efficiency of healthcare with a Computerized Patient Record System (CPRS). This system organizes and presents all relevant data on a patient in a way that directly supports clinical decision making. This data includes medical history and conditions, problems and diagnoses, diagnostic and therapeutic procedures and interventions. The goals of CPRS are to:

- Improve the efficiency of entering orders
- Improve the accessibility of on-line clinical information and results
- Provide a complete mechanism to more closely follow the “authorization” level of the user
- Enhance patient/provider linkage
- Support for specific patient events
- Develop an integrated discharge utility
- Provide a consistent, event-driven, windows-style Clinical User Interface

Some supporting modules for the system include Radiology/Nuclear Medicine, Laboratory, Inpatient and Outpatient Pharmacy, Adverse Reactions Tracking, Dietetics, Patient Information Management System, and Imaging. These modules are in various stages of development and implementation in the medical centers.

Some of the ways that this system improves the quality of care for patients is by:

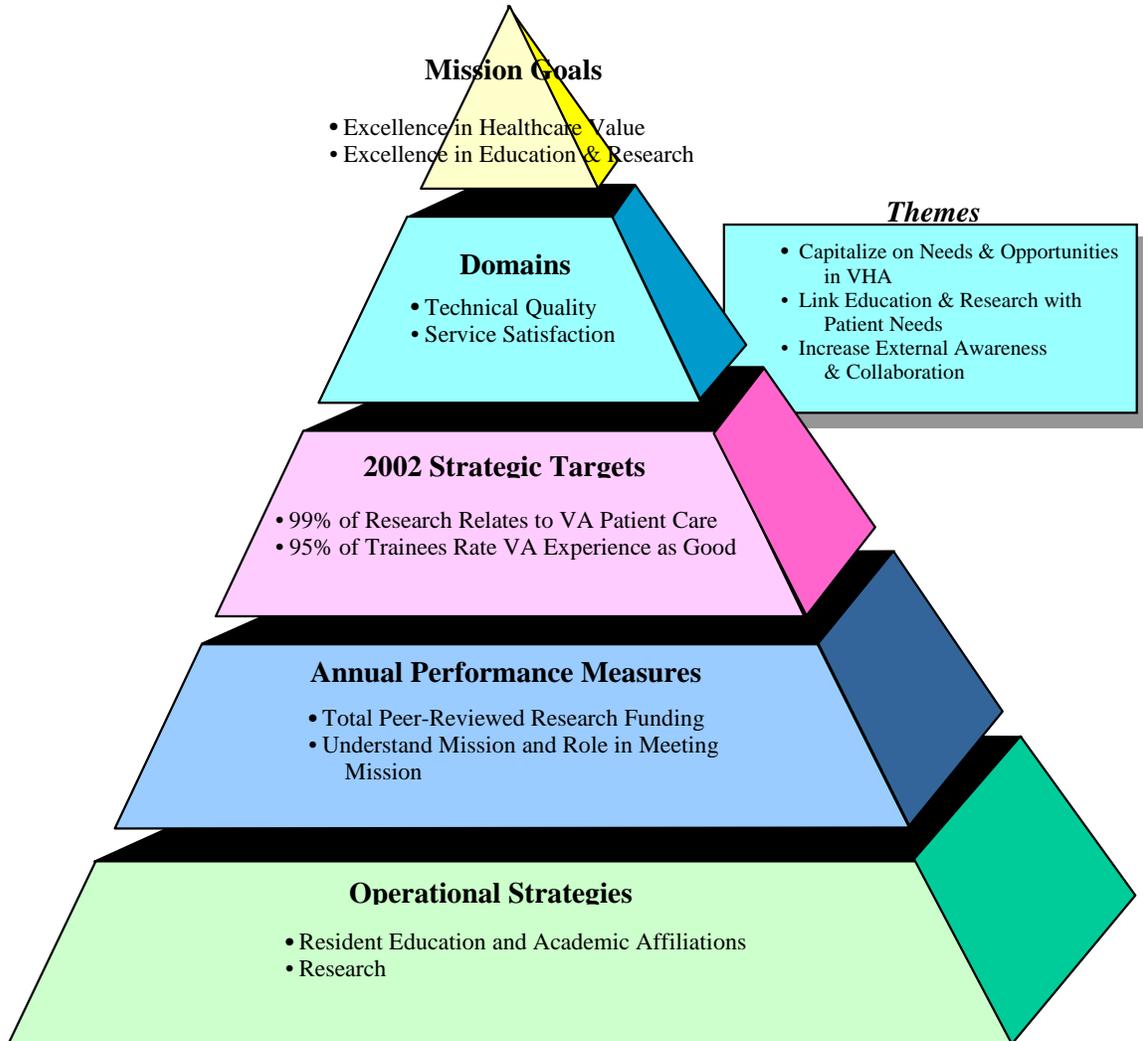
- Pre-defining and personalizing complete order sets and integrating them with progress notes, results, procedures, diagnosis, and problem lists
- Extracting DHCP data
- Electronic signature and co-signature routing
- Linking patients to teams, attending physician, and primary care providers
- Linking to scheduling for new appointments, canceled appointments, and an auto-rebook function which cancels and re-orders tests and procedures
- Minimizing redundant entry of information during discharge process
- Improving clarity and reduce ambiguity through one clinical user “front-end”

Networks In Action

- VHA is actively pursuing an Ambulatory Care Data Capture Project which establishes “industry standard” ambulatory care data, capturing diagnostic and procedural codes and provider specific information. The standardized collection of ambulatory care data supports continuity of care, quality management, resource allocation and medical care cost recovery.
- Implementing a network-wide computerized patient record system (Networks 12, 17)
- Expedite development of uniform electronic medical record accessible from all access points (Network 21)
- Network is conducting the national Alpha testing for the Clinical Information Resources Network software product that provides a view of the patient’s care across all treatment sites (Network 8)
- Locally developed Graphical User Interface for DHCP is nearing completion and will be pilot tested in one VAMC in FY 1998 (Network 16)
- Implement Ambulatory Care Data Capture at all facilities (Network 2)

CHAPTER 10: LINK EDUCATION AND RESEARCH TO PATIENT CARE

Link Education and Research to Patient Care





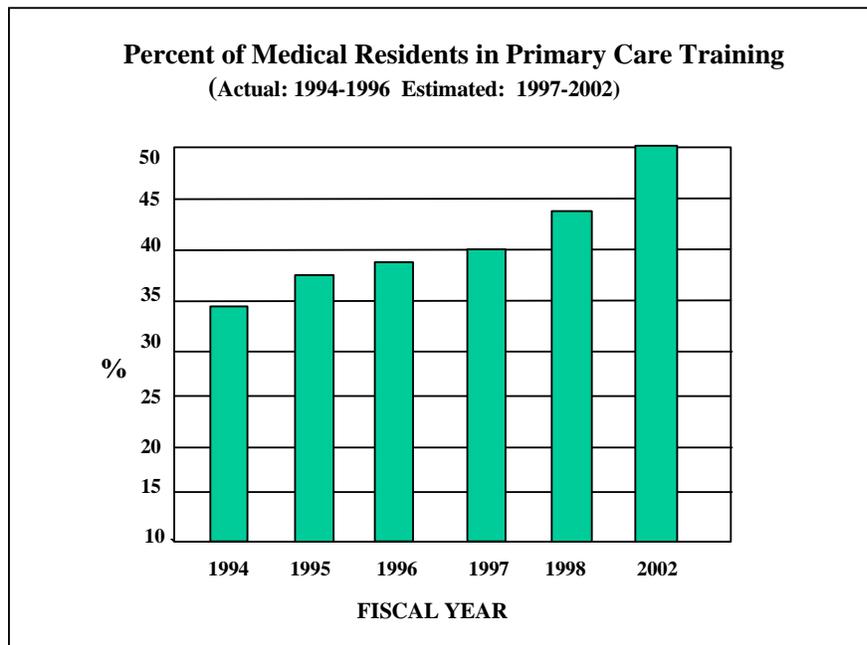
RESIDENT EDUCATION AND ACADEMIC AFFILIATIONS

Strategically, VHA is redirecting educational resources to primary care and renegotiating affiliation agreements to assure they match the strategic goals and objectives of this plan. Building on the long-standing, close relationships between the VA and the nation's academic institutions, VHA seeks to play a strategic leadership role in reshaping the education of future healthcare professionals. This is critical to having quality staff to meet primary care enrollment and care delivery.

In FY 1996, the Under Secretary for Health appointed a Residency Realignment Review Committee to advise on realignment of VHA's medical residency programs to ensure that they meet the present and future healthcare needs of both VHA and the nation. The committee made the following recommendations regarding primary care that have been adopted by VHA:

- Fill 50% of resident positions in primary care
- Reallocate 750 specialty resident positions to primary care
- Eliminate an additional 250 specialty residency positions

The 2002 objective to train 50 % of medical care residents in primary care demonstrates how VHA's mission for education supports its primary goal of patient care (Figure 18).



FY 1998 is an estimate. FY 2002 is a goal.

Figure 18

In conjunction with our effort to move forward with formulation of the healthcare system for tomorrow, VHA will review and renegotiate all of its academic affiliations over the course of the next two years and issue new signed affiliation agreement documents. The review and renegotiation process is not an end unto itself. It is anticipated that it will be the basis for long-term planning for academic affiliations with medical school partners. National principles to be used in this process are:

Chapter 10: Link Education and Research to Patient Care

- Healthcare workforce training, medical education, and research are most beneficial to patient care and most valuable to learners when they are aligned with the best models of patient care
- Education and research should be accountable to the healthcare system's needs. Accordingly, they should be managed with performance expectations and outcome measures
- VHA's educational offerings should emphasize areas of greatest need to veterans and those of society. They should be especially concentrated in areas for which VHA has special expertise. The numbers and types of healthcare professionals should be determined by the needs of the system and the needs of the nation
- Academic affiliation agreements with VHA should be fair and equitable to all parties

Networks In Action

Network plans reflect the national strategy to systematically redirect residency training positions to primary care. They reflect the attention being paid to affiliations as a partner in redirecting the system to primary care and maintaining necessary specialty care. Collaboration throughout the networks to achieve this goal are reflected in their plans:

- All Networks are reducing subspecialty and increasing primary care training positions
- Realign residencies and re-negotiate affiliation agreements (Networks 2, 6)
- Plan to involve affiliates in reengineering processes in FY 1998-99 (Network 21)
- With affiliate, continue "Medical Education Rounds" program geared for rural, primary care physicians and the needs of Bath's practitioners (Network 2)
- Assess all affiliation orientation programs for effectiveness and maintain effective training through resident supervision and monitoring of attending physicians' supervisory skills (Networks 15, 16)
- Establish a residency allocation committee to review reallocation of residency positions within the Network (Network 16)



RESEARCH

The research program goal is to discover knowledge and create innovations to improve the health and care of veterans and the nation. Program objectives are:

- Create and maintain a sound infrastructure for the research program in VHA
- Ensure that the research program is responsive to the needs of the veteran and VHA
- Appropriately balance basic, applied and outcomes research
- Expand collaborative investigative efforts with government and non-government entities
- Maximize special research opportunities available in VHA

While the total number of projects funded and the number of new projects funded continue to be performance measures, the percentage of proposals in Designated Research Areas (DRA) and the number of investigators receiving funding from VHA or non-VHA sources have been added as additional measures.

External funding and collaboration will be measured by the percent of projects and the percent of funding from extramural sources and the number of collaborative agreements with other government or private sector organizations. Together, these performance measures demonstrate the alignment of research with VHA healthcare needs and our linkage to external funding and collaboration.

Performance measures are also being developed which will address the program objective of capitalizing on the special research opportunities available to VHA. These include increasing the awareness and understanding of

Chapter 10: Link Education and Research to Patient Care

VHA's role in healthcare education and research, and demonstrating the rapid operationalizing of VHA-sponsored and conducted research supporting VHA policies and procedures.

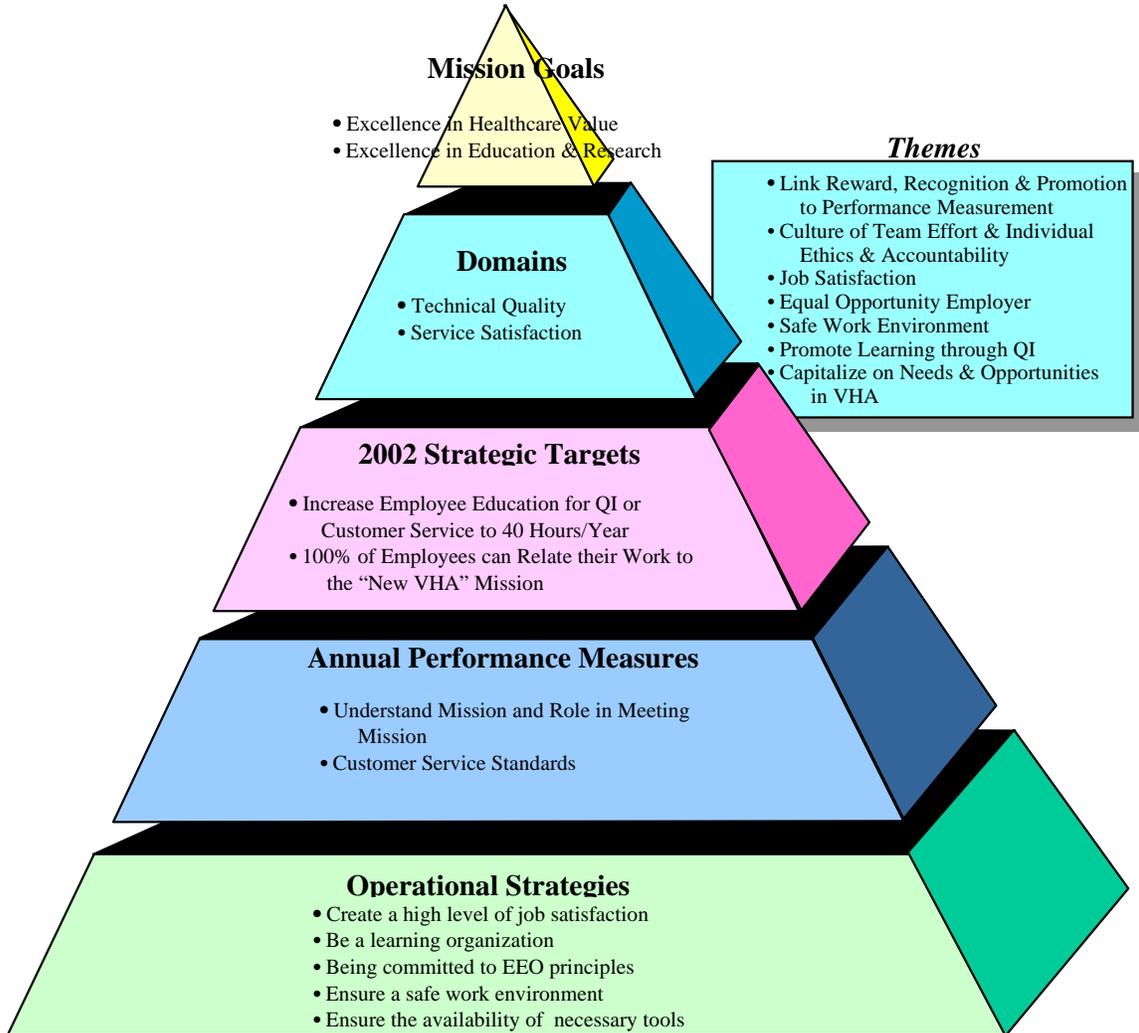
Network plans describe a variety of actions to focus research on the priority healthcare needs of veterans. They consider research as a strategy to build the knowledge necessary to improve the capability of networks to better serve veterans.

Networks In Action

- During FY 1997, a Research Advisory Council will institute the network's strategy (Networks 1, 3)
- Product line management to be studied as part of an HSR&D project (Network 2)
- Increase in research funding by 10% and the establishment of new network centers of research excellence (Network 2)
- VAMCs who do not have research corporations will establish them in FY 1997 (Network 8)
- Develop a Clinical Information Resources Network [CIRN] (Network 11)
- Develop and implement a network health services research strategic plan (Network 14)
- The network will emphasize research in line with the national trends of primary care, systems analysis, outcomes research and healthcare guideline development and capitalize on the special research opportunities available through its two Spinal Cord Injury Centers and Geriatric Research Education and Clinical Center (Network 17)

CHAPTER 11: EMPOWER EMPLOYEES

Empower Employees



Vision for Change recognized that “cutting red tape and micro-management, putting customers first, and empowering employees to get results by delegating authority and responsibility” would be essential to creating a new veterans healthcare system.

The *Prescription for Change* states that “Well-trained and empowered employees are more likely to provide high quality service, innovate and be maximally productive.” This is why VHA elected to set “Mission Goal 5: Be an Employer of Choice” as one of its long-term corporate goals.

Chapter 11: Empower Employees

Giving employees increased levels of responsibility to work more independently has certain preconditions. The ***Prescription*** let VHA executives know that as a minimum this involves:

- Creating high level job satisfaction
- Being a learning organization
- Being committed to the principles of equal opportunity
- Ensuring that employees have the necessary tools
- Maintaining a safe working environment
- Minimizing the effects of reductions in force
- Ensuring a secure work environment

The Under Secretary for Health also recognized that job satisfaction depended on employees knowing what was expected from them and what measures would be used to evaluate individual and group performance. As the pyramid depicts on the previous page, to satisfy this need, in addition to the Mission Goals, VHA is promulgating the 2002 Strategic Targets and annual performance measures. Now that headquarters and VISN staffs have been empowered with more authority, it is up to them to decide how best to live up to the new responsibilities.

Networks In Action

The networks responded to the Under Secretary's challenge in a number of ways. In general, networks intend to:

- Implement individual and group performance measurement systems
- Empower employees through the use of new organization models (service lines)
- Educational offerings designed to further the concepts of the new VHA culture
- Expand the use of information technologies, telemedicine or automated medical records, to increase employee versatility and productivity within a team environment

The Office of Employee Education is also responding to the Under Secretary's challenge to make employees more productive:

- Total Quality Improvement (TQI) educational courses are available
- TQI performance framework emphasizes that individuals and teams are the best locus of process redesign (a course on Self Directed Work Teams)
- Baldrige performance excellence criteria that emphasize the linkage of all employees to the goals and objectives of the organization.

Decentralization and the consequent need to empower employees individually and collectively is not an easy process. The fundamental challenge is to preserve the VHA national organized system of care but be flexible enough to encourage innovation and entrepreneurial activity.

CHAPTER 12: SPECIAL PROGRAMS

Program Designation

VHA has designated certain clinical activities for “special program” status. Typically, these are clinical services that address illnesses specific to the service-connected veteran population or are areas of special VHA expertise. The plan to restructure the VHA identified 12 special emphasis programs:

Blind Rehabilitation
Geriatrics and Long Term Care
Homelessness
Persian Gulf Veterans Programs
Post Traumatic Stress Disorder
Preservation Amputation Care and Treatment (PACT)
Prosthetics and Orthotics
Readjustment Counseling
Seriously Mentally Ill
Spinal Cord Dysfunction
Substance Abuse
Women Veterans Programs

The designation was made with the understanding that the list is likely to evolve over time. It was recognized early that each would have to have the special attention of management in headquarters and in the field. A project to develop measures to monitor special emphasis program resource allocation, performance and customer satisfaction with special emphasis services was undertaken by the Office of the Under Secretary. After extensive stakeholder consultation and input, the performance measures were promulgated in 1996.

Persian Gulf Syndrome

VA has initiated several programs to respond to the needs of Persian Gulf veterans including scientific research, medical care, disability compensation, and outreach efforts. VHA offers these veterans a free, complete physical examination with laboratory studies whether or not the veteran is ill. A centralized registry of participants, begun in August 1992, is maintained to enable VHA to update veterans on research findings or new compensation policies through periodic newsletters. This clinical database also provides information about possible health trends and may suggest areas to be explored in future scientific research. To draw definitive conclusions about the health of Persian Gulf War veterans, a carefully designed and well-executed research program is underway. VHA conducts wide-ranging research projects evaluating illnesses, as well as risk factors in the Gulf environment, spending more than \$3.6 million annually. The activation of four research centers has enabled VHA to broaden its activity from descriptive evaluations to greater emphasis on hypothesis-driven research. VHA also provides support in the claims processing of medical care provided to dependents of Persian Gulf War veterans.

In addition to the above, the Secretary, Department of Veterans Affairs, sits on the Persian Gulf Veterans Coordinating Board, which is also composed of the Secretaries of the Department of Defense and Health & Human Services. The Coordinating Board, established by the President in January 1994 to respond to the health problems of Persian Gulf veterans, maintains working groups that coordinate the federal response to

Chapter 12: Special Programs

Gulf War veterans' needs in clinical care, compensation, research, and other program areas. An interagency action plan, which was delivered to the President on March 7, 1997, calls for an ongoing commitment to revisit key issues and reshape the government's response as more is learned from research about the complex illnesses of Gulf War veterans.

Readjustment Counseling Services

VHA authorized readjustment counseling as a special emphasis program with a separate operating budget and line of authority for delivery of readjustment counseling through the community-based Vet Centers. Since inception, the Vet Centers have emphasized community-oriented, holistic services designed to assist veterans and family members access to available care. For many veterans, the Vet Centers are the community access point for VA healthcare and the point of after-care referral for veterans released from inpatient programs. Case management and coordination of care across the spectrum of needed services are well developed Vet Center functions. Vet Center community outreach and brokering of care provides the means for implementing the priorities of delivering timely and effective services to new eras of veterans and helping high risk groups such as minorities, women, the disabled, and high combat exposed veterans access to available services.

Planning for Special Emphasis Programs

In the *Prescription for Change*, VHA states that improving the accessibility, quality and cost-effectiveness of VHA's special emphasis programs will be one of the most urgent transformation objectives. It further identifies the development of facility-specific, network-specific and national performance information for clinical cohorts, service lines and special emphasis programs, along with VHA and non-VHA comparative information as important management objectives. In the 1996 network strategic planning guidance and in subsequent special guidance from the Under Secretary to key staff and line officials, VHA reiterated the Agency's commitment to preserve and enhance special services. Likewise, high on VHA's restructuring agenda has been the development of an equitable resource allocation methodology (VERA), which supports VHA's special emphasis programs. More needs to be done to constantly improve special emphasis programs. This will be done through close monitoring of the resource and program performance indicators by facility, network and headquarters officials.

In addition, the requirements of Public Law 104-262, Section 104, Management of Health Care, Section 1706 (b) (1) are reflected in the Network plans. According to this subsection, in managing the provision of hospital care and medical services, the Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans, both in a manner that affords reasonable access to care and services for those specialized needs, and ensures that overall capacity of the Department to provide such services is not reduced below the capacity of the Department, nationwide, to provide those services, as of the date of the enactment of this section.

Examples of Headquarters initiatives include:

- Obtaining Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation for all VHA rehabilitation programs by the year 2000. To date, five medical rehabilitation, pain and Traumatic Brain Injury (TBI) programs have received CARF accreditation
- All Spinal Cord Injury Centers (SCI) have been scheduled for CARF training this fiscal year
- SCI Centers will work with their respective SCI Outpatient Support Clinics, SCI Primary Care Teams, and SCI Coordinators to facilitate an efficient, coordinated and appropriate delivery of care, referred to as the "hub and spoke" model
- Homeless, Post Traumatic Stress Disorder (PTSD), Addictive Disorders and Seriously Mentally Ill programs will develop new demonstration models for their patient populations
- Under Secretary for Health directed VHA to provide data required to monitor performance measures for the Special Emphasis Nursing Home Care Programs

Network Strategic Plans Address Special Programs

Networks plan to protect the integrity of special emphasis programs and maintain current operating levels as mandated in the law while restructuring operations to provide more efficient delivery systems.

Networks In Action

The following is a general summary of actions planned by networks to maintain or strengthen special emphasis programs:

- Establish as a service line (Networks 3, 6)
- Combine with other service into a service line (Networks 2, 22)
- Improve access and linkage to other programs (Networks 1, 2)
- Appoint program coordinators (Network 1)
- Train/educate coordinators (Networks 4, 7)
- Establish network-level councils (Networks 8, 9)
- Shift more care to outpatient services (Networks 7, 10)
- Provide special services telemedical care (Network 10)
- Augment special services from community (Networks 5, 9, 16)
- Develop clinical guidelines (Networks 8, 9)
- Develop education and research ties (Network 5)
- Establish Special Emphasis Programs Clinical Advisory Board (Network 14)
- Establish hub and spoke system for SCI services (Network 20)
- Become member of the National Chronic Care Consortium (Network 2)

Commitment of network management is demonstrated by the appointment of network-level service line managers, and network-level councils and coordinators. It is noteworthy that certain special programs are organized as separate service lines. However, the special programs selected for service lines vary by network. It is characteristic of the realignment and restructuring of special emphasis programs that veterans have been actively involved in redesigning how they will function in the future.

Special Program Population

The size of the veteran populations requiring special services has been partially defined for six programs: Spinal Cord Injury/Dysfunction, Blind Rehabilitation, Traumatic Brain Injury, Post Traumatic Stress Disorder (PTSD), Seriously Mentally Ill, and Amputees.

<i>Program</i>	<i>Number of User Veterans</i>	<i>Period Used</i>
Spinal Cord Injury/Dysfunction	37,270	1988 - 1996
Blind Rehabilitation	25,925	1994 - 1996
Traumatic Brain Injury	3,710	1994 - 1996
PTSD	46,162	1996
Seriously Mentally Ill	271,126	1996
Amputees	10,748	1994 - 1996

Table 2

The SCI and TBI estimated user population is derived from special registers. The blind rehabilitation and amputee estimates were obtained from inpatient and outpatient files compiled to analyze the size of these two populations. In the future, VHA will continue to analyze the veteran population to more accurately establish the size of the pool of veterans who can benefit from special services programs.

Funding Special Programs

The Veterans Equitable Resource Allocation (VERA) methodology was created to support a number of VHA's goals. Among VHA's goals, the following have a direct impact on the funding of special emphasis programs:

- Treating the greatest number of veterans having the highest priority for healthcare
- Allocating funds fairly according to the number of veterans having the highest priority for healthcare
- Complying with Congressional mandate (PL 104-262)

The VERA methodology recognizes that VHA treats two sets of patients—those with special healthcare needs (Special Care) and others with “routine” care needs (Basic Care). Because there are two different types of patients, VERA will provide networks with a different national price for each type of patient. In this manner, networks will receive more equitable funding than in the past. In turn, networks must be able to demonstrate that the funds allocated for special services are used in proportion to the number of special service patients who need such care.

In summary, Special Programs remain in the focus of VHA healthcare delivery. The Under Secretary for Health has defined the development and maintenance of these services as a specific responsibility for both headquarters and field managers. The resource allocation system has been revised to ensure that special program services are maintained at the current level of performance or improved. VHA is defining the special veteran population to improve program development for special services. The Under Secretary has and will continue to emphasize stakeholder involvement in the planning and development of special emphasis programs.

PLAN CONCLUSIONS

This strategic plan identifies the accomplishments and future direction of VHA. The results accomplished and projected in the plan demonstrate improvements in cost, access, customer satisfaction and quality. This balanced approach to improvements, as indicated in the following figures, demonstrates internally and externally that a large, complex public system can change dramatically and systematically.

TIMELINESS OF ACCESS IS IMPROVING

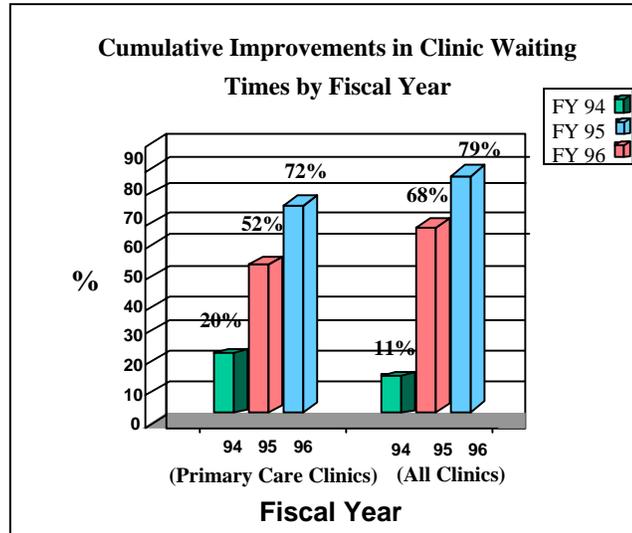


Figure 19

EVEN AS NEW USERS INCREASE

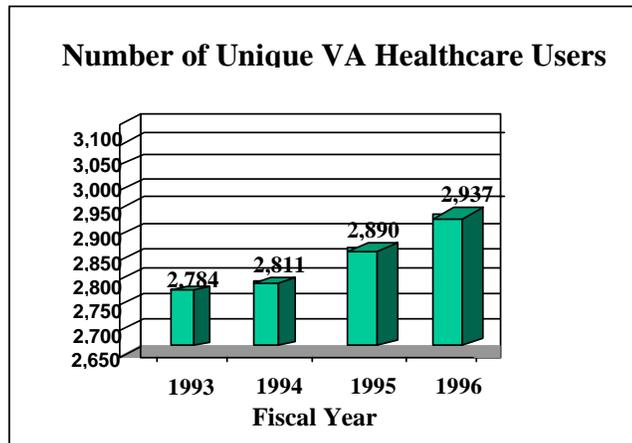


Figure 20

COST PER PATIENT IS DECLINING

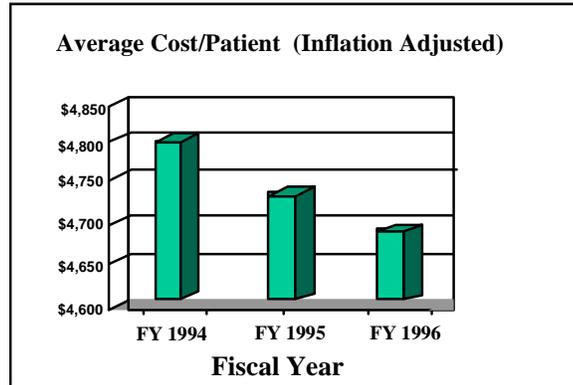


Figure 21

WHILE SATISFACTION IS IMPROVING

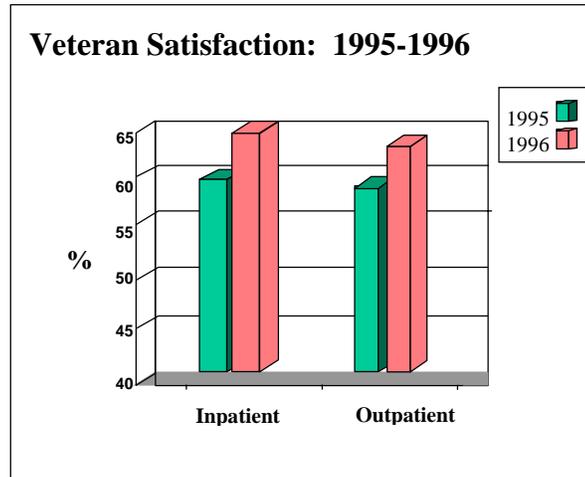


Figure 22

AND HEALTH CARE SERVICES ARE SHIFTING FROM AN INPATIENT TO AN OUTPATIENT SETTING

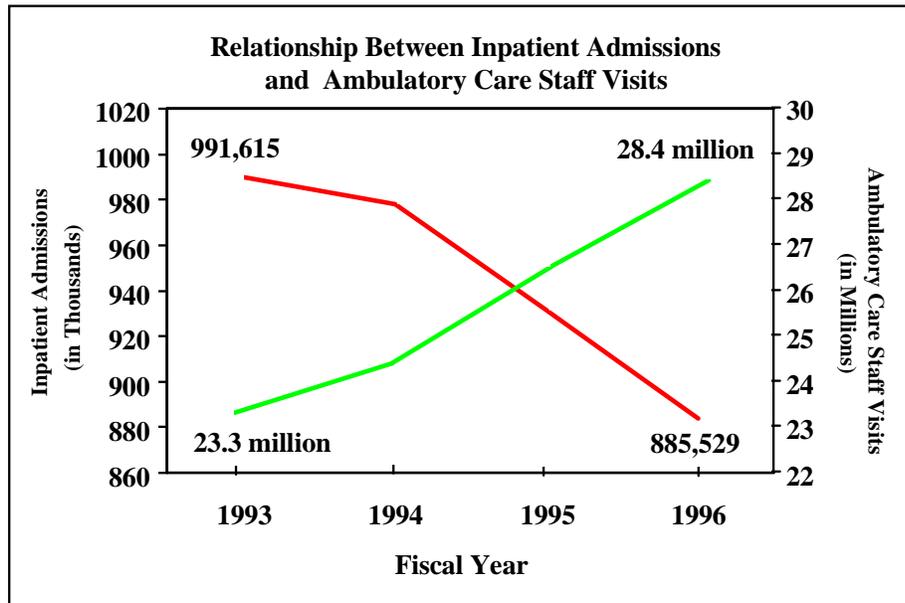


Figure 23

Perhaps even more important, the strategic management framework to align the organization to continue to improve and move in the direction outlined in the *Prescription for Change* is in place. Implementation and accountability for implementation, through aligned goals, domains, targets and actions, as illustrated in the pyramid below, will enable this systematic transformation to continue.



APPENDIX

APPENDIX A

STRATEGIC PLAN FEEDBACK QUESTIONNAIRE

Briefly answer the following questions so that we can improve the next strategic plan. Please send your comments on the form itself, or on another document, to the Under Secretary for Health, c/o Office of Policy, Planning and Performance (105) at 810 Vermont Ave. N.W. Washington D.C. 20420.

1. What parts of the plan did you find helpful in understanding how VHA is transforming its healthcare delivery system?

2. How could the plan be improved?

3. Other Comments