

# PLANNING FOR THE NEW MILLENNIUM

## VHA SUMMARY OF NETWORK STRATEGIC PLANS



**DECEMBER 1999**

**VETERANS HEALTH ADMINISTRATION  
OFFICE OF POLICY AND PLANNING (105)  
HEALTHCARE ANALYSIS & INFORMATION GROUP (HAIG)**

# Prologue

Quality strategic planning is critical to the Veterans Health Administration's (VHA) future budgets and positive relations with our stakeholders. Strategic Plans are roadmaps that detail the direction networks intend to take to meet the short and long-term health care needs of the veteran population. They are especially important in communicating future strategies and actions to Congress, OMB, and Veteran Service Organizations.

Strategic Plans are also integral to VHA's corporate reporting and offer direct evidence of the progress made at the local level to implement national goals and strategic targets. Plan input is used to build VHA's annual budget and performance plan as well as the Department's five-year strategic plan.

Building on the Strategic Management Framework designed to implement *Vision for Change* and *Prescription for Change*, the 1999 strategic management framework carries through the direction set in *Journey of Change I* and *Journey of Change II*, integrates refinements that are derived from progress in achieving the "new VHA," and demonstrates continued evolution to better reflect VHA goals and strategies. The following document contains the executive summaries of the 22 Network Strategic Plans. Their efforts to document past accomplishments and identify future strategic initiatives allow VHA to plan more effectively at the national level and to ensure the continued support of the stakeholders.



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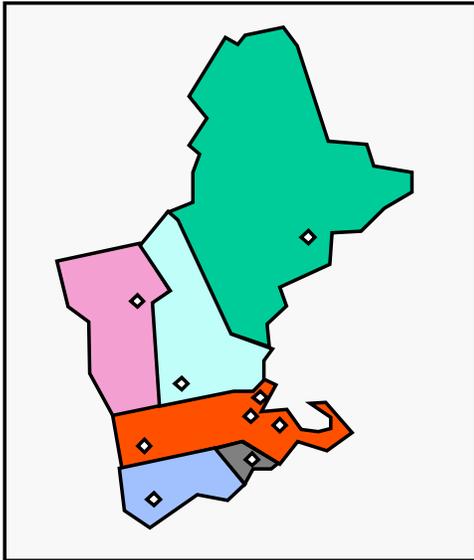
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# Department of Veterans Affairs Veterans Health Administration



## Strategic Plan FY 2001 - FY 2005

October 1, 1999

# Journey of Change in New England

# Executive Summary

## **History**

Over the past several years, the VA New England Healthcare System has implemented improvements in Health Care delivery using both *The Journey for Change* and *The Prescription for Change* guidance provided by VA Headquarters. There has been an emphasis towards integration, consolidation and standardization of services, a focus on management efficiencies, an increased emphasis on third party reimbursements and enhanced clinical information systems throughout the network. Evaluation of measures of Quality and Access to care have produced excellent results when compared to all VISNs across the Nation.

Early planning initiatives identified access to an array of services as being extremely important to our veteran community. The key factor to providing this access within this integrated system was a high quality Primary Care System that could be accessed as close to home as possible. The most visible signs of this basic commitment to primary care have been the expansion of access through the development of additional Community Based Outpatient Clinics (CBOCs) throughout the network and the establishment of an Ambulatory Care Service Line.

The network has been successful in shifting from a system focused on inpatient services (decrease of 38.6% ADC between FY 1996 (1854.1) and FY 1999 (1139.01))<sup>1</sup> to one with an emphasis on ambulatory care with Primary Care as a focal point<sup>2</sup>. The goal for each veteran to have an identified Primary Care Provider is nearly achieved. Timeliness of services continues to be a goal which has seen remarkable improvement. The use of Ambulatory Surgery has expanded, and when benchmarked, it is rapidly approaching or exceeding community standards. Alternatives to care have been expanded and sharing agreements have increased.

## **FY 2000 funding impact on the FY 2001 – 2005 Strategic Plan**

Major budgetary concerns are facing VISN 1 for FY 2000. Projections range from a \$40 to \$80 million dollar shortfall to provide current services. Utilizing the FY 2000 President's Budget plus an additional 1.1 billion dollars in funding proposed for the VHA budget, VISN 1 will have to implement a more efficient clinical delivery system and possibly, will have to downsize clinical programs. These efficiencies must be considered for planning purposes for the 2001 to 2005 planning cycle.

## **FY 2000 - VISN 1 Planning Strategy**

Members of the VISN 1 Strategic Planning Group met to discuss impact of the FY 2000 VISN 1 budget and FY 2001 to 2005 Strategic Planning. Numerous strategies were discussed and presented to the Executive Leadership Council to address projected budget shortfalls. Leadership concurred in adopting the following priority order for retention of programs that are provided within the VHA and VISN 1:

### **Special Emphasis Programs:**

Spinal Cord Injury, Blind Rehabilitation, PTSD, Homeless Veterans Treatment and Assistance Programs, Seriously Mentally Ill, Prosthetics and Sensory Aids Service, Preservation Amputation Care and Treatment (PACT) Program, Geriatrics and Long-Term Care, Persian Gulf Veterans Program, Readjustment Counseling Service, Substance Abuse Services Program, and Women's Veterans Health Program. These programs demonstrate the essence of the agency's commitment to veterans and underscore the leadership role the agency has played in providing care in these areas.

### **Ambulatory Care, including Primary Care:**

Leadership remains convinced that more veterans would be able to receive appropriate care in this setting. VISN 1 looks to Ambulatory Care as the primary growth opportunity for the network.

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<sup>1</sup> KLF Menu (FY 99 through August)

<sup>2</sup> Outpatient visits increased 9.6% between FY 96 (1,698,252) and FY 99 (1,861,968) (August)

Source: KLF Menu

### **Chronically Mentally Ill, including Substance Abuse:**

Based on historical demand, the special expertise VHA demonstrates in providing care to this group of veterans, and the relative lack of alternatives in the community, these programs were ranked high on the VISN's list of priorities.

### **Long Term Care:**

Although the total veteran population is decreasing, the number of aging veterans is increasing. The demand for services for aging veterans is high and is expected to increase.

### **Acute and Specialty Inpatient Care:**

VISN 1 in conjunction with its affiliated Medical Schools has a distinguished history in providing high quality secondary and tertiary care. As VISN 1 has increased its focus on meeting community standards on appropriate admissions, continued stays and enhanced Ambulatory Care services, the demand for acute inpatient care has decreased. High quality programs are readily accessible in the community as a possible alternative to inpatient care, particularly with affiliated medical schools and their associated facilities.

This VISN 1 priority listing emphasizes the seriousness of the monetary constraints and the depth of discussions concerning future planning. It was agreed that a more efficient clinical delivery system will emerge from all five areas identified above.

A basic strategy of growth and a more efficient clinical delivery system will be complemented by actions that would identify alternatives for low volume and relatively high cost acute inpatient programs. Additionally, a modest set of actions designed to promote equity and reduce costs in long-term care will be explored.

Special Emphasis programs (as previously listed) have been identified by Veteran Service Organizations and VHA as essential services that are provided to those veterans with unique and major medical conditions. The network will protect its capacity to provide care to this distinguished group of veterans.

Ambulatory Care will continue to be the core component of VA New England Healthcare System's strategy along with a strong emphasis on Primary Care to promote the health care of veterans.

Acute care and extended or long-term care, including community and home-based care, fill out the continuum that will continue to be provided to veterans in New England. Modifications in how this care is provided may be necessary under specific budgetary circumstances, as noted above and below.

### **Central Guidance Concerning Planning Scenarios**

Developing the Strategic Plan for FY 2001 and beyond requires reference to central guidance concerning four budget scenarios. The FY 2001 to 2005 Strategic Plan's formal charge is to address the following scenarios in FY 2001 with planning initiatives identified by VISN:

- Freeze (as expected by the Balanced Budget Amendment)
- +\$0.5 billion
- +\$1.0 billion
- +\$1.5 billion.

The impact of these budget projections on VISN 1 remains serious. With projected pay raises proposed and inflationary costs projected, the VISN 1 plan must address the following projected potential deficits in each scenario:

<b>Budget Scenario</b>	<b>Budget Impact</b>
Freeze	-\$112 million
+\$0.5 billion	-\$92 million
+\$1.0 billion	-\$71 million
+\$1.5 billion	-\$51 million

All remaining years of the planning cycle (2002 to 2005) assumes a budgetary freeze based on FY 2000 resources.

## **Planning Strategies for FY 2001 and Beyond**

Leadership approved the following areas of emphasis for future planning purposes:

### **Growth Strategy**

Increased revenues generated by an aggressive and formal outreach program to spur growth will become an initiative. A strategy which focuses on informing veterans of services and benefits, underscoring quality and access will be initiated.

### **Clinical Delivery System**

Emphasis again will be placed on achieving a more efficient clinical delivery system. Historically, increased efficiencies contributed the majority of cost savings. New initiatives in these areas will be addressed during the next two years. As we improve performance, programs will be adjusted accordingly. Decreased demand, increased technology, and the monitoring of utilization patterns to meet accepted benchmarks in health care and quality of services are areas that can have impact on program size. Specific efficiencies will be identified. Target goals will be established and Leadership will monitor movement toward these goals for the desired results.

### **Primary Care and a Basic Benefits Package**

VA New England Healthcare System is committed to ensure that each enrolled veteran (146,762) has access to a Basic Benefits Package. Key to this strategy is the emphasis placed on primary care. Predictable and high quality primary care improves health in the least costly setting. To make primary care as accessible as possible, CBOCs have been established and more will be added throughout each region of the network. This structure will enable veterans to access the entire range of benefits through primary care clinics. Components of the Basic Benefits Package will be provided directly by the VA at either CBOCs or the parent hospital or referral to other VA facilities or community facilities under contract with the VA.

Confidence in the consistency of high quality care is supported by high compliance with National Performance Measures. VA New England Healthcare System has scored extremely high on indices of preventive medicine. Veterans will show their satisfaction by their loyalty to the network and spreading the word of the value of VA health care to other veterans. The strategy of promoting primary care is the core approach of VA New England Healthcare System. Any veteran in any part of New England can easily access high quality primary care.

There is active consideration to establish new CBOC's in Massachusetts, and southern Maine. Two new CBOC's will open in Connecticut in the fall of 1999. The unexpected low demand for care at Framingham's CBOC will require modification of its operation. With the completion of the Ambulatory Care addition at the Jamaica Plain facility, and the expiration of the Causeway facility lease, a new location for a Boston Outpatient Clinic is being identified where Primary Care and Mental Health services will be available.

VA New England Healthcare System will make certain that any veteran can access primary care easily and timely, identify a person or team that provide his/her care, and be assured of its quality.

### **Hospital Care**

The advances in primary care and ambulatory surgery have impacted on the demand for acute care requiring inpatient hospitalization. This effect has been observed in both private and public health care organizations. VISN 1 has adopted an effective method of increasing efficiency by the application of community standards for reducing inappropriate admissions and continued lengths of stay. Compliance with community standards combined with high utilization of ambulatory surgery and quality primary care has reduced the demand for inpatient beds within VISN 1.

VA New England Healthcare System has been successful in treating more veterans in alternative settings which has resulted in a more cost effective delivery system. The demand for hospital beds continues to decline, and has resulted in additional excess capacity. Educating and shifting staff to the ambulatory care setting continues to be a major challenge.

Issues of low volume programs are complicated by veterans' preference that routine hospital care, as determined by community standards, be provided locally. Referral to distant centers is acceptable only when highly technical interventions are required. Contracting for care increases patient satisfaction, but depresses further the demand for beds. Low volume programs also raise the issue of maintenance of quality and high costs per episode.

If increased growth and management efficiencies do not meet predicted budgets, VA New England Healthcare System proposes a strategy of developing partnerships with community providers of acute care that will guarantee quality care and improved local access.

### **Long Term Care**

There have been significant developments affecting patients who require long-term care. The use of available high quality specialized community alternatives in the New England area has intensified. This array of alternatives to institutionalized care has afforded patients greater opportunity for socialization, freedom of movement and personal expression and choice. Through community based services, patients may live closer to home or in their communities of origin, while they are supported and monitored by case-managers, nurses, and social workers who are specifically assigned to the community.

VHA provided guidance that VA Nursing Home Care Units should move toward the philosophy of transitional programs designed to facilitate the movement of patients to the least intensive and dependent form of care in the most appropriate setting. However, at the same time, elderly constituents continue to request chronic care in record numbers. There is now an opportunity to reconsider how this care is funded and the role of VA NHCU beds. One means of addressing this problem involves emphasizing the historical partnership with State Veterans Homes.

VA New England Healthcare System examined its practice of providing specific veterans with indefinite contracts for care in community nursing homes. The current focus is to address the clinical care needs of enrolled veterans at the least intensive level with special attention to care in the home. Telecare and Telemedicine will receive more attention in the near future.

New England has enjoyed a rich supply of nursing homes. Each state has at least one State Veterans Home and all have a large number of community nursing homes. Given the ready access to community-based nursing homes, VA New England Healthcare System plans to follow a policy of providing no more than a 30-day contract to transition veterans into the community. This initiative will increase access and ensure that resources are used to treat as many veterans as possible.

Within the perspective of additional reductions in resources, there will be an emphasis to use VA NHCU as a transitional program. Based on veterans' preferences, transitional care is a lower priority than chronic care. If the demand for VA NHCU beds decreases due to the emphasis on their use as transitional to community-based programs, the strategy will include the closure of any vacant units. This plan, however, assumes that demand will be sufficiently strong, especially during the next ten years, that no VA NHCU bed will be eliminated. Conversely, expansion of NHCU beds within the walls of current facilities is financially impossible considering the current funding projections for VISN 1.

Finally, VA New England Healthcare System recognizes the value of the State Veterans Homes and will adopt a strategy to enhance the traditional partnership relationship. The network will work with each State to maximize their efforts to increase their capacity to deliver extended care to veterans.

### **Education and Research**

VA New England Healthcare System's commitment to education and research will be tested during the planning cycle. Smaller inpatient units and expanded ambulatory care with timely service will demand innovative methods to ensure that each resident has a quality training experience. There is an ongoing examination of the appropriate educational opportunities for trainees within VA. Primary Care and intensive, high tech Ambulatory Care underscore training opportunities consistent with current day medical practice and our academic mission. The Medical School Deans are lending their expertise to VISN 1 in an effort to develop appropriate options to protect the legacy of high quality graduate medical education and to reflect transitions occurring in the private sector.

Research has made the transition to comply with the established standards that all research be relevant to designated areas which are pertinent to the mission of VHA. In addition, the Network's Health Systems Research & Development program has achieved extraordinary accomplishments in terms of funding and results. Outcome research has become a major hallmark of the network.



# **FY 2000 Business Plan**

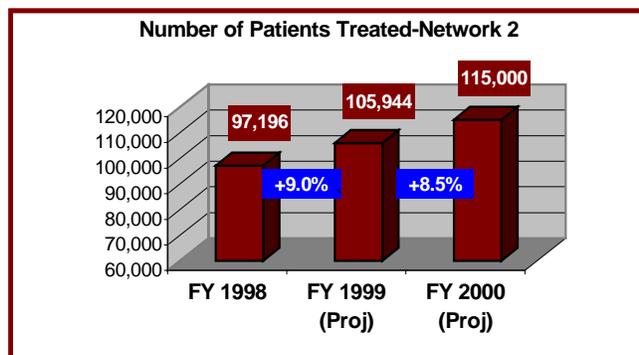
## **VA Health Care Network Upstate New York**



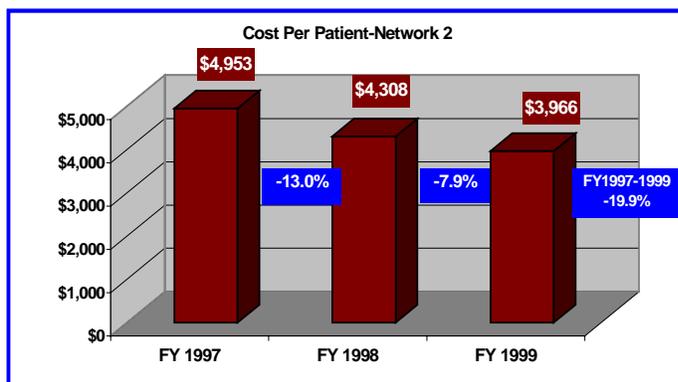
**October 11, 1999**

## Executive Summary

The VA Health Care Network Upstate New York is initiating plans for the continued transformation of its health delivery system in order to improve services to the veteran population. Network 2 will continue to strengthen its three principal missions of patient care, education and research while serving as the primary backup to the Department of Defense for emergency preparedness. The Upstate New York Network will treat a greater percentage of the veteran population in Fiscal Year 2000 through the continued redirection of care to the outpatient, home and community settings. In Fiscal Year 1999, Network 2 will treat a projected 106,000 patients, a nine-percent increase over the preceding year. Plans have been formulated to further increase patients served by an additional 8.5% in FY 2000, from 106,000 to 115,000. While increasing the number of veterans served, Network 2 will also strengthen vital special emphasis programs including Serious Mental Illness, Post Traumatic Stress Disorder, (PTSD) Spinal Cord Injury, AIDS, Agent Orange and Women Veterans Programs, among others. Network 2 will continue to provide more convenient services to veterans by locating programs in closer proximity to their homes. In FY 1999, over 27% of veteran patients received care in Community Based Clinics, as compared to 23% the preceding year. In FY 2000, further improvements in patient access will be accomplished through the establishment of 11 additional Community Based Clinics throughout Upstate New York. Currently generating the 3<sup>rd</sup> highest market share among 22 networks (17% in FY 1999), Network 2 is positioned to further increase its share to 18.5% of Upstate New York's veterans.



Improvements in network productivity in FY 1999 are largely attributable to improved health delivery practices, including reduced unit costs, improved use of alternate treatment settings and a decrease in unnecessary hospitalization. Cost per patient decreased from \$4308 in FY 1998 to a projected \$3966, a decrease of 11.7% (including the effects of inflation). Network 2 cost per patient is currently the 3<sup>rd</sup> lowest among 22 networks. In accordance with unit cost reductions, acute bed days of care declined by more than 27,000 in FY 1999 or 21% as compared to the previous year (129,263 to a projected 101,635). Home care services continued to increase in FY 1999, with an additional 16.2% of patients enrolled in Home Based Primary Care (HBPC) with further increase of 20% projected for FY 2000. Plans for significant expansion of vital programs and services is largely attributable to an improved financial situation in Fiscal Year 2000. Improved productivity and corresponding unit cost reductions have generated enhanced performance as measured by the Veterans Equitable Resource Allocation (VERA) Model,



the principal determinant of network budget allocations. In accordance with the proposed Congressional Budget for Fiscal Year 2000 (as of October 1, 1999), Network 2 is positioned to receive a general operating budget of \$444.0 million, an increase of approximately \$53.3 million or 13.6% over the prior year. This improved financial position emerges in sharp contrast to the previous three years during which Network 2 incurred significant losses in its operating budget. Between FY 1996 and FY 1999, budget losses of over \$50 million dollars were sustained, including the effects of inflation. Budget shortfalls produced employment

reductions of 17% or 1083 Full Time Employee Equivalents (FTEE) during this period, from 6309 FTEE in FY 1996 to 5226 in FY 1999. Staffing losses were effected through combinations of attrition, reductions in force or staff adjustments. The much-improved operating budget for FY 2000 will permit required patient care enhancements

while allowing for moderate employment increases of approximately 50 FTEE across the Upstate New York Network. Budgetary increases will provide for programmatic expansion while also covering the cost of national mandates including Hepatitis C, pharmaceutical increases, prosthetics, including hearing aids and eyeglasses, emergency care and other special emphasis programs.

Network 2 is also committed to improving customer service including reductions in waiting times, standardization of care through disease management programs and clinical guidelines. Access to care is being improved through Virtual help desk, Network 2's Web Page and through a 24-hour telephone help desk. Network 2 is undergoing an integration of its patient data base among all facilities and community based clinics to improve continuity of care and timely access to patient information from any location.

Network 2 Proposed Budget		
FY 1999	FY 2000 (Projected)	Change
\$390.7 M	444.0 M	+\$53.3 Million (+13.6%)

### Network Goals for Fiscal Year 2000

The VA Health Care Network Upstate New York has established five principal goals through which it will continue to transform its health delivery system. Network goals have been established in order to generate demonstrable improvements in veterans services, to optimize use of resources and to better meet the needs of the veteran population of Upstate New York. Goals are consistent with VA Headquarters' plans to improve the process of health care delivery, while assuring an enhanced level of quality of care and veteran satisfaction. In accordance with the following five goals, a series of operational strategies were developed to assure their achievement.

The 5 Strategic Goals are as follows:

1. **Expand Access to Care**
2. **Increase Health Care Value**
3. **Improve Customer Service**
4. **Improve the Health Status of the Veteran Population**
5. **Enhance Employee Development**

### Network Goals for Fiscal Year 2000

Expand Access to Care	Increase Health Care Value	Improve Customer Service	Improve the Health Status of the Veteran Population	Enhance Employee Development
<ul style="list-style-type: none"> <li>◆ Increase Patients Treated By 7,000 or 6.6%</li> <li>◆ Open 11 Community-Based Outpatient Clinics (CBOCs)</li> <li>◆ Expand Home Based &amp; Adult Day Health Care Services</li> <li>◆ Expand Telemedicine To Clinics &amp; Home Sites</li> <li>◆ Increase Outreach To Seriously Mentally Ill Patients</li> <li>◆ Establish Network Authorization Office to Improve Transfers &amp; Emergency Care</li> </ul>	<ul style="list-style-type: none"> <li>◆ Improve Patient Utilization Through Analysis Of Actuarial Data</li> <li>◆ Improve Intervention With High Risk Populations</li> <li>◆ Generate Alternate Revenue Through Sharing Agreements</li> <li>◆ Reengineering Of Human Resources, Fiscal, Health Information</li> <li>◆ Target Community Grants to Fund Outreach Efforts</li> </ul>	<ul style="list-style-type: none"> <li>◆ Optimize Clinic Hours of Operation and Patient Flow</li> <li>◆ Utilize Quick Card Customer Feedback</li> <li>◆ Establish Veteran Service Centers at all Clinic Sites</li> <li>◆ Improve Internet Web Site Information to Better Inform Veterans</li> <li>◆ Develop Knowledge Management Office to Optimize Data Usage</li> </ul>	<ul style="list-style-type: none"> <li>◆ Implement Disease Management Initiatives for Diabetes, Substance Abuse, PTSD</li> <li>◆ Fully Apply Clinical Practice Guidelines</li> <li>◆ Improve Chronic Disease and Prevention Index Performance</li> <li>◆ Improve Quality of Life for Extended Care Patients</li> <li>◆ Achieve Computerization of Medical Record &amp; Computerized Imaging</li> </ul>	<ul style="list-style-type: none"> <li>◆ Implement High Performance Development Model</li> <li>◆ Implement Leadership Development Initiatives</li> <li>◆ Provide Training to Enhance Programs including Dementia, Alzheimer's Disease, Serious Mental Illness, PTSD</li> <li>◆ Provide Minimum of 40 Hours Continuing Education For All Employees</li> </ul>

\*Selected strategies are included above. The complete list of initiatives for each of the 5 goals may be found in the narrative portion of the FY 2000 Business Plan.

## Health Care Strategies for FY 2000

### Patient Care

Network 2 has introduced plans to assure that the full continuum of services is provided to veterans. This will be accomplished through the availability of health screening programs, greater involvement of geriatrics and mental health staff on Primary Care Teams, and expanded partnership with community organizations. Network 2 maintains staffed programs in the inpatient, outpatient, and home care settings while also maintaining nursing home care unit beds, through either VA-operated or contract nursing homes within the community. Network 2 will strive to provide a consistent level of care to the veteran population through greater uniformity and standardization of services, greater application of clinical practice guidelines and disease management protocols and through the establishment of standards for all clinical disciplines. Network 2 will assure that programs and services are provided through ongoing monitoring against established criteria, the use of periodic status reports and their presentation to the Network Executive Leadership Council (ELC).

- ◆ Implement Disease Management Initiatives
- ◆ Strengthen Special Disability Programs
- ◆ Establish Veteran Service Centers at all Sites
- ◆ Establish Network Authorization Office

Network 2 will continue to refine its health delivery system, developing its data systems through an integrated medical record. The intent is to provide greater accuracy to enhance patient information. Network 2 is embarking on profound improvements in health delivery through advancement of disease management programs, greater use and application of clinical practice guidelines. This represents a profound enhancement in health delivery, through standardization of practices, while encompassing and applying a wider body of health care knowledge now available for providers. Plans have been formulated to achieve effective intervention with high risk patient populations including diabetic, cardiac and hypertensive patients. Network 2 is committed to improving the Health status of the veteran population through greater Mental Health and Geriatric support to Primary Care Teams, computerized imaging and through improved outreach programs for high risk veteran groups. Partnerships will be forged with community organization, in order to optimize the use of health care resources, while assuring that state of the art services are available to veteran patients.

Network 2 is committed to strengthening its Special Disability and Special Emphasis Programs that have long characterized VA health care delivery. Workload is projected to increase or remain stable in Fiscal Year 2000 in all high priority areas as shown below:

**Workload for Special Disability and Special Emphasis Programs-Network 2**

Special Disability Programs	Workload FY 1999	Workload FY 2000	% Change
Amputation	50	60	20.0%
Blindness	1,300	1,300	0.0%
Post Traumatic Stress Disorder	1,560	1,663	6.6%
Serious Mental Illness	500	525	5.0%
Spinal Cord injury & Disorders	500	533	6.6%
Traumatic Brain Injury			
Inpatient	1	1	0.0%
Outpatient	6	6	0.0%
<b>Other Special Emphasis Programs</b>			
Addictive Disorders	1,016	1,200	18.1%
Agent Orange	122	132	8.2%
AIDS	293	339	15.7%
Former Prisoners of War (POW)	200	200	0.0%
Nursing Home Patients	2,400	2,500	4.2%
Geriatric Clinic Outpatients	2,100	2,479	18.0%
Home Based Primary Care Patients	2,412	2,894	20.0%
Adult Day Health Care	560	644	15.0%
Gulf War Programs	650	700	7.7%
Homeless Program		1,787	
Ionizing radiation	169	169	0.0%
Prosthetics & Sensory Aids	54,000	58,000	7.4%
Substance Abuse	5,000	5,330	6.6%
Women Veterans	5,809	6,192	6.6%

## Education

In Fiscal Year 2000, the VA Health Care Network Upstate New York will demonstrate continual improvement through systems redesign and a commitment to developing the knowledge and skills fundamental to successful health care delivery. During FY 1999, new affiliation agreements were executed with all current academic partners throughout the network. Plans are currently underway to consolidate allied health affiliations, in order to achieve one corporate agreement, rather than a series of site-specific affiliations. Network 2 will expand both the number and quality of academic affiliates, strengthening communication and working relationships with network academic partners. In FY 2000, Network 2 will improve the processes and outcomes for graduate medical and associated health trainees within VISN 2. To achieve this, the network has augmented and supplemented our continuing education efforts with distance learning opportunities available to all clinical care professionals

## Research

Network 2 will continue its firm commitment to VA research, specifically in those most germane to veterans' health care. Plans have been introduced to double the level research funding by 100% over the next five years, thereby strengthening research efforts while increasing the number of research participants. Specific areas of research interest include oncology, cardiology, geriatrics, and dental implants, among others. The Research program will be strengthened through allocation of additional provider time to conduct research, and by generating additional funding to support research efforts.

## Physical Plant & Equipment

Network 2 has introduced plans to upgrade current physical plant and equipment through an overall modernization program, with specific emphasis on enhancing outpatient and primary care clinics. In accordance with targeted increases in primary care workload, outpatient clinic space will be upgraded throughout the network, including examination rooms and waiting areas. This is intended to improve patient access and flow throughout ambulatory care settings, while also affording greater patient comfort and privacy. Network 2 continues to upgrade the current buildings in accordance with Information Technology (IT) requirements to accommodate planned growth in computer applications and related technologies. With greater emphasis placed on alternatives to hospitalization, mental health outpatient programs will be enhanced, including residential rehabilitation programs. Non-Recurring Maintenance (NRM) projects will similarly be applied to improve space for geriatrics & extended care programs including Adult Day Health Care (ADHC) and Home Based Primary Care (HBPC) programs. Network 2' only Major Project for clinical expansion is a Magnetic Resonance Imaging (MRI) addition at Syracuse, scheduled for FY 2002, at an estimated cost of \$6,000,000.

## Additional Strategies for FY 2000

The Upstate New York Network will transform its health delivery system through reengineering of health delivery processes, improved customer satisfaction and the application of best clinical practices. No program closures are planned for FY 2000 nor any change in the current mission of existing facilities or outpatient clinics.

The number of patients treated is projected to increase by 8.5% in FY 2000, with facility-specific totals as follows:

**Patient Projections for FY 2000**

Network 2 Facility	FY 1998	FY 1999 (Projected)	FY 2000 (Projected)	% Change FY 1998-2000
ALBANY	25,219	29,469	31,432	24.6%
BATH	9,844	10,661	11,371	15.5%
BUFFALO*	31,732	28,751	30,666	-3.4%
CANANDAIGUA*	6,876	11,757	12,540	82.4%
SYRACUSE	29,907	32,418	34,577	15.6%
<b>VISN 2</b>	<b>97,196</b>	<b>105,944</b>	<b>115,000</b>	<b>18.3%</b>

\*Rochester OPC patients credited to Canandaigua beginning October 1998

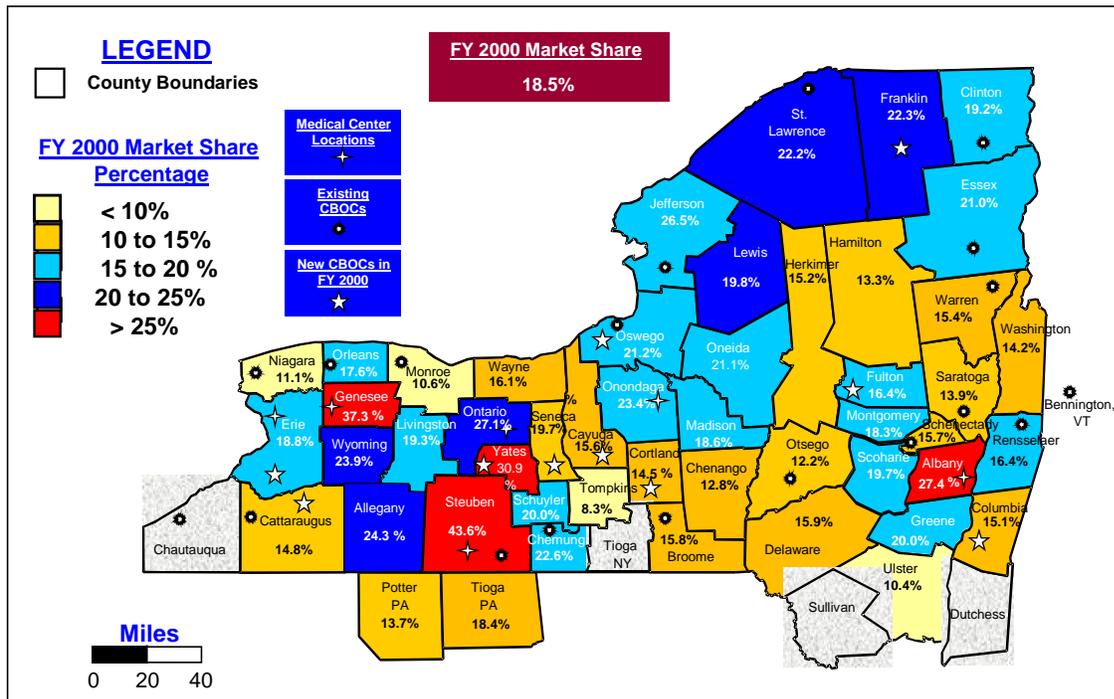
Application of computer technology to health care decision making, automation of medical records and the introduction of telemedicine will continue to position Network 2 for future success. The implementation of a Care Line structure of health delivery will underscore the importance of patient-centered care, while strengthening health care teams throughout the organization. Cost shall be reduced through a systematic approach of treating patients at the optimum level of care with success dependent upon superior customer service as the driving force behind all operations. A Network Authorization Office (NAO) is being established to improve the timeliness and effectiveness of Patient Transfers, Emergency Services and Fee Basis treatment at non-VA facilities. A Network Compliance Program is being introduced to assure completeness of clinical documentation, accuracy of medical record coding and increased workload accuracy. This program will also minimize rejected insurance claims, while enhancing compliance with Health care financing Administration Standards (HCFA) standards, as well as billing and medical record maintenance.

### Treating Greater Numbers of Veterans in Fiscal Year 2000

Treating approximately 99,000 veterans, Network 2 achieved a projected market share of 17% in Fiscal Year 1999 as compared to 15% the prior year. Improved outreach efforts, coupled with the opening of 11 Community-based Clinics, will expand market share to a projected 18.5% in FY 2000. The Upstate New York Network will continue to intensify efforts in those counties in which market share is low, by providing convenient and accessible health care services. Through an improved health care system,

Network 2 will strive to deliver high quality health care health care services to greater numbers of veterans in Fiscal Year 2000.

## Veteran Market Share by County-FY 2000 VA Healthcare Network Upstate New York





**FY 2000**

# ***Business Plan***

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## Executive Summary

The New York/New Jersey Veterans Healthcare Network (VISN 3) is improving and streamlining its current operations in order to provide the best quality care for its veterans going into the next century. VISN 3 is comprised of five integrated hospitals, composed of nine main divisions. The New Jersey Health Care System includes the East Orange and the Lyons division. The New York medical centers are the Bronx, Hudson Valley Health Care System (Montrose and Castlepoint divisions), Northport, and the New York Harbor Health Care System (Brooklyn, New York and St. Albans divisions). VISN 3 remains a leader in service to veterans and continues to enhance and develop new programs, some of which have been recognized nationally. Network 3 is continuing to improve its efforts to provide more care on an outpatient basis or in a non-institutional setting providing the best quality of life for our veteran patients.

VISN 3 continues to see more and more patients, while decreasing their cost and increasing their revenue share. In FY 1998 and FY 1999 we have opened new Outpatient Based Clinics in various underserved areas providing better access to our veterans and decreasing our waiting times. We have reduced bed days of care by over 63% in 4 years. Hospital ADC has been reduced by 55% in this same time frame. Ambulatory surgery rates have increased. The VISN used Hoptel and Observation beds and insures that the patient is utilizing the appropriate bed level of service. Inappropriate admissions are down as well as length of stays. The VISN has established an Enrollment Task Force to insure maximum reimbursement for work that we do and to aid in the sharing of best practices within the VISN to enroll additional veterans.

In FY 1997 - FY 1998 each facility was reviewed by JCAHO. All facilities received three-year accreditation with one third of VISN facilities receiving Accreditation with Commendation. All facilities received scores over 90%.

In addition to outstanding scores in the JCAHO review, the VISN has shown improvement in nearly all network performance standards in FY 1999. Most notable was a 16% improvement in follow up for mental illness. There were also significant improvements in all areas of the National Customer Feedback Ambulatory Care Survey (using the most recent data available), including a 33% improvement in Courtesy scores, one of the most critical patient satisfaction factors. To further incorporate veterans concerns into our planning process, the VISN reconstituted the Service Evaluation and Action Team (SEAT) to enable broader representation (patient advocates, and customer service representatives from all VISN facilities) and a broader consideration of veterans concerns.

VISN 3 Lost Time Claims Rate came down by over 20% in the last two years.

The biggest challenge that VISN 3 faces are the continued budget reductions and the absorption of inflation. The VISN has already absorbed, between inflation and VERA reductions, a loss of over \$200,000,000. The VISN expects to have reductions in their budget in FY 2000 of over \$100,000,000 due to inflationary absorptions, VERA and paying for unfunded mandates.

The VISN has successfully reduced their budget of the \$200,000,000 without compromising the quality of care for our patients. They have achieved the savings by the following actions:

- Reductions of wards/units and beds

- Conversion of inpatient beds to domiciliary or residential care

- Reduction of cumulative FTEE in FY 2000

- Changes in staffing mix

- Reductions in overtime

- Laboratory and Service Consolidations

- Enhanced utilization review

- Outsourcing when less expensive

- Reductions in control points

- Consolidations of contracts

- Consolidation of food preparation

- Reduction in acquisition staff due to centralization of contracting and purchasing to the VISN level.

- Reduce lease costs

VISN 3 is continuing to evolve into a health care network. Over the last few years, the VISN has successfully consolidated the laundry activities to one site. The VISN consolidated the acquisition component of Supply Service into one service, which has saved administrative costs for the salary of the employees that do the procurement for the VISN. More importantly, the consolidated acquisition service, which we call the Network Acquisition Program (NAP), is standardizing and consolidating the contracts that the VISN requires. This has already saved millions of dollars and each year will save even more. The VISN has a product line for Spinal Cord Injury and has just approved one for the Homeless Program. The VISN also has a consolidated Prosthetic Service, which is viewed nationally as a model program. All of these programs are improving the quality of the services provided, and in some case also saving funds which can be used to provide care to a greater number of veterans. The VISN is in the process of expanding the use of consolidated services and care lines throughout the network. A Product Line for Spinal Cord Injury was developed which has aided access to acute inpatient care for these veterans and aided in the reduction of waiting times on an outpatient basis. More recently, a Product Line was approved for our Homeless Program. This Product Line will build on our already successful Spinal Cord Injury Product Line, which received the 1998 Public Service excellence Award. The Homeless Program has already had many accomplishments including finding housing for many of our homeless veterans at discharge, increasing the Compensated Work Therapy Program contracts and developing a Veterans Construction team.

VISN 3 believes that by integrating the facilities within our VISN we can provide improved care to more veterans. This is accomplished by reducing duplicative services, especially in the administrative areas of the medical centers. To this end, the VISN has integrated the two facilities in New Jersey, the two facilities in Hudson Valley and more recently the Brooklyn and New York facilities.

In order to continue to evolve into an integrated network, in FY 1999 VISN 3 formed a Planning Council in order to insure our organizational changes will provide efficient and standard care to all our veterans. This Council will aid in the development of standard business practices and insure that quality of our veteran's increases.

VISN 3's biggest challenge remains the immense budget reductions that have already been taken and can continue to be expected in future years. The VISN has done much to reduce their costs and at the same time maintain quality of care. One success that began in FY 1998 was the consolidated pooling of Biomedical Funds, which VISN 3 calls their Metropool Program. In order to save dollars, all the facilities in the VISN pooled their Biomedical funding and eliminated many contracts on biomedical equipment. This saved the VISN close to one million dollars in FY 1998 and considerably more in FY 1999. Another one of VISN 3's huge success stories is their Medical Care Cost Recovery Programs. The VISN has collected over 36 million dollars through August of 1999, which is the largest collection recovery in the nation. The VISN has also focused on their Sharing Programs. Collections are up 33 % just since last year. The number of sharing contracts is up 25%, as is the number of pending contracts. With all the new contracts on the horizon, we are confident that our revenues in this area will continue to rise in even greater proportions. The Consolidated Contracting Program that began in FY 1998 was fully operational in FY 1999. Due to this consolidation, the VISN has saved close to two million dollars in recurring salary costs as well as millions of dollars in consolidating many of our high dollar contracts. These dollar savings will only increase in future years as the unit continues to consolidate contracts.

The VISN recognizes how important it is to invest in Information Technology, in order to move forward in all our initiatives. To this end, we have invested heavily in infrastructure (cabling and network equipment). The VISN believes that our clinicians and administrators must have the best possible technology tools to provide superior care. Because of this, the VISN is standardizing applications and equipment. One of our most important initiatives this year was to insure that all our facilities had implemented the Computerized Patient Record System by the end of FY 1999. The other critical initiative was to insure Year 2000 Readiness. VISN 3 is pleased to report that we have been successful in both these endeavors.

VISN 3 created a Telephone Triage Program centralized in the Bronx VA. This program enabled the VISN to save one million dollars by consolidating this function to one medical center and giving our patients better access to services and information.

The VISN realizes that easily, accessible reliable clinical and administrative data is imperative to have in order to continue to move forward in improving operations. The Decision Support System (DSS) information database is an important tool. The VISN DSS Council has put a major focus on standardization of their databases in FY 1999. All facilities in the VISN are now fully implemented and have met their target dates. Each year, the DSS system is used to answer more workload, cost and clinical outcome questions.

The VISN recognizes how important it is to continue to educate our employees in a very focused approach. A new education council was formed this fiscal year to meet the needs of the VISN. The VISN decided to incorporate the High Performance Development Model as the method for insuring that education goals are met.

The VISN cannot be successful without full cooperation of our labor partners. Our VISN has created a VISN partnership to aid in labor, management and all employees working together to give the best quality of care to our veterans.

With the population of VISN 3 patients aging so dramatically (they are the oldest in the nation), it is critical for the VISN to plan for the enhancement of Geriatrics and Extended Care. The VISN has an ongoing Geriatrics and Extended Care Team that continues to work on providing guidance for our geriatric and extended care products in the VISN. One of their major concerns has been the need to promote alternatives to institutional care for those veterans unable to live independently without the services of skilled and unskilled health care workers. They have created revised Admission and Discharge Criteria that the VISN has adopted this fiscal year.

Research is always a major focus for this VISN. Our research program has continued to increase since FY 1997, with the aid of our Research Advisory Council. Our biggest accomplishment was the establishment of our MIRECC, which we expect to increase our research programs by at least 6 million per year.

Another major focus for the VISN has been our Prevention Program. The Preventive Medicine Council has been charged with insuring that we meet the goal of the prevention index. We have already made significant improvements and have many activities underway to insure additional improvements in this area for our veterans.

VISN 3 has a Primary Care Council working on standardizing expectations, policies and procedures. They are also working on establishing panel sizes and how to measure the panel sizes achieved. The Women's Health Council is actively working on similar issues including that women's health needs within the VISN have been addressed. With our huge mental health population in mind, the VISN has created a Mental Health Task Force. One of the important areas they are working on is access for this patient population to Domiciliary Care and/ or residential care as appropriate. Some other major initiatives for this group are the admission criteria for admission to Mental Health Services, a common treatment planning instrument and increased outreach availability.

VA Stars & Stripes Healthcare Network  
*SERVING THOSE WHO SERVED*

*Altoona, PA Butler, PA Clarksburg, WV Coatesville, PA Erie, PA Lebanon, PA  
Philadelphia, PA Pittsburgh, PA Wilkes-Barre, PA Wilmington, DE*

**VISN 4's**  
***FY 1999***  
***Executive***  
***Summary***

# Executive Summary

## **OVERVIEW**

Geographically, the VA Stars & Stripes Healthcare Network includes 63 of 67 counties in Pennsylvania and Delaware; 7 of 21 counties in New Jersey; and portions of West Virginia, Maryland, Ohio and New York. The network maintains relationships with 11 medical colleges, providing access to numerous private sector entities. The network faces many challenges in its environment (e.g., a declining population base, static appropriations and an aggressively competitive private health care sector). The veterans served by the network comprise an increasingly older population. The network's estimated FY 1999 veteran population is 1,673,100.

## **INTRODUCTION**

On behalf of the veterans, stakeholders and employees of the VA Stars & Stripes Healthcare Network, I am pleased to present this Executive Summary. The pace of change in health care has accelerated over the past year. This is reflected in many changes that have taken place within our VA and the VA Stars & Stripes Healthcare Network. Extraordinary efforts have been made to address the many challenges facing the network. As we look forward to the next five years, significant strategic and financial planning actions will be necessary to secure the network's future as a vital and sustainable resource for veterans. Drawing upon the exceptional talents of our clinical and administrative workforce, along with input from external and internal stakeholders, we have created a Strategic Plan for FY 2000 that provides a direction for success in these uncertain but exciting times. Our financial and strategic planning for FY 2001 and beyond will begin shortly after the submission of the FY 2000 Strategic Plan.

The quality of our Strategic Plan is critical to VISN 4's future budgets and positive relationship with our stakeholders. This Strategic Plan serves as a roadmap that details the direction our network intends to take to meet the short and long-term health care needs of the veteran population. Our VISN Strategic Plan will be used for a variety of purposes but will especially be important in communicating future strategies and actions to stakeholders, VHA Headquarters, Congress and OMB.

The need for VISN 4's Strategic Plan becomes more compelling each year in order to defend program expenditures and account for the continued restructuring of our health care system. VISN 4 addresses the network's approach to three critical strategic issues:

- providing a full continuum of care,
- providing a predictable and consistent level of care; and,
- assuring implementation and accountability.

The VA Stars & Stripes Healthcare Network is in the forefront of change as a leader in restructuring the VHA. Many of these changes are evidenced by our FY 1999 planning accomplishments. Notable improvements have occurred in technical quality, cost, customer service, access and functional status. These five domains of health care value are critical factors upon which the vision and mission of the network are based. Along with these accomplishments come continuing opportunities for improvement as monitored by VISN 4's Performance Measurement Tracking & Monitoring System as well as VHA's annual performance measurement system.

Building on our competitive advantage of a strong linkage with veterans and stakeholders, we have strengthened our internal capacity for planning, coordination and implementation. Our council structure (Health Services, Resource & Planning, Marketing & Development, Human Resource & Education and Management Assistance) has been effective.

To continue our implementation of a Uniform Benefit Package for the network, we have established six (6) Paradigm Groups: Acute Care, Administrative Overhead, Behavioral Health, Clinical Support, Long Term Care and Primary Care.

The objectives for the Paradigm Groups include:

- increase quality: technical and perceived (e.g., customer satisfaction)
- integrate services across the network
- increase efficiency, demonstrated by increased numbers of patients treated and services provided
- keep costs at a constant level (inflation will be absorbed though increased efficiency)
- add new services (as required by the Uniform Benefits Package)

Our next Plan for FY 2000 will build upon FY 1999's accomplishments. It will also link Network Operational Strategies and FY 2000 Performance Goals to Annual Performance Measures. Finally, it will address how we will achieve VHA's "10 for 2002" strategic targets and VA's Corporate Goals.

## MISSION

VA Stars & Stripes Healthcare Network, part of the U.S. Department of Veterans Affairs, is dedicated to providing health care and social services to veterans who have earned, deserve, and are entitled to those services. There are more than 1.5 million veterans in our service area. In 1998 we served over 187,000 patients, primarily veterans living in Pennsylvania, Delaware, and several counties within West Virginia, Ohio, New Jersey, and New York.

### Health care Facilities:

Our network includes 10 medical centers located in:

Altoona, PA (814) 943-8164	Erie, PA (800) 274-8387	Pittsburgh, PA -VA Pittsburgh Health care System:
Butler, PA (800) 362-8262	Lebanon, PA (800) 409-8771	University Drive Division (800) 309-8398
Clarksburg, WV (800) 733-0512	Philadelphia, PA (800) 949-1001	Highland Drive Division (800) 647-6220
Coatesville, PA (800) 290-6172	Wilkes-Barre, PA (877) 928-2621	H.J. Heinz III Progressive Care Center (412) 688-6000
	Wilmington, DE (800) 461-8262	

We are committed to providing care as close to the homes of our veterans as possible. We now offer services in more than 30 freestanding community-based outpatient clinics in communities within Pennsylvania, Delaware, and areas of West Virginia, Ohio, and New Jersey. More clinics will be opening soon.

## SERVICES AND PROGRAMS

Our network offers comprehensive services ranging from preventive screenings and checkups to long-term care, including nursing home care. We also have special programs for women, minority, and Gulf War veterans and for other veterans' needs including:

- ✓ Prosthetics
- ✓ Post-Traumatic Stress Disorder (PTSD)
- ✓ Spinal Cord Injury/Dysfunction
- ✓ Homelessness
- ✓ Visual Impairment
- ✓ Sexual Trauma Counseling

Our veterans are eligible for a comprehensive, "Uniform Benefits Package" of inpatient and outpatient services. Veterans receiving health care benefits can receive a free ID card showing their entitlement to VA care and services. Services provided within the Uniform Benefits Package include:

- ✓ Preventive services
- ✓ Primary health care and diagnosis/treatment
- ✓ Surgery, including outpatient surgery
- ✓ Rehabilitative services
- ✓ Mental health and substance abuse treatment
- ✓ Home health care
- ✓ Respite and hospice care
- ✓ Urgent and limited emergency care
- ✓ Drugs and pharmaceuticals

## CLINICAL AND RESEARCH EXPERTISE

More than half of all practicing physicians in the United States received part of their education in the VA health care system. Nationally, approximately 100,000 health care professionals receive training in VA Medical Centers. VA Stars & Stripes Healthcare Network has affiliations with over 10 medical programs and universities, such as the University of Pennsylvania, the University of Pittsburgh, Penn State, West Virginia University, and Thomas Jefferson University.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) regularly evaluates all VA Medical Centers within the network, and our excellent JCAHO scores have consistently demonstrated the high quality of our facilities. In fact, our Erie VA Medical Center has received the Department of Veterans Affairs' *top* honor-- the "Robert W. Carey Award for Quality in Healthcare." The network has also three of the VA's nationally recognized "Programs of Excellence": the Substance Abuse Treatment Unit at the Philadelphia VA Medical Center, and the Home-based Primary Care and Renal/Dialysis Programs at the VA Pittsburgh Healthcare System.

We also conduct groundbreaking medical research on such health care concerns as chronic obstructive pulmonary disease, transplant surgery, diabetes, and post-traumatic stress disorder. A Geriatric Research, Education and Clinical Center (GRECC) has been established at the VA Pittsburgh Healthcare System to increase knowledge of the aging process and improve the overall quality of care for the older population. The Pittsburgh GRECC will focus on strokes in the elderly.

## NETWORK HEALTH CARE DELIVERY

Our Network Plan reflects success in making a number of key changes in the way in which health care services are provided to veterans. As a network, we continue to incorporate managed care principles and concepts to ensure that high quality patient care is provided in the most appropriate, cost-effective setting. Aspects of managed care that are reflected in the Network Plan include:

- Assigning patients to primary care teams who are responsible and accountable for providing a large majority of veterans' health care needs

- Expanding the use of clinical practice guidelines

- Implementing case management and utilization management programs to ensure enhanced continuity of care as well as efficient and appropriate service/resource utilization

- Implementing both clinical and administrative service lines based on broad groupings of patients (e.g., Mental Health, Extended Care, etc.) and functions (e.g., Business Office, Information Technology, etc.)

Coupled with the move to managed care, we are shifting the focus of health care delivery from inpatient, hospital-based settings to ambulatory settings. We are directing our efforts toward enhancing quality and patient satisfaction, reducing cost and increasing efficiency. We continue to increase the number of surgeries and other procedures performed on an ambulatory basis at the same time that we are decreasing the number of operating beds and bed days of care. In doing so, productivity has increased and surgical complications have decreased.

Integration and consolidation of clinical programs, support services and management within facilities is another strategy that we are implementing to increase efficiency, improve patient satisfaction, and enhance the quality of care that we provide. Additionally, we are developing consolidated network-wide contracts for a variety of services and products.

## **TECHNOLOGY, EDUCATION AND RESEARCH**

Our network continues to emphasize the importance of new technology as well as education and research in ways to enhance quality, increase efficiency and improve veterans' (customer) satisfaction. Implementation of telemedicine, video conferencing and other telecommunications initiatives has enhanced our capability to share information and best practices. Additionally, these initiatives helped foster a patient-centered culture. Improved clinical and administrative information systems (e.g., Decision Support System DSS, Computerized Patient Record System CPRS, etc.) are being integrated with existing databases. This will enable the network to achieve our goal of becoming a fully integrated, interlocking system of care.

Increased training and educational opportunities for employees, patients, and clinicians are another integral component of the network's strategic efforts. These efforts will be enhanced by the use of state-of-the-art technologies (e.g., computer-based training, distance/satellite learning, video teleconferencing, etc.). Further enhancements will come from changes in how we provide health care services (e.g., realigning residency positions toward primary care).

From a national perspective, research initiatives will be increasingly coordinated across networks, special emphasis will be placed on linking research with veterans' needs (e.g., geriatric, mental health, long term care, rehabilitation, etc.).

## **CUSTOMER SERVICE, SATISFACTION AND QUALITY**

The preeminent characteristic of our plan is a renewed emphasis on customer service and quality. network customers encompass not only patients but also employees, stakeholders, Congress, Veterans Service Organizations and other concerned organizations.

The strategies employed by the network will increase customer service and satisfaction. Our actions will: provide customer service training for employees; ensure a safe, friendly, and comfortable work environment free of discrimination and harassment; enhance relationships with stakeholders; reduce travel time to access services and patient waiting times; and, recognize employees for significant contributions and performance.

## **ACCOMPLISHMENTS**

- ◆ Increased enrollment by 6.6% from 175,741 unique patients seen in FY 1998 (through August 21) to 187,347 unique patients enrolled in FY 1999 (through August 21).
- ◆ Activation of four (4) CBOC's during FY 1999 with three (3) additional clinics approved and pending implementation in the near future. These clinics are in addition to the fourteen (14) CBOC's already in operation, which have undergone the congressional approval process begun in March 1995.
- ◆ Increased MCCF collections by 11.3% from \$29,672,099 as of August 1998 compared to \$33,034,750 collected through August 1999. VISN 4 is among the top three or four networks in the country for the amount of MCCF collections. Four of VISN 4's VAMCs held rankings in April 1999 in the top ten of VAMCs throughout the nation for the amount of MCCF dollars collected.
- ◆ Collection of almost \$3 million of additional external revenue (other than MCCF) during FY 1999.
- ◆ Reduction in the cost per patient (unique) from \$3,830 in FY 1998 (through August) to \$3,797 in FY 1999 (through August).
- ◆ Total VERA Funding for Research has increased from about \$8,000,000 the base year in FY 1997 to approximately \$11,500,000 in FY 1999.
- ◆ Implemented use of Primary Care Program Enhancement (PCMM) VISN-wide.
- ◆ Implemented use of Pain as 5<sup>th</sup> Vital Sign VISN-wide.
- ◆ Our percentage increase in peer-reviewed research grants of 92.3% was the largest in the nation.
- ◆ Established a network-wide process for the handling of Patient Safety Alerts.
- ◆ Actively promoted reporting of adverse events VISN-wide.
- ◆ Standards for care for the prevention and treatment have been established and implemented VISN-wide.

- ◆ Standardized oncology care across the network by ensuring that all VISN facilities provide access for their patients to an accredited cancer center.
- ◆ Achieved reductions in specialty resident slots required by the Petersdorf Commission.
- ◆ Standardized glucose monitoring devices for use in the medical centers as well as use by outpatients for a projected annual savings of \$400,000.
- ◆ Developed *first-ever* network *Welcome Package* to foster patient retention.
- ◆ Continued to build relationship with patients through production/distribution of *Veterans First*, including use of newsletter feedback coupons that generated hundreds of responses.
- ◆ Produced *first-ever* network fact sheet for stakeholders; also published on our Web site.
- ◆ Initiated joint project with PA Department of Military and Veterans Affairs on *first-ever* billboard campaign to increase veterans' awareness of our services and their eligibility for benefits.
- ◆ Integration of planning and resource management functions through the establishment of the Resources and Planning Council (originally developed as the Resource Advisory Council). The council is the last forum for review and recommendations on planning and resource issues before submission to the Executive Leadership Council/Network Director for final decision.
- ◆ Consolidation of contract for VISN's 1, 2, and 4 for insurance matching/identification to increase MCCF collections, and supplemental funding for the significant growth seen in prosthetics (greater than \$7 million above the VACO distribution).
- ◆ VISN 4 identified as Best Practice for Y2K Project Management by VAHQ
- ◆ Developed a Performance Measurement & Tracking System on the Network Web Site.

## **FUTURE DIRECTIONS**

### **Acute Care:**

- Validate appropriateness of admissions (medical necessity of admissions and continued stays days); bed service and acuity level of services provided and length of stay by Acute Medicine and Surgery
- Evaluate Acute Medical and Surgery ALOS and costs
- Reduce Network Cost per Discharge
- Reduce Network Staffing Costs
- Increase Occupancy Rate
- Increase Network Funds Available for: Ambulatory Care Programs (Prime VA Focus)

### **Administrative Overhead:**

- Development of a resource pool for medical equipment contracts
- Consolidation of service contracts within the VISN
- VISN wide purchase orders for various supplies and materials
- Develop a comprehensive space plan that addresses the usage of all space at each facility
- Reduce administrative overhead
- Reduce human resource cost per employee at each facility
- Consolidate billing and collection functions
- Increase supervisory ratio

### **Behavioral Health:**

- Expand outreach and contract housing services to homeless veterans
- Expand community based case management services to support patients being discharged to the community
- Expand use of existing programs including on-site residential care, substance abuse treatment, observation beds, and telepsychiatry.

**Clinical Support:**

- Right size the support services
- Utilize technology to provide services in a high quality, cost efficient manner
- Attain savings through consolidation and sharing
- Increase Dental specialty access to within 30 days
- Histology services to be provided at Hubs
- Reduce Pharmacy Window waiting times
- Timely transcription of radiologic exams

**Long Term Care:**

- Establish or enhance Home Health Care Services at each facility to include home health care staff; care management for high risk patients (hospice, COPD, CHF); and partnering with community agencies to provide LTC
- Expand Home Based Primary Care
- Ensure a LTC Continuum of Care to include transitional beds, Nursing Home Care Units, Community Nursing Home Care, Assisted Living, Residential Care, Adult Day Care and Respite Care dependent on the clinical needs of patients
- Collaborate with community agencies to ensure reliable referrals and a full range of services within the veteran's community

**Primary Care:**

- Enhance the delivery of and access to Primary Care including VA, CBOCs and health fairs
- Improve Customer Service through increased opportunity for patient education and increased consistency of primary care provider team in order to build provider/patient relationships.
- Increase utilization of electronic resources to support clinical providers (technology)
- Support use of Chronic Disease Index and Prevention Index within Primary Care

# *VA Capitol Network FY 2001-2005 Strategic Plan*



Martinsburg VA Medical Center  
Washington DC VA Medical Center  
VA Maryland Health Care System:  
Baltimore Medical Center  
Fort Howard Medical Center  
Perry Point Medical Center

## Executive Summary

As the new millennium approaches, the VA Capitol Network continues the implementation of our strategic initiatives that are designed to transform our network-wide health care services into an integrated health care delivery system. This process is reflected in our network goals and priorities, performance measures, and continuous monitors. Our vision is to assure that our integrated health care delivery system excels in achieving the Department's goals by providing excellence in health care value, excellence in customer service, and advances in education and research. We will strive to hold ourselves exceptionally accountable and become an employer of choice for our employees.

Our network vision and goals are synchronized with VHA's mission, strategic targets, and performance measures. We look forward to implementing the planned initiatives that have been outlined in our strategic plan. These initiatives will advance our progress in establishing a comprehensive integrated health care system that is responsive to our veterans, our staff, and other key stakeholders.

The VA Capitol Network Strategic Plan covers the period from 2001 to 2005 and is intended to outline how we will continue to:

1. Improve the value of our health care services
2. Promote managed care principles
3. Become more efficient
4. Focus on selected areas of clinical expertise
5. Increase the number of veterans served
6. Find new sources of revenue

The network utilizes participatory task forces and committees that engage and empower employees at all levels in the organization. These task forces and committees help to evaluate services and processes within the network, help to monitor goal oriented performance measures, and make recommendations to consolidate, realign, and/or redesign services and functions. A key example of this successful process is displayed by the accomplishments of the Information Management Committee and its various subgroups. Their hard work and their goal focused performance has resulted in the full implementation of the electronic medical record. VISN 5 was the second VISN in the county to achieve this implementation. Another example is the Year 2000 (Y2K) task force that includes staff from all levels of the organization and has worked together to develop VISN-wide Y2K contingency plans, and has successfully tested each medical center's utility and power plant systems. A clinical application of this process can be seen in the development of a VISN-wide research proposal to ensure implementation of the Diabetes Clinical Guidelines. This proposal will result in the evaluation of the outcome of the combined disease-management and educational approach of high-risk patients with type-two diabetes.

The enhancement of communication with key stakeholders is being emphasized throughout the network. We strive to continually seek stakeholder participation in our planning efforts and disseminate information in a timely manner to keep everyone informed. Information and feedback from patients is obtained directly through patient satisfaction surveys and through our patient advocates, such as the Veterans Service Organizations and Patient Representatives. Quarterly meetings are held with our Management Assistance Council (MAC). The MAC is composed of representatives of the major veteran organizations in our network, as well as union representatives from each of our medical centers, deans from our affiliated medical schools, and our medical center leadership. Congressional legislators and their staff are invited to a Congressional Open Forum every six months. Employees are kept informed through such vehicles as interactive quarterly visits with the Network Director and employee membership on our many committees and task forces. Additionally, the Network Director meets every four to six weeks with union presidents and provides quarterly Network Awards to individuals or teams for major contributions for customer satisfaction and achievement of network goals. The VA Capitol Network Newsletter is published quarterly to further enhance communications.

Improving the value of our health care services for our veterans is paramount in our strategic plan and initiatives. The development of new treatment modalities, improving the management of care and the reduction of inpatient lengths of stay are principal methods being used to improve our health care services. Our many task forces utilize this premise as a major strategic goal. Key focal points include reducing unnecessary duplication of services, developing consistency in the provision of care by implementing network-wide clinical practice guidelines, and implementing admission and discharge criteria, and screening processes. The promotion of managed care principles such as primary care, preventive care, and community-based care also supports our enhancement of health care services. The use of a primary care provider who is responsible for the care of specific patients improves access to care, patient education, and reduces duplication of services. The network is working to improve our outreach efforts and community programs, especially health promotion and disease prevention programs. The implementation of VISN Service Lines is also intended to improve customer service by enhancing communication across facilities and by increasing the quality and value of care to our veterans. Service Lines will help us provide consistent high quality care, become more cost effective and increase market share by attracting new users for these services.

The VA Capitol Network Marketing Committee is developing a comprehensive marketing plan that will support our strategic goal of increasing our market penetration rates and the number of our unique veterans. Communications/Marketing, Chapter 6 in our Plan, outlines the market analysis and strategies that will be used to accomplish our strategic goal of designing VISN capabilities to meet veteran needs and expectations, defining a strategy to attract new veteran users and implementing that strategy to make VHA a more attractive choice for veterans. In addition, we have opened three new Community Based Outpatient Clinics (CBOCs) in the latter part of FY 1998 and five new CBOCs in FY 1999 to improve veteran access to VA health care. Furthermore, VA Headquarters' approval has been provided for four new VISN clinic proposals.

To supplement our appropriated funding, new sources of revenue are being explored. A proposal has been submitted by our network to participate in the Medicare pilot program, and we are strengthening our relationship with the Department of Defense. We hope to increase the number of reimbursable services provided to the Department of Defense by collaborating on additional sharing agreements and developing other joint ventures.

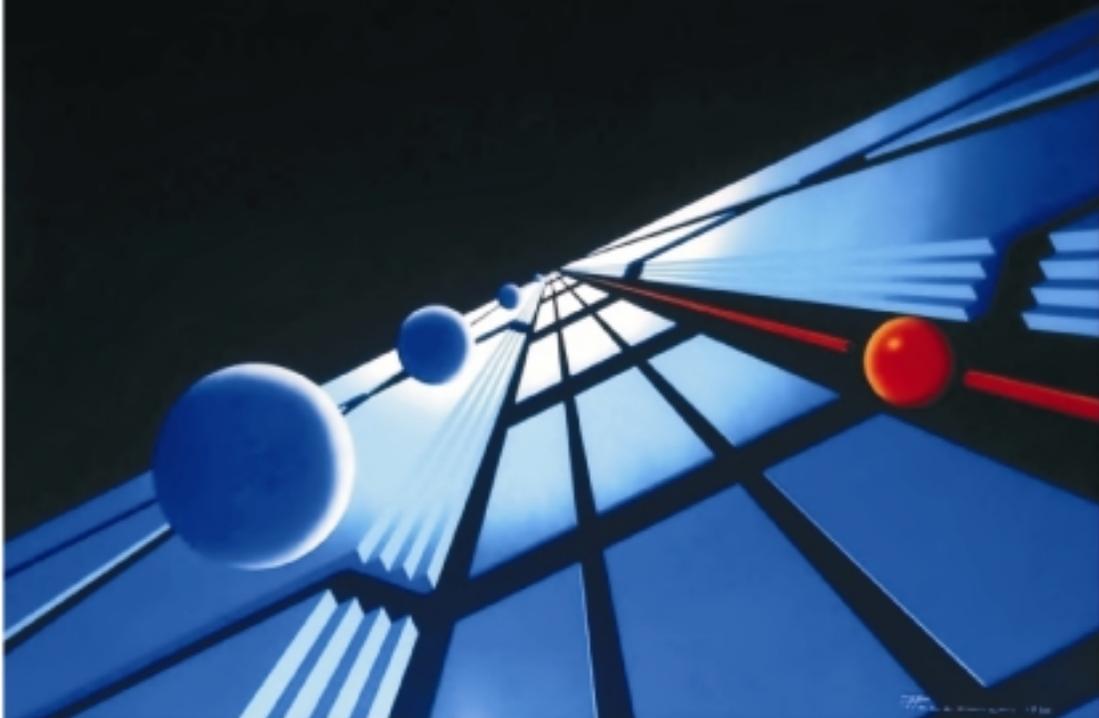
The network's capital strategy makes our medical centers and other health care sites more accessible to our veterans, are outpatient oriented, support a continuum of care, and are efficient to operate. We are investing in infrastructure improvements as necessary to ensure continued delivery of care in existing facilities with improved customer satisfaction. All major facility decisions are based on the premise that we will provide quality care, in the most appropriate setting, by highly qualified practitioners, in a cost efficient manner. This philosophy has led to the evaluation of our Fort Howard facility and its possible mission change. Further details regarding this initiative may be found in Chapter 7 of our Plan, Capital Plans/Alternatives to institutional Care/Contracting.

The VA Capitol Network presents our strategic plan which approaches the new millennium with enthusiasm, and with a specific strategy to develop an efficient integrated health care delivery system that is responsive to veteran health care needs and ready to meet future challenges.



# **FY2000 - FY2005 BUSINESS & STRATEGIC PLAN**

October 1999



**VA Mid-Atlantic Health Care Network**

## Executive Summary

The VA's Mid-Atlantic Health Care Network spans North Carolina, most of Virginia, and the southwest portion of West Virginia. Over 1.2 million veterans live in this area. The VISN operates eight VA Medical Centers, eight VA Nursing Home Care Units, one Domiciliary, one Satellite Outpatient Clinic, and 10 Community Based Outpatient Clinics. The network's VAMCs are Asheville, NC; Beckley, W. VA; Durham and Fayetteville, NC; Hampton, Richmond, and Salem, VA; and Salisbury, NC. The VISN's Medical Centers are all affiliated with major medical and allied health education institutions. The VISN has strong research programs clustered in Richmond and Durham but extending to virtually all VAMCs. Several large DoD installations are located in VISN 6 with sizable numbers of military retirees residing near those bases. DoD's TRICARE Region 2 is situated largely within VISN6's boundaries.

VISN 6 has been in operation for more than three years and has capitalized on many opportunities and addressed many challenges. The Strategic Planning Board and its 10 subcouncils have been active in planning change and performance improvements across the VISN. The Plan reflects significant accomplishments and proposed initiatives consistent with VA system-wide goals. Integration of care across the network by means of the three pilot Service Lines has helped focus priorities for improved services to veterans throughout the network. All facilities received accreditation from JCAHO this year.

The Mid-Atlantic Health Care Network's continuing challenges are to:

- Ensure provision of the right care to eligible veterans in the right place, at the right time, and at the right price;
- Ensure provision of high quality health care that surpasses ever changing health care industry and VA standards;
- Effectively and efficaciously manage human, financial, infrastructure, equipment, informatics, and other capital asset resources;
- Involve stakeholders in planning for the future;
- Provide a safe, maximally functional and rewarding health care environment; and
- Continually improve patient, family, visitor, internal and external stakeholders' satisfaction.

The network's new challenges are to:

- Do all of the above in a predictable and consistent manner so that veterans and family members will have a clear understanding of what is provided where and how;
- Ensure that the VISN's range of services and programs span a continuum of care;
- Evaluate programs with measurable standards, objective, and outcomes; and
- Operate within budgeted dollars.

This planning cycle presents the Network's Strategic Direction for Fiscal Years 2002 – 2005, preceded by its Business Planning Direction for FY 2000 – 2001. The narrative portion of the Business and Strategic Plan also includes completed Financial & Operating Strategies and will in the future include a detailed FY 1999 Accountability Report and Performance Plan and Capital Assets Plan.

The VISN's five strategic goals directly relate to VA Corporate Goals and VHA Mission Goals.

Based on VAHQ guidance and budget projections, in FY 2000 VISN 6 plans to trim administrative costs, acquire income or cost savings from a number of actions, improve quality of care, and open at least five new CBOCs. In addition, resources permitting, the network plans to fund additional Primary Care teams and improve the Mental Health Care continuum. Design work for renovating Special Emphasis bed units (Spinal Cord Injury & Disorder and Mental Health) will commence if the VISN's major capital asset projection application is approved. In FY 2001, if the allocated budget permits, the VISN will continue to reduce administrative costs, achieve income and cost savings, and may be able to open two or more CBOCs, improve access to specialty (medical and surgical) care, and further improve access to Primary Care. In FY 2002 – 2005, under current planning guidelines, the VISN will need to

reduce about \$20 million per year from operating budgets by further reducing administrative overhead; reviewing clinical care for cost efficiencies, and generating income from outside sources. The network will also apply for funding of three to four capital asset major projects. These are: Special Emphasis Program upgrades/renovations (if not funded in prior years); Medical / Surgical Ward renovations; upgrading the Charlotte CBOC to a Satellite Clinic; and renovating all ambulatory surgery sites.

These goals and proposed initiatives will be the priorities for VISN 6 with the continuing sustained commitment to provide excellence in Service as defined by our customers.

**FY 2000**

**Atlanta Network  
(VISN 7)**

**Strategic Plan**

Submitted October 1, 1999

## Executive Summary

The Atlanta Network (VISN 7) Strategic Plan is aimed primarily at providing information to individuals and groups that have a stake in the integrated health care system operated by VISN 7 in the states of Alabama, Georgia, and South Carolina. These stakeholders are individuals interested in the health care system or they may represent many individuals such as veterans service organizations, elected officials, VHA Headquarters officials, community leaders, VISN 7 employees, union officials or others. This Strategic Plan in general informs stakeholders on the current status of the VISN 7 integrated health care system, future plans and strategies, and some of the challenges associated with implementing those plans and strategies. Future plans and strategies are intended to further the following goals of VISN 7:

Deliver the maximum possible health care value to our patients.

Satisfy and delight our veteran patients with quality and compassionate care so that VISN 7 is their provider of choice.

Continuously improve patient safety by redesigning high risk and safety critical processes based upon best practices internal and external to health care.

Ensure access to services so that early treatment and continuity of care is provided to the maximum number of veterans.

Improve and /or maintain the functional status of veterans served.

Operate cost effective business management services to ensure that the maximum possible resources go to the direct care of patients.

Implement employee education programs to support VISN priorities that drive health care value.

Provide support for the Graduate Medical Education of health care providers

To Enhance the provision of health care services that meet the needs of the VISN's veterans and the U.S. health care system.

Implement service lines management to ensure a uniform standard of quality and cost effective health care value throughout the network.

Focus network sponsored research on health care priorities identified by network clinicians, customers and stakeholders.

Maximize the use of information technology to improve clinical and administrative decision-making.

Continue to reallocate resources to outpatient and community based care systems to assure that services are provided in the least restrictive and most cost effective environment.

Maintain emergency preparedness capabilities to provide veterans with services required as a result of catastrophic occurrences.

Maintain the capacity to deliver high quality cost-effective care to veterans with special health care needs.

### **Chapter II. Internal/External Assessment**

The VISN 7 Strategic Plan presents several key factors and issues that have produced both lessons learned and challenges that must be factored into plans for the future of VISN 7. Some of these factors and issues are internal to VHA and its constituencies while others are more global affecting the health care industry in general. Many of these are either overlapping or have important direct or indirect relationships to each other. The following factors and issues key to the future of VISN 7 are discussed:

Change in the focus of care from inpatient care to outpatient care managed by a primary care provider

Current and future continuum of care offered to veterans

Organizational changes aimed at improving the quality and predictability of services offered to veterans

Veteran enrollment trends

Budget impacts of inflation, new mandates, policies, and special programs

Adjusting human resources to meet veterans' needs

Reviews of the missions of VA medical centers

### Chapter III. Network Strategic Direction

The Network Strategic Direction section addresses VISN 7's strategy toward implementing the key missions of VHA in VISN 7. The health care mission of VHA is presented in regards to:

- Assuring the Continuum of Care
- Assuring a predictable and consistent level of high quality care
- Assuring implementation and accountability
- Customer Service

There is emphasis placed on the role of Service Lines utilized by VISN 7 and on outlining organizational responsibilities for the health care mission. Plans, organization and responsibilities are also provided on the Research, Education, and Emergency Preparedness missions within VISN 7.

### Chapter IV. Special Populations

Veterans with spinal cord dysfunction, blindness, traumatic brain injury, amputations and non-stroke neurological loss of limb, PTSD, and serious mental illness (SMI) including SMI related to substance abuse and homelessness have been identified by Congress as special populations. These programs are considered an important part of the continuum of care offered to veterans in VISN 7. The status of these special programs and plans for the future are provided or referenced. Of special note is the progress made in serving mentally ill veterans and the future operational and construction plans made for serving veterans with spinal cord injury/dysfunction.

### Chapter V. Financial Issues and Projections

Overall key issues discussed in the Internal/External Assessment plus additional issues have a significant impact on the financial viability of VISN 7. Those issues include:

- Veteran enrollment trends
- Budget impacts of inflation, new mandates, policies, and special programs
- Adjusting human resources to meet veterans' needs
- Reviews of the missions of VA medical centers
- New user patterns
- Compliance issues
- Veterans Equitable Resources Allocation (VERA) System

Three out of the four budget planning scenarios for FY 2001 required by VHA Headquarters (Freeze, +0.5M, +1.0M) will result in a deficit that must be made up through budget reductions. Even at the +1.5M level, the addition to the VISN 7 budget will result in less than a 1% increase over the projected FY 2000 funding level. Following is a summary of the budget projections:

	<b>FY 2001 ESTIMATED FUNDING VERSUS EXPENDITURES VARIANCE</b>			
	(Dollars in Thousands)			
	<u>\$Freeze</u>	<u>\$0.5B</u>	<u>\$1.0B</u>	<u>\$1.5B</u>
<b>Est. FY 2001 Revenues</b>	<b>909,487</b>	<b>933,880</b>	<b>958,274</b>	<b>982,687</b>
<b>Est. FY 2000 Operating Expenditures</b>	<b>981,801</b>	<b>981,801</b>	<b>981,801</b>	<b>981,801</b>
<b>Est. FY 2000 Deficit or Excess</b>	<b>-72,314 -</b>	<b>47,921</b>	<b>-23,527</b>	<b>896</b>

In order to meet the deficits projected above in FY 2001, VISN 7 will employ three overall strategies including:

- Efficiencies and Program Improvements
- Reductions Affecting Operations Including Access and Waiting Times
- Mission Review

Implementation of some detailed strategies must start now in order to bring about the savings projected by FY 2001 due to the delays in making personnel changes as discussed in the section on Human Resources.

#### **Chapter VI. Human Resources**

Some of the human resources challenges facing VISN 7 are discussed in relation to adjusting human resources to meet veterans' needs. Specifically, the need for flexibility in adjusting human resources as changes in modes of service delivery occur is crucial to maintaining the continuum of care needed by veterans. These changes have also resulted in a need for fewer employees throughout the VISN. The need for fewer employees coupled with the legal mandate to meet budgetary allocations resulted in a reduction of 835 FTEE (employees) since the inception of VISN 7. However, this decrease represents only 7.4% of the 11,253 FTEE existing in FY 1995.

Although VISN 7 lacks much of the flexibility needed to adjust human resources efficiently, other initiatives are being undertaken to improve the effectiveness of existing human resources including:

- Primary Care/Mental Health Cross Training
- Productivity Standards
- Implementation of a VISN 7 Business Office
- Consolidation of Clinical Support Services
- Career Development Centers

#### **Chapter VII. Performance and Quality**

The management and improvement of quality is a key network process that is organized at the medical center and VISN levels based upon the VISN's strategic emphasis on providing a consistently high level of quality throughout the network. This strategic emphasis is accomplished by an integrated VISN management system of clinical service lines in conjunction with the Health Center for Quality Evaluation (HCQE), medical center quality management programs, the VISN Clinical Leadership Council and the implementation of key strategies such as improved information systems. Through these mechanisms VISN 7 is successfully addressing the national quality initiatives on:

- Patient Safety
- Pain Management
- Waiting Times

Performance measurement is also addressed by service lines (including the HCQE), medical center quality management programs, and the VISN Clinical Leadership Council. Types of key measures that are monitored VISN-wide include:

- Headquarters mandated VISN Director Performance Measures
- Government Performance and Results Act (GPRA) Measures
- VISN Selected Performance Measures

VISN 7 has also adopted a strategy to improve the information systems that can facilitate the improvement of quality. Elements of the strategy include:

- Computerized Patient Record System (CPRS) Implementation
- Clinical reminders
- Primary Care Management Module (PCMM) Implementation
- Performance measurement of the continuum of care

## **Chapter VIII. Communications and Marketing**

Stakeholder communications and marketing are essential to the success of VISN 7 and a variety of means are employed to provide information on those programs and changes affecting stakeholders including:

- Direct personal contact with stakeholders
- Network Communications Work Group Study
- Management Assistance Council (MAC)
- Regularly scheduled briefings by medical center directors
- Network Director and key network staff briefings
- VISN 7 newsletter, *Today's Veteran*
- Mail outs to stakeholders of key documents
- Membership of stakeholders on task forces
- VISN office and medical center Public Affairs Officers

## **Chapter IX. Capital Plan**

VISN 7 has developed a capital asset management program vital to the effective management of its capital assets. Principles considered in the development of the Network Capital Assets Plan included the need for baseline assessments of space, the condition of the infrastructure and its related capital components, identification of performance gaps and related functional requirements, exploring alternatives to Capital Assets (OMB's "three pesky questions") and ultimately choosing the Best Capital Assets. Also addressed in the Capital Plans section are specifics on:

Long-Term Care Survey aimed at determining space available for long-term care

Alternatives to Institutional Care including:

- Coordination and Advocacy for Rural Elders (CARE) Research Project
- Geriatric Research, Education and Clinical Center (GRECC)
- VISN 7 Standardized Admission Criteria for Long term Care Programs
- Development of Hospital Based Primary Care (HBPC)
- Medical Center Level Plans

Contracting (specifically related to Community Based Outpatient Clinics)

## **Chapter X. Summary of Strategies**

A summary of the overall strategies to be utilized by VISN 7 in the coming years in order to meet the health care needs of veterans in an efficient and cost effective manner within budgetary limits is detailed in this chapter of our Plan.



# **Network Strategic Plan FY2000**

## Executive Summary

The Florida-Puerto Rico Veterans Integrated Service Network (VISN 8) includes 60 of 67 Florida counties; 19 south Georgia counties; and all of Puerto Rico and the U.S. Virgin Islands. Currently 1,723,130 veterans reside in the VISN, 44 percent of whom are age 65 years and older. The average VA market share for VISN 8 facilities increased to 16.7 percent in 1999.

VISN 8 has five VA medical centers and one integrated veterans health system. There are also 27 outpatient clinics; 10 are multi-specialty clinics and 17 are primary care community-based outpatient clinics (CBOCs). In FY 1999, two ambulatory care additions at medical centers were completed, and three new or expanded multi-specialty clinics were opened. Three more expanded multi-specialty clinics, and 20 new CBOCs will open between FY 2000 and FY 2003.

In FY 1999, VISN 8 served an estimated 287,860 unique patients (+20,414 over FY 1998 levels). By 2005, unique patients are targeted to increase 24 percent over FY 1999 levels. Outpatient workload increased 38 percent between FY 1996 and FY 1999, to 2,872,095 visits. At the same time, hospital bed days of care decreased 30 percent, while hospital inpatients treated decreased by 18.6 percent. The decrease in bed days of care exceeded the reduction in hospital inpatients treated due to shorter lengths of stay (-13.7%). Hospital operating beds were reduced to 1,521 in FY 1999, or a 39 percent decrease (-976 beds) from FY 1996 levels. These statistics evidence the dramatic shift from an inpatient to outpatient setting.

In FY 2000 and beyond, VISN 8 will make further shifts from inpatient to outpatient settings, both in workload and resources. Access to VA care will be improved as additional CBOCs are established, outpatient clinic backlogs are reduced, and collaboration with the community, public sector, and other VA facilities and VBA is increased. Average patient unit costs will be maintained or reduced, and any additional dollars received through the VERA process will be used to reduce waiting times, improve patient safety, and increase veterans served. Technological requirements to increase access to care, and to make patient clinical information available across all sites of care, will be implemented. Efforts to consolidate selected services and functions between neighboring VA facilities in geographic areas of the VISN, i.e., north Florida, central Florida, and south Florida, will be pursued.

VISN 8's **Mission** and **Vision**, respectively, are:

Provide a full continuum of high quality, patient-focused health care to veterans.

Become health care provider of choice for veterans.

VISN 8's **Values**, as expressed in the following statements, are:

We are fully committed to excellence in the delivery of health care to veterans, and in the service we provide to our co-workers and other stakeholders.

We shall earn and maintain the trust of our patients, stakeholders and employees, as we show respect and compassion toward them.

We shall encourage innovation VISN-wide and promote collaboration between facilities within the VISN, as well as with our partners in the community.

VISN 8's **goals** are associated with each of the five VHA mission goals.

*Goals related to excellence in health care value:*

- Increase access to more veterans patients;
- Ensure patients are treated in the most appropriate setting;
- Maximize function of special veteran populations.

*Goals related to excellence in service as defined by customers:*

- Improve coordination of care;
- Improve patient satisfaction with timeliness of service;
- Increase the satisfaction of veterans, dependents, and stakeholders who interact with VA employees; and
- Assure patient and employee safety in the delivery of health care services.

*Goals related to excellence in education and research:*

Structure clinical education to reflect changes in health care delivery; and  
Link research initiatives with evidence-based patient care.

*Goals related to exceptional accountability:*

Improve operational efficiencies through effective utilization management;  
Improve quality of data used to support decision-making;  
Consolidate/share services and procurements, both within and between facilities;  
Identify new sources of revenue to supplement appropriated funds.

*Goals related to an employer of choice:*

Recognize and reward employees' contribution to VISN goals;  
Provide educational opportunities for employees, and involve employees in decision-making; and  
Ensure fair workforce treatment through equitable and timely personnel decisions.

Strategies identified to address these VISN goals are:

- ◆ Ensure full deployment of the Network Strategic Plan to all employees and stakeholders to enhance two-way communications and to facilitate the Plan's implementation at all levels.
- ◆ Support the enrollment function by improving recruitment and retention of administrative support staff through increased training and creation of upward mobility programs.
- ◆ Address staffing issues in outpatient areas to eliminate specialty clinic backlogs, reduce primary care waiting times, and streamline administrative functions by:
  - Hiring and/or contracting for more specialists and technical support staff,
  - Increasing the mix of mid-level providers and administrative support staff,
  - Freeing up staff through consolidation of selected services in geographic areas.
- ◆ Reduce inappropriate referrals to specialty clinics, for improved utilization management, by using Milliman & Robertson guidelines, or similar criteria.
- ◆ Implement technology advancements for clinical decision support to care providers.
- ◆ Continue to provide training for both coding staff and clinicians to ensure timely and accurate documentation of encounter forms and medical records.
- ◆ Prioritize employee education needs VISN-wide for improved customer service and to re-educate and train those shifting from inpatient to outpatient programs.
- ◆ Promote VISN-wide collaboration on evidence-based research by encouraging requests for proposals (RFPs) through the VISN 8 HSR&D Advisory Committee.
- ◆ Improve utilization management in outpatient settings using Milliman & Robertson guidelines, or similar criteria, to ensure appropriate referral process.
- ◆ Establish a Home Care Service Line, incorporating care management principles, by piloting a home care model in various settings through a VISN-sponsored request for proposals.
- ◆ Use Tele-health/Telemedicine capabilities to expand home care services provided to veteran patients both to improve quality and access to care.
- ◆ Ensure all terminal patients have individualized plans for end-of-life care in accord with patient and family wishes, with pain management, and psycho-social and spiritual support.
- ◆ Improve patient and employee safety by redesigning six high risk service delivery systems identified through the Adverse Event Reporting System.
- ◆ Ensure that key issues of customer service, including coordination of care, inter-facility transfers, and access, are addressed with performance expectations for all employees; develop Network Director's award for employees providing superior customer service.

- ◆ Identify and develop interdisciplinary competencies in patient health education to enhance disease prevention and health promotion.
- ◆ Address full spectrum of long-term care modalities for SCI/D veterans, including care by families and friends, paid attendants, respite care, residential care, and assisted living.
- ◆ Address potential impediments to care, such as providing medication management at PTSD treatment sites (e.g., vet centers). Encourage PTSD research to enhance care of veterans.
- ◆ Pursue national policy change to credit mental health patients receiving follow-up care in a substance abuse or geropsychiatry clinic within 30 days of discharge from psychiatry ward.
- ◆ Establish therapeutic and procedural standardization for all substance abuse treatment programs consistent with clinical guidelines expected soon from VAHQ. Promote increased funding for contract residential homes at all sites to enhance recovery.
- ◆ Collaborate/partner with community providers for transitional housing for homeless veterans.
- ◆ Develop a VISN-wide contracting model for maternity care for women veterans.
- ◆ Study feasibility of consolidation, within geographic areas of the VISN, for functions of select services - laboratory, radiology, A&MM, facilities management, nutrition & food services, surgery, and human resources.
- ◆ Correct environmental problems identified in leased and VA-owned satellite outpatient clinics; GSA and VA building standards employed were unsuited to VISN 8's more tropical climate.
- ◆ Renovate infrastructure within medical centers and outpatient clinics to streamline patient care delivery by creating additional exam rooms per provider.
- ◆ Streamline billing and revenue collection processes by consolidating MCCF/TriCare functions between facilities geographically, or VISN-wide.
- ◆ Address financial issues confronting VISN 8 such as funding for major activations, the cost of providing care to Priority 7 veterans, monitoring the shift of resources from inpatient to outpatient care, and increasing prosthetic costs and other mandated/entitlement changes.



**STRATEGIC BUSINESS PLAN**

**DEPARTMENT OF VETERANS AFFAIRS**

**MID SOUTH HEALTHCARE NETWORK**

**VISN 9**

## Executive Summary

Strategic planning accomplished at the network level links with and compliments the VHA strategic targets and performance measures. Building on the network strategic planning process, linked with the objectives outlined in the *Prescription for Change II*, the Network Policy Board has developed an implementation plan to achieve the objectives.

The Mid-South Healthcare Network is comprised of 7 medical centers with one medical center having two divisions, and 11 community based clinics. The medical centers are located in:

<b>Huntington, WV</b>	<b>Memphis, TN</b>
<b>Lexington, KY – Cooper Drive</b>	<b>Mountain Home, TN</b>
<b>Lexington, KY – Leestown Road</b>	<b>Murfreesboro, TN</b>
<b>Louisville, KY</b>	<b>Nashville, TN</b>

Community-based clinics serve an important role in reaching patients in a geographically dispersed area. Current locations include:

<b>Bowling Green KY</b>	<b>Hopkinsville, KY</b>	<b>Prestonsburg, KY</b>
<b>Charleston, WV</b>	<b>Jonesboro, AR</b>	<b>Smithville, MS</b>
<b>Chattanooga, TN</b>	<b>Knoxville, TN</b>	<b>Southern, IN</b>
<b>Ft. Knox, KY</b>	<b>Madison, TN</b>	

### Mid South Healthcare Network

#### Mission Statement

*To provide comprehensive, appropriate health care services to veterans consistent with mandated benefits. To manage the provision of services in the optimal setting to provide high quality, accessible, cost effective care to veterans.*

#### Vision Statement

*The health care system of choice for veterans.*

To effectively position the network, strategic development and implementation is an on-going process based on data and strategic thinking. In the broadest of terms, the Network Guiding Principles are: **Enhance Quality, Improve Access, Provide Excellent Customer Service, Reduce Cost.**

The specific plan to achieve this overall strategic plan is detailed in the accompanying pages. To achieve our mission we have developed a detail listing of initiatives to assist the network in accomplishing our goals. The initiatives are presented in the summary of strategies.

The significant issue facing the Mid-South Network in the immediate future is the budget allocation process. Uncertainty in budget allocations and unfunded mandates requires managers to re-examine current processes and program efficiencies. Restructuring and planning must incorporate a structured approach with maximum flexibility. VA corporate goals, VHA Mission Goals, VHA Strategic Targets and Performance Measures are the guiding principles in all network planning. The four principles to network strategic planning are:

- Visionary leadership
- Continuous quality improvement
- On-going planning
- Performance evaluation

The Network Policy Board is comprised of the Network Director, Deputy Network for Operations, Clinical Manager and the Medical Center Directors. Through the Network Policy Board, specific work groups have been established to study and evaluate program efficiencies and effectiveness on a network scale.

Selection of a Network Director from the private sector has heightened an awareness of external factors affecting strategic planning and financial planning in the network. As a matter of policy, the Mid South Healthcare Network actively involves our stakeholders in all aspects of network business. Stakeholders include service organizations, educational affiliates, employees, congressional staff, and headquarters staff. Every effort is made to involve our stakeholders with matters of concern. This policy is exemplified by the media coverage received on the proposed integration of Murfreesboro and Nashville medical centers.

Communication plays an important and vital role in assessing our strategic position within the marketplace. On a regular basis, the Network Director holds meetings with service organization representatives and educational affiliates to discuss budget, reorganization efforts, performance measures, and customer satisfaction. Townhall meetings are conducted with employees as the Policy Board rotates its monthly meeting sites. Congressional staffers meetings are held at the medical center level as well as network level annually. Business and planning initiatives are coordinated and communicated with headquarters staff to ensure national priorities are being met.

The need for work groups and/or special studies is solicited through ideas and suggestions at the grass root level and corporate level. Councils are used as a forum to implement and monitor recommendations and procedural changes. This approach has resulted in a number of recommendations and policy changes that have contributed to the concept on a single integrate system of health care. Success stories and best practice ideas are disseminated throughout the network through electronic communications, training sessions and townhall meetings.

The Mid South Healthcare Network has a primary service area which and provide health care services to veterans in Tennessee, Kentucky, West Virginia, Mississippi, Arkansas, Virginia, Georgia, Indiana and Ohio. There are 262 counties within the Mid South Healthcare Network. The area we serve is over 150,000 square miles and has a wide mixture of rural and urban population centers. Over 177,000 veterans received care through one of the 7 medical centers or its community-based clinics.

By examining our current market penetration reports, the potential for increasing our uniques is evident. The FY 1998 Market Penetration analyses for VISN 9 indicates we treated 129,627 of 442,322 Category A veterans residing within our primary service area. A market penetration of 29% indicates a potential market supporting further growth.

Movement from a Medical Center fixed structure, focused delivery system to a more fluid service area community based system has been a general tenant of strategies articulated at the national level for the past three years. Yet the pace of change has not been generally demonstrated within VISN 9. Issues resulting from the FY 1999 budget shortfall, changing management philosophies and style as well as changes in the nationally articulated goals and objective are prime drivers for development of additional strategic initiatives.

Formulation of the FY 2000 strategies has been undertaken with the assistance of outside consultants as well as an external VHA audit and external audits for service organization, discussion with affiliate, management assistant council partners and input from congressional staff. Stakeholder and independent review and comments have been actively sought since the proposed transition to a regional and community based delivery system is substantial. Significant time has been spent on restructuring network leadership, management relationships, committees and reporting systems. This has been undertaken as part of movement toward a more instilling a philosophy that supports a regional and community based approach to service delivery while at the same time support integration of resources within the network.

## **INITIATIVES FOR FY 2001**

Based on funding projections for future years the network is prepared to take a systematic approach to control cost and position ourselves for workload changes. The listing below provides the action items we have identified that will enable the network reduce operating cost and streamline services. Clearly, changes of the magnitude listed below are not without controversy; however, the projected decrease in veteran population, the emphasis on outpatient treatment and the decline in bed days of care further support the need for change.

### ***A. Reduce the Number of Patients:***

No initiatives planned

### ***B. Process/Efficiency Improvements:***

Enhance Lease Program at Mt. Home

### ***C. Program/Service (Benefits Package) Consolidations/Realignments/Reductions:***

1. Restructure Acute/Long Term within the Network
2. Consolidate Medical Media/Library - Network-wide
3. Staff Reductions in Chaplain Service

### ***D. Facility Integrations/Mission Changes/Closures:***

1. Integrate Inpatient Psych at Nashville with Murfreesboro
2. Integrate Intermediate Medicine at Nashville with Murfreesboro

### ***E. Personnel/Staffing/Labor Relations/General FTE Reductions:***

General Reduction in Force of 150 FTEE - Network-wide

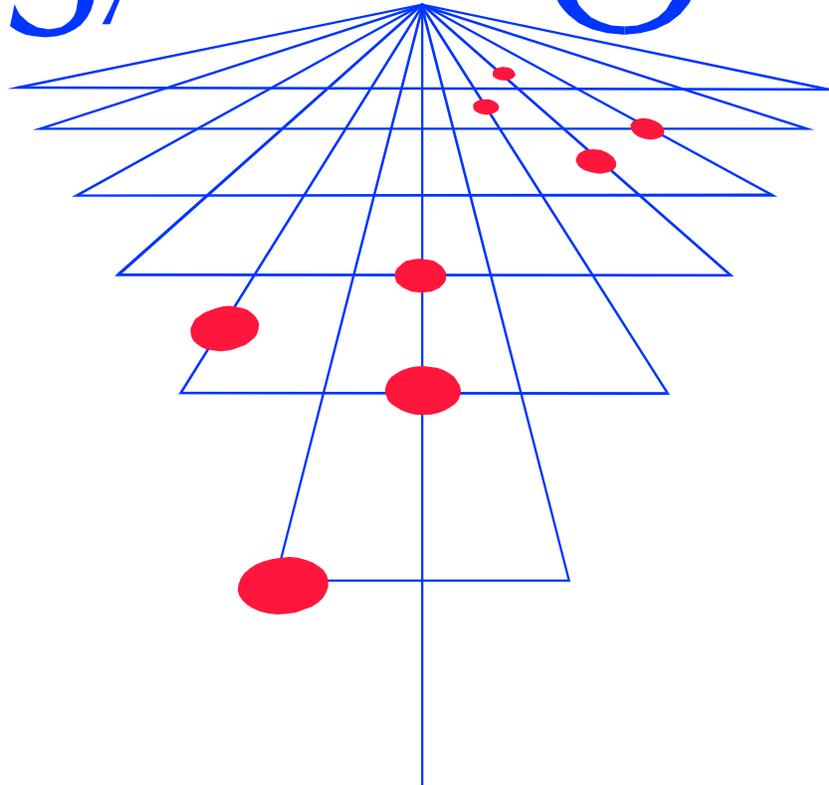
### ***F. Other Cost Savings Strategies or Action:***

1. Convert Capital to Operating Funds
2. Prosthetics Central Purchasing
3. VISN Adjustment on Projected Revenues
4. Protocol Driven Hepatitis C Care
5. Non-Admin Hours Management
6. VISN 9 Pharmacy Benefits Management
7. Adjustment to Provider Mix
8. Centralized Fee Basis Controls
9. Reduction in Beneficiary Travel
10. Reduce Utility Costs

The network continues in a positive direction in regards to performance, increasing the number of unique patients we treat, improving access to care, decreasing costs, reducing admissions and increasing our technology. The network has heavily invested in upgrading computerized patient record systems and the associated infrastructure to create a seamless data system between facilities. Teleradiology and telemedicine are just two areas where the network is preparing for future development. Staff training/education, cost efficiency measures in LTC, Laboratory and Pharmacy, medical record documentation and DSS advancements are just a few areas where the network has taken an aggressive and lead role in achieving network priorities.

As care becomes more regionalized, the use of telemedicine will increase. Our network provides specialty care in a number of programs. These programs excel in providing care to the patients and promoting the mission of the VA. Unique capabilities include multi-organ transplantation at Nashville VAMC, spinal cord injury care at Memphis VAMC and long term care psychiatry at Murfreesboro.

# VA Healthcare System of Ohio



**STRATEGIC PLAN**  
**FISCAL YEARS 2000 – 2004**

**October 1, 1999**

**Laura J. Miller**  
**Network Director**

## Executive Summary

The VA Healthcare System of Ohio enters the new millennium as a vibrant, integrated, health care system. As a system, we have begun the cultural transformation to a patient-focused organization. This cultural transformation includes new ways of delivering care, new organizational structures, and new relationships. As we began the journey in 1996, we knew it would take years to complete. The progress and accomplishments of the past few years are but a window to the opportunities we see before us in the future.

A significant role of planning in this network is celebrating our accomplishments. Those accomplishments have been focused on significantly improving access to the veteran population, developing enhancements and improvements to special programs for veterans, converting services to an outpatient arena, improving our patient care facilities and infrastructure, implementing computerized medical information systems across the network and meeting or exceeding most of the national clinical and quality measures. The continuing evolution of care lines has been and will be a primary mechanism for success.

Our Strategic Plan for FY 2000-2004 describes in detail the environmental and demographic factors affecting our network; the accomplishments of the past year; and a comprehensive range of initiatives that we are undertaking. These initiatives, independently and in sum, are intended to address two of the critical strategic issues facing the Veterans Health Administration: providing a full continuum of care, and providing a predictable and consistent level of care. The assurance of the third strategic issue, implementation and accountability, is operational in nature and will be achieved by a combination of reporting mechanisms and the care line organizational structure.

Our Network Strategic Planning Process identified a need to develop overall goals for the future. These goals are guideposts against which to measure progress and priorities. The ensuing planning activities always looked to these four goals for clarity and direction: assuring an appropriate patient focus, maintaining the financial health of the network, contributing to the public good in the areas of research and education, and developing a high performance work force. Based on these overall goals, the following specific initiatives have been developed and approved, along with a myriad of additional initiatives described in the full Strategic Plan:

- ◆ The Primary Care Line will continue to expand access to care, and has targeted a 10% growth rate for the next two years. This will be accomplished by additional Community Based Outpatient Clinics, productivity monitors, systems supports and primary care teams. Additionally the Primary Care Line will improve the effectiveness of referrals to specialty care.
- ◆ The Mental Health Care Line has two major initiatives: to increase outpatient access, including access to specialized treatment programs; and to size inpatient and residential services appropriately to the distribution of the veterans population.
- ◆ The Rehabilitation Care Line will plan outpatient, home care and telemedicine alternatives to inpatient care. They will also focus on coordination of care for patients with Spinal Cord Injury/Disease and the activation of the new Spinal Cord Injury Unit at the Wade Park (Cleveland) campus.
- ◆ The Medical-Surgical Specialty Care Line has several major initiatives planned. They will improve the timeliness of specialty consultations and referrals. The case management program will continue to evolve. Dialysis, oncology, critical care and cardiology work groups are developing initiatives around standardization and clinical guidelines. And screening and treatment of Hepatitis C will continue and expand.
- ◆ The Geriatrics and Extended Care Line will increase our investment in home and community-based long term care. They will also review the staffing mix in VA Nursing Home Care Units, and will identify specific needs for sub-acute care patients.
- ◆ The Clinical Support Services Care Line has initiatives to review productivity and turn around times in the clinical laboratory, dental and imaging services; to assure equitable patient access to dental services; and to implement new technologies in both the laboratory and imaging services.

- ◆ All services have identified data validation as an area for ongoing improvement. Our information management program will establish a mechanism to capture progress notes electronically, to implement VistA Imaging, to expand telemedicine, and to establish patient-to-provider electronic communications.
- ◆ Numerous projects are at various stages of planning and completion to provide major improvements in both the inpatient and ambulatory care areas across the network. These projects address deficiencies in patient privacy, infection control, patient flow and aesthetics.
- ◆ Integration of administrative services is being pursued as a cost efficiency measure. Improvements in business office functions and Medicare compliance are also major initiatives.
- ◆ In the area of employee education, a major customer service training program will be delivered in FY 2000, along with implementation of a number of elements of the High Performance Development Model.

Each of these initiatives and others are detailed in the full Strategic Plan. The dedicated, committed and highly competent staff of the network are committed to doing their utmost to succeed in these initiative, and by doing so will ensure that we provide our patients with the right care, at the right time and in the right place.

# STRATEGIC PLAN



October 1999



# Executive Summary

The VIP Network Strategic Plan sets the stage for achieving organizational improvement. It supports national mission goals, strategies and performance targets described in the Prescription for Change and further enumerated in the Journey for Change.

## **Mission, Vision, and Value Statements**

The vision of the VIP Network is to be a recognized leader in health care delivery, education, research and disease prevention; the provider of choice for veterans and other customers; the employer of choice; and good stewards within our communities.

The mission of the VIP Network is to be an integrated veterans health care system providing high quality, coordinated, comprehensive and cost-effective services to veterans and other customers in Michigan, Indiana, central Illinois, and northwest Ohio.

The VIP Network embraces the values of VHA: Trust, Respect, Excellence, Commitment, and Compassion; and expands on them as shown below. These values guide collective behavior and actions in carrying out the mission of the network.

- ◆ Treating others fairly and with respect
- ◆ Focusing on the needs of customers
- ◆ Building a system of care for veterans in the network
- ◆ Ensuring customer accessibility to care, including appropriate distribution of personnel and financial resources
- ◆ Demonstrating integrity and commitment in all actions
- ◆ Promoting a workplace where the contributions of all people are important
- ◆ Valuing diversity in fellow employees and customers
- ◆ Encouraging innovation, creativity and critical thinking
- ◆ Managing public resources responsibly
- ◆ Rewarding excellence and constructive risk-taking
- ◆ Encouraging collaboration with colleagues and external partners
- ◆ Demonstrating a willingness to change
- ◆ Promoting teamwork.

## **Chapter I – Internal & External Assessment**

As a player in the larger health care industry, the VIP Network responds to forces driving the changing health care market and faces competition from the private sector for patients, and particularly those who have insurance and/or are low users of health care services. The VIP Network must also respond to Department level influences such as the Government Performance and Results Act (GPRA), National Performance Review (NPR), and the General Accounting Office (GAO). The VIP Network develops its strategy based on strategic direction set forth in the *Vision for Change*, *Prescription for Change*, and *Journey for Change I and II*. Strategy is focused on several key areas including implementing primary care, reducing variation in the quality of care, emphasizing outpatient care, enhancing cost-effectiveness of both clinical and administrative system, and becoming patient-focused.

In addition, VHA has set expectations for the VIP Network to decrease its average expenditure per patient by 30 percent, increase the number of users by 20 percent, and increase the portion of the budget obtained from non-appropriated sources to 10 percent. For several years, the VHA medical care budget has remained essentially flat in inflation-adjusted dollars. Recent decisions surrounding eligibility reform and the definition of the basic benefits

package have introduced the potential for large numbers of veterans to enroll with VA. Facility mission realignment continues to be a major focus with heightened interest resulting from GAO studies regarding integration efforts. The VIP Network was identified as having multiple site markets which will require evaluation with regard to care site missions.

The VIP Network provides services throughout a large and geographically diverse region. It serves nearly 160,000 unique patients who live across 94,000 square miles. Currently, 21 care sites provide care to about 12 percent of the total veteran population. As can be expected, market share increases when geographic access is taken into consideration. The total number of veterans in the VIP Network is expected to decline through 2002; however, the Priority 1-6 veterans population will remain fairly stable.

## Chapter II – Performance & Quality

In its effort toward continuous quality improvement, the VIP Network is undertaking a number of quality initiatives. These include:

- ◆ working with the Institute of Healthcare Improvements (IHI) on projects to decrease waiting times in clinics and delays with veterans obtaining appointments;
- ◆ working with the IHI to reduce adverse drug events;
- ◆ implementing a shared decision making project;
- ◆ appointing a statistical consultant to work on issues such as patient satisfaction, hepatitis survey, ORYX data, and shared decision projects;
- ◆ evaluating community based outpatient clinics;
- ◆ forming a Quality Management Committee;
- ◆ sponsoring a JCAHO educational conference;
- ◆ evaluating the patient advocacy program;
- ◆ analyzing clinic waiting time data; and
- ◆ monitoring specific performance outcomes in the External Peer Review Program (EPRP).

## Chapter III – Human Resources

In the past four years, staffing levels have gone from a high of 9,004 FTE to a current level of 8,110. Physicians, nurses, and other clinical staff compose 58 percent of staff. An increase in turnover is expected in the next five years as 26.2 percent of all employees are eligible for retirement. Future recruitment challenges are expected in the following areas, some due to the failure of pay systems to keep pace with the salaries of highly sought staff:

Pharmacists/Clinical Pharmacists	Nurse Practitioners
Licensed Practical Nurses	Police Officers
Physicians	Fire Fighters
HR Specialists	Oral Surgeon
Physical Therapists	Periodontist
Nuclear Medicine Technicians	Clerical
CRNAs	Occupational Therapist
Orthotist/Prosthetist	Ultrasound Technicians
Registered Nurses	Corrective Therapists
Physician Assistants	Physical Therapy Assistant

A number of new initiatives will have a significant impact on the role of the physician, including additional responsibilities for use of the electronic medical records and in meeting all Medicare/HCFA compliance standards, resulting in increased time spent by physicians to provide care and meet documentation standards. To assist in meeting this demand on time, there has been an increase in mid-level practitioners. The network will continue to encourage retooling or reengineering of positions and retaining employees versus implementing reductions in force.

With the flattening of the organization through reengineering, the VIP Network is embarking on the implementation of the High Performance Development Model to allow staff to develop to their full potential and take leadership throughout the organization.

Efforts have been made to create an employee centered workplace, such as:

- ◆ establishing an Employer of Choice Committee to address issues raised in the Employer of Choice Survey;
- ◆ instituting five network awards to support and encourage essential goals;
- ◆ setting aside \$1 million to be used to enhance local employee education efforts;
- ◆ emphasizing workplace security;
- ◆ conducting a survey on violence in the workplace;
- ◆ minimizing employee injury;
- ◆ enhancing the Employee Assistance Program; and
- ◆ supporting the Alternative Dispute Resolution programs.

Effective Partnership Council activities have included new uniform/dress code policies, creation of the alternative dispute resolution process, new employee recognition programs, negotiation agreements, Y2K employee leave plans, and alternative work schedules. Labor representatives serve on many of the network committees and task forces.

#### **Chapter IV – Communications / Marketing**

Customer service is the cornerstone for communications and marketing in the VIP Network. The network has focused its efforts on soliciting and systematically responding to feedback from customers. The network established a Customer Satisfaction Committee to oversee customer service initiatives set forth in the VIP Network Satisfaction Plan. The following is a list of some of those initiatives:

- ◆ employee training;
- ◆ reward and recognition systems;
- ◆ measurement system to assess patient satisfaction;
- ◆ CARE training;
- ◆ evaluation of community based outpatient clinics on satisfaction;
- ◆ expansion of DHCP for scheduling appointments;
- ◆ implementation of simulation models of patient flow through clinics;
- ◆ publicity of best practices; and
- ◆ expansion of “secret shopper” evaluation tool.

The VIP Network has established a Marketing Committee to provide a centralized structure and common approach for managing overall marketing efforts throughout the network. The following marketing tools are utilized by the network:

- ◆ network logo and identity;
- ◆ standards and guidelines for using logo and identity;
- ◆ consolidated patient correspondence;
- ◆ VA Word-of-Mouth Program;
- ◆ continuing education programs;
- ◆ full-color brochure for network care sites;
- ◆ all-employee newsletter entitled “News at 11”; and
- ◆ patient newsletter.

## **Chapter V – Financial Plan**

The network's Financial Plan identifies key operating assumptions based upon expected resource allocation in the tactical and strategic years. Key assumptions include:

- ◆ shift of care delivery to outpatient settings;
- ◆ zero growth in inflation-adjusted appropriated dollars;
- ◆ advances in information technology, increased partnerships;
- ◆ continued implementation of strategies for managing the care of patients; and
- ◆ retention of major missions and expectations for collection of third party reimbursement.

Major investments are expected in the areas of improved access, integration of care delivery, meeting national mandates, and information technology. Savings are expected to be achieved through efficiencies, cost containment, standardization, and process improvements. Revenues are expected to be generated through medical care cost fund (MCCF) collections, sharing agreements, enhanced use initiatives and innovative partnerships.

## **Chapter VI – Special Populations**

In this submission, the VIP Network establishes a baseline for evaluating special populations. The baseline includes an inventory of programs and services that support special populations, as well as an inventory of best practices, monitors, and future initiatives identified by network facilities. Network initiatives are described and include the activities of the Geriatrics and Extended Care Service Line, the Mental Health Service Line, the Spinal Cord Injury and Disorders Committee, and the Women Veterans Program. Other major network initiatives are underway for Prosthetics and Orthotics.

## **Chapter VII – Capital Plans**

The VIP Network Capital Plan provides an overview of the infrastructure and equipment requirements for all network facilities. Priorities in this arena include:

- ◆ activation of community-based outpatient clinics;
- ◆ shifting care to the outpatient setting;
- ◆ improving facility infrastructure, space functionality, and patient care environment;
- ◆ demolition of vacant buildings;
- ◆ enhanced-used projects;
- ◆ maintenance and repair; and
- ◆ replacement and upgrading of equipment.

VIP Network facilities submitted capital asset surveys, five-year capital investment plans, and three-year equipment plans. These represent a logical strategy for infrastructure facility maintenance and allocation of equipment activation resources to support network program requirements. Included are planned construction projects in major, minor, and NRM categories, planned leases, performance-based energy project, and equipment items with estimated cost greater than \$150,000 for each facility. Capital summaries are provided for the network and each facility.

## **Chapter VIII – Network Strategic Direction**

The network's strategic direction is derived from the assessment of influential external factors and the internal analysis of how well the network is positioned to respond in the future. The VIP Network will pursue four major overarching strategies in the next two to three years: integration of programs, development of service lines in mental health and geriatrics and extended care, assessment of when care could be contracted, and generation of new revenues. The VIP Network has established seven goals to be achieved over a five year horizon:

- ◆ to be a provider of choice for veterans;
- ◆ to function as an integrated delivery system providing a full continuum of care;

- ◆ to provide high quality care;
- ◆ to sustain education and research missions that complement the clinical delivery system;
- ◆ to demonstrate a high level of commitment to employees;
- ◆ to strengthen financial position; and
- ◆ to provide safe and functional environments for patient, employees, and visitors.

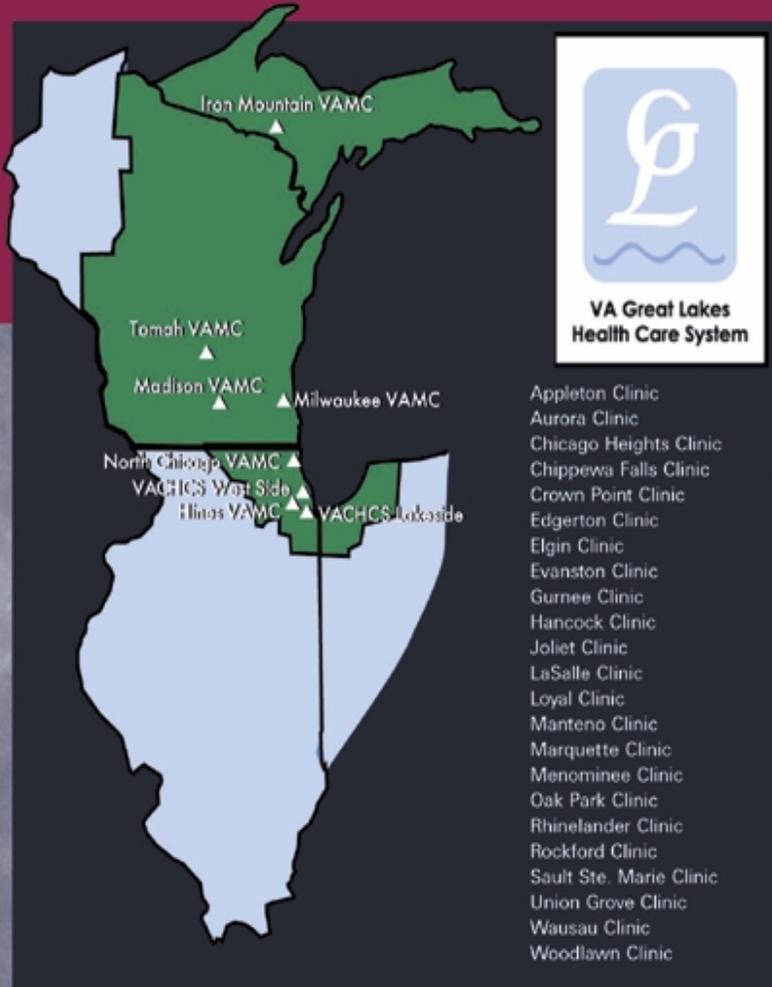
### **Chapter IX – Summary of Strategies**

This chapter presents the objectives and tactical actions supporting each network goal and assigns responsibility and timeframes for implementation. The chapter also illustrates the alignment of network goals with VHA mission goals, domains of health care value, and performance measures. Areas of emphasis include:

- ◆ improving access and customer service;
- ◆ providing continuity and managing the care of patients;
- ◆ ensuring a consistent high level of care quality;
- ◆ developing a high performing workforce;
- ◆ sustaining strong education and research programs;
- ◆ achieving efficiencies and new revenues; and
- ◆ managing information technology infrastructure and capital assets.

VISN 12

# THE VA Great Lakes Health Care System



## Network Plan

2000

 Department of Veterans Affairs

# Executive Summary

## **Background**

Our mission is to serve the veteran, many of whom have put themselves in harm's way to preserve our freedoms and way of life. The famous Abraham Lincoln quote, "... to care for him who shall have borne the battle and for his widow and his orphan ...," sum up the overarching goal of the VA Great Lakes Health Care System. VISN 12 takes seriously this mission to care for those veterans who seek VA services. VISN 12 will continue to provide care that is "second to none," and is committed to maximizing the use of its resources to assure that this is accomplished.

The past year has again seen significant progress in VISN 12's transformation to a fully integrated health care delivery system. Like last year, FY 2000 requires the VISN to continue meeting the challenge of maintaining and improving services in spite of a constrained resource base. This network plan describes the strategic direction and initiatives that are planned be accomplished in FY 2000 and beyond to assure our success under this challenging scenario. These include numerous initiatives aimed at managing cost reductions without any harm to quality or access.

VISN 12 continues to have the challenge of being a highly affiliated network, with six of its eight major medical care sites affiliated with medical schools and other universities. Accordingly, the VISN trains a large number of students/trainees throughout its system. This plan maintains the VISN's commitment to excellence in education and research.

As VISN 12 continues to re-engineer its health care delivery system, it is committed to maintaining its capacity for the specialized treatment and rehabilitative needs of veterans. This is operationalized through the continued commitment of providing the full continuum of special emphasis program services. This plan further builds on earlier initiatives aimed at using VISN 12 resources more efficiently while improving the quality of services. Employees and stakeholders will continue to be involved as the VISN discusses methods in which the special emphasis programs may be improved.

Central to VISN 12's health care delivery system re-engineering efforts is the shift of care from a bed-based, hospital inpatient system to one grounded in ambulatory care. During FY 1999, the VISN continued to close hospital beds as more health care was delivered in the ambulatory setting. VISN 12 will also continue to pursue improving the accessibility of primary care for veterans by opening several new community based outpatient clinics (CBOCs) in underserved areas or where there are geographic or other barriers to care.

With the passage of Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, VISN 12 now has a significantly expanded ability to obtain, or share health care resources with, or from, the private sector and other Government entities, enabling the VISN to provide better and more efficient health care to veterans. As the VISN continues to re-engineer into a fully integrated health care delivery system, it will continue to utilize the flexibility this law provides and continue to explore opportunities that will improve access to veterans, maintain or improve quality, and contain costs.

## **VISN 12 Delivery System Options Study**

The recently released findings and recommendations of the VISN 12 Delivery System Options Study Steering Committee places a significant element of uncertainty into VISN 12's strategic planning. The Options Study report **is currently out for review and comment by all stakeholders**. Restructuring options contained in the report will have a significant impact on VISN 12 strategies and financial projections. Thus, it should be noted that, in light of the Option Study's findings and recommendations, strategies and financial projections contained in this plan are subject to change.

The Steering Committee was formed in response to the April 1998 Government Accounting Office (GAO) report, "*VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services.*" The Committee was charged with completing a comprehensive assessment of the Veterans Health Administration (VHA) health care delivery system in the Chicagoland area (including Lake County) and developing options and selecting a recommended configuration for optimally aligning resources with veteran need for VISN 12 while preserving the other missions of VHA in the VISN.

The restructuring recommended by the Steering Committee builds upon the strategic initiatives of VISN 12 to continue integration efforts and to balance service supply with veterans demand while preserving access. VISN 12 has made significant progress towards improving care to veterans through modifying its health care service delivery system in accordance with the overall strategic direction of the “New VHA.” Given the projected demand, the Steering Committee concluded that only one tertiary acute care facility is needed in the Chicagoland area. The options considered by the Steering Committee differ principally in the magnitude of the consolidation of medical, surgical, and neurological acute services.

**Recommended Option (Option One):** Acute medical, surgical, neurology and subacute inpatient services from the VA Chicago Health Care System (VACHCS) West Side Division, Hines VA Hospital and North Chicago VA Medical Center are relocated to the VACHCS Lakeside Division. The VACHCS Lakeside Division also retains specialty ambulatory care services. The VACHCS West Side Division receives Psychosocial Residential Rehabilitation Treatment Program (PRRTP) services from the North Chicago VA Medical Center. The VACHCS West Side Division also retains its existing ambulatory care services, with additional ambulatory care volume from the VACHCS Lakeside Division. The Hines VA Hospital is restructured to accommodate all acute and long-term psychiatry, special emphasis programs [i.e., blind rehabilitation and spinal cord injury (SCI)], extended care, and existing PRRTP and ambulatory care services. The North Chicago VA Medical Center inpatient volume is redirected, with 5% of beds to the Milwaukee VA Medical Center and 95% of beds to the VACHCS Lakeside Division; except for PRRTP, which is redirected to the VACHCS West Side Division, and subacute, which is directed to the VACHCS Lakeside Division. Ambulatory surgery is relocated from the North Chicago VA Medical Center to the VACHCS West Side Division. All other ambulatory care services at the North Chicago VA Medical Center are retained or a new CBOC is built or leased at or near North Chicago. The Milwaukee VA Medical Center and Madison VA Hospital missions remain relatively unchanged.

**Option Two:** The VACHCS West Side and North Chicago VA Medical Center acute medical, surgical, neurology and subacute inpatient services are relocated, with 60% added to the VACHCS Lakeside Division and 40% added to the Hines VA Hospital. The VACHCS Lakeside Division also retains its existing ambulatory care services. The VACHCS West Side Division receives PRRTP services from the North Chicago VA Medical Center. The VACHCS West Side Division also retains its existing ambulatory care services. In addition to the added inpatient beds, the Hines VA Hospital is restructured to accommodate all acute and long-term psychiatry, special emphasis programs, extended care, and existing PRRTP and ambulatory care services. The North Chicago VA Medical Center inpatient volume is redirected, with 5% of beds to the Milwaukee VA Medical Center and 95% of beds to Chicago (60% to the VACHCS Lakeside Division and 40% to the Hines VA Hospital); except for PRRTP, which is redirected to the VACHCS West Side Division, and subacute, which is split between the VACHCS Lakeside Division and the Hines VA Hospital. Ambulatory surgery is relocated from the North Chicago VA Medical Center to the VACHCS West Side Division. All other ambulatory care services at the North Chicago VA Medical Center are retained or a new CBOC is built or leased at or near North Chicago. The Milwaukee VA Medical Center and Madison VA Hospital missions remain relatively unchanged.

**Option Three:** The VACHCS Lakeside Division acute medical, surgical, neurology and subacute inpatient services are relocated, with 60% added to the VACHCS West Side Division and 40% added to the Hines VA Hospital. The VACHCS West Side Division also retains its existing ambulatory care services and receives PRRTP services from the North Chicago VA Medical Center. All the VACHCS Lakeside Division existing ambulatory care services are relocated to a new built or leased CBOC near the VACHCS Lakeside Division. All services are relocated from the VACHCS Lakeside Division, resulting in the closure of the Lakeside Division campus. In addition to the added inpatient beds, the Hines VA Hospital is restructured to accommodate all acute and long-term psychiatry, special emphasis programs, extended care, and existing PRRTP and ambulatory care services. The North Chicago VA Medical Center inpatient volume is redirected, with 5% of beds to Milwaukee and 95% of beds to Chicago (60% to the VACHCS West Side Division and 40% to the Hines VA Hospital); except for PRRTP, which is redirected to the VACHCS West Side Division, and subacute, which is split between the VACHCS West Side Division and the Hines VA Hospital. Ambulatory surgery is relocated from the North Chicago VA Medical Center to the VACHCS West Side Division. All other ambulatory care services at the North Chicago VA Medical Center are retained or a new CBOC is built or leased at or near North Chicago. The Milwaukee VA Medical Center and Madison VA Hospital missions remain relatively unchanged.

**Option Four:** The VACHCS Lakeside Division acute medical, surgical, neurology and subacute inpatient services are relocated, with 60% added to VACHCS West Side Division and 40% added to the Hines VA Hospital. Acute psychiatry and rehabilitation services are relocated from the VACHCS Lakeside Division to the VACHCS West Side Division. The VACHCS West Side Division also retains its existing ambulatory care services and adds PR RTP services. All the VACHCS Lakeside Division ambulatory care services are relocated to a new built or leased CBOC near the Lakeside Division. All services are relocated from the VACHCS Lakeside Division, resulting in the closure of the Lakeside Division campus. In addition to the added inpatient beds, the Hines VA Hospital retains existing ambulatory care services while PR RTP beds are relocated to the VACHCS West Side Division. The North Chicago VA Medical Center, the Milwaukee VA Medical Center, and the Madison VA Hospital missions remain relatively unchanged.

**Option Five:** The VACHCS West Side Division acute medical, surgical, neurology and subacute inpatient services are relocated to the VACHCS Lakeside Division. The VACHCS Lakeside Division also retains specialty ambulatory care services. The VACHCS West Side Division adds acute psychiatric and PR RTP services and retains its existing ambulatory care services, with additional ambulatory care volume from the VACHCS Lakeside Division. The Hines VA Hospital campus is totally closed and ambulatory care services are provided through a CBOC. All long-term psychiatry, rehabilitation, blind rehab, and extended care are relocated to the North Chicago VA Medical Center. The North Chicago VA Medical Center also retains medical, subacute, acute psychiatry and PR RTP services. Ambulatory care services at the North Chicago VA Medical Center are retained or a new CBOC is built or leased at or near North Chicago. The Milwaukee VA Medical Center receives acute SCI services. The Madison VA Hospital missions remain relatively unchanged.

**Option Six:** Acute medical, surgical, neurology, psychiatry and subacute inpatient services are relocated from the Madison VA Hospital to the Milwaukee VA Medical Center, as is PR RTP. Also all ambulatory care services are retained at the Madison VA Hospital and the Milwaukee VA Medical Center. Ambulatory care services at the Madison VA Hospital are retained or a new CBOC is built or leased at or near Madison. The VACHCS Lakeside Division, VACHCS West Side Division, Hines VA Hospital and North Chicago VA Medical Center missions remain unchanged.

## **Strategic Direction**

Under the overarching concept of providing 80% of care within 30 minutes of veteran's homes, 90% of care within 2-3 hours of veteran's homes, and 100% of care within the VISN, the initiatives described in this plan will continue to accelerate the transformation of VISN 12 into a fully integrated health care delivery system. Strategically, VISN 12 will continue to develop a health care system that provides the full spectrum of care services while simultaneously ensuring that all veterans within the network have time access to needed care however simple or complex.

With this conceptual framework in mind, VISN 12 will continue to develop a health care system fundamentally supported by a strong primary care base. This means continuing to support the development of a system that improves accessible first contact care, that fosters continuity of care, that provides care comprehensively tailored to veteran needs including special emphasis programs, and that improves the coordination of health care delivery across the continuum and setting of care. A key strategy is to maximize the accessibility and value of care delivered in the community based outpatient clinic setting.

Given the high prevalence of mental health and substance abuse disorders in the veteran population served by VISN 12, mental health care will continue to be an important and special component of the continuum of care. In the mental health area, FY 2000 will be a year of assessment and evaluation. From the studies conducted, data-driven recommendations will be made regarding the need for changes in resources, practice, and policy that, when implemented, will provide more predictable and consistent care across the VISN.

Implementing plans that will decrease the total number of hospital operating beds is still important to the overall VISN strategic direction. The strategies outlined in this plan are directed at continuing a decrease in the use of inpatient resources, primarily acute care and intermediate care beds. This will be accomplished by developing an effective utilization management program. It is anticipated that some of the savings from decreasing the use of inpatient resources will need to be applied to facilitating more effective outpatient care.

In the area of long term care, this plan assures maintenance of VISN 12 long term care services while incorporating and managing new demands through the use of non-institutional services, fee for services, contracts, and State Veterans Homes, as appropriate. The overarching focus highlights the expansion of home and community based services incorporating a growth philosophy that decreases the reliance/dependence upon hospital or institutional programs. This means accentuating the “least restrictive” services that assures care in the most appropriate setting to achieve optimal health outcomes and quality of life, and to maximize scarce resource utilization.

## **Quality Management**

VISN 12 has elected to focus on the central concept of quality, rather than merely the development of information systems that generate quality data. This particular perspective views information as a means to an end, and therefore asks all participants to link together the varying bytes of information in the pursuit of qualitative analysis and decision making.

To this end, VISN 12 has established a quality and informatics committee structure, otherwise known as the VISN 12 Quality Council. The Council will continue to assist the VISN in the overall goal of becoming and operating as a fully integrated health care delivery system. It will continue to plan, develop and research the means to meet executive and clinical quality needs within the VISN. The Council will also work in concert with VISN facilities to improve data validation and integrity, charter subcommittee needed to evaluate and research new or existing quality initiatives, and develop, oversee, and coordinate the full implementation of all quality and informatics products and solutions within the VISN. In completing these assignments, the Quality Council will continue to emphasize a customer-focused approach with attention to developing processes that support seamless care. Improvement activities are geared toward moving the VISN facilities to the national medians in those cases where performance is below the mean and for higher achievements for those who have already surpassed the mean.

## **Communications**

VISN 12 will actively continue to communicate with and seek input from its affiliates and stakeholders regarding strategic planning initiatives and other VA issues of interest. VISN 12 takes the approach that an effective communication process enhances the public image and visibility of VISN 12 programs and services, as well as maintaining current patients and encouraging those not enrolled in VA health care to use the services for which they are eligible.

Working with a consultant, VISN 12 is developing a comprehensive communications plan that effectively addresses all the VISN’s internal and external stakeholders. The background context for working with a consultant contractor is the transformation and transitioning of the VISN’s operational and management structures over the past three years. Now, considering the recently released findings and recommendations of the VISN 12 Delivery System Options Study Steering Committee, it is more imperative than ever to develop a communications plan that generates support for the VISN’s strategic direction, and minimizes negative publicity related to implementing the plan.

## **Financial**

VISN 12 continues to address serious funding shortfalls and continues planning for additional restructuring, program consolidations, and other re-engineering efforts to ensure that expenditures do not exceed available resources. As previously mentioned, the restructuring options contained in the VISN 12 Delivery System Options Study report will have a significant impact on VISN strategies and financial projections.

The financial profile of VISN 12 indicates that while the VISN has made progress in improving its operating efficiencies, the declining veteran population projected for FY 2010 will not obviate the need for continued improvements in operating efficiencies that result in substantial cost savings. In addition, the VISN must continue to aggressively pursue revenue generation through medical care reimbursement and sharing agreements. To be successful in generating these revenues, Medicare subvention must be approved. Restructuring the health care delivery system in VISN 12 has the potential to be the vehicle by which the network can generate substantial savings to allow for program improvements and/or VHA resource distribution changes.

## **Conclusion**

To accomplish its stated mission and strategic goals, VISN 12 will continue to operationalize a multifaceted approach. This includes, but is not limited to, actively shifting the provision of care to the least costly setting; identifying and implementing clinical and support service efficiencies; improving productivity; eliminating unnecessary activities and services; contracting out services where cost efficiencies can be gained without compromising quality; reducing overhead where feasible; effectively managing resources, including capital and human resources; and creating financial incentives that reward support of the VISN's strategic initiatives. This approach should allow VISN 12 to continue providing outstanding service to veterans and be their provider of choice.



**VA Upper Midwest  
Healthcare Network**

# **Network Strategic Plan**

**Year 2000 – 2005**

**Department of Veterans Affairs  
October 1999**

## Executive Summary

The VA Upper Midwest Healthcare Network, VISN 13, presents its Strategic Plan for 2000 – 2005. All goals and strategies in the plan support the network's mission to improve the health and well being of network veterans.

### **Advancing the Vision**

Our vision is to be a comprehensive, integrated health system that provides health care value through excellence in customer satisfaction, cost-effectiveness, quality outcomes, access and improved patient functional status.

We are striving to be an employer of choice and a leader in education, research and delivery of veterans' benefits.

We are also working towards becoming an active community and federal partner accountable to customers and stakeholders.

Since the network was formed in 1996, the VA health care delivery system has changed substantially, most notably the major shift of care from the inpatient to outpatient setting. As every year passes, we move closer to achieving our vision. Here are highlights of accomplishments during FY 1999.

Headquarters selected the network as a pilot site for revising the way patient incidents are reported. Veterans with Hepatitis C are treated through a new network-wide program. Health care providers exceeded standards for evaluating patients for chronic disease and for preventable illnesses.

Veterans completed a survey evaluating their functional status. The data will create the baseline information needed to compare future functional status survey results.

Veterans report they are more satisfied with the health care at VISN 13 VA medical centers than elsewhere in the VA health care system.

Access improved for veterans residing in Brainerd, Fergus Falls, and Maplewood, Minnesota and in the Chippewa Falls, Wisconsin area where the network established new VA community based outpatient clinics.

Forty percent of all employees participated in 30 hours of continuing education, ten of which was in the continuous improvement area.

### **Ensuring a Continuum of Care**

Veterans from the seven priority groups will continue to be able to enroll for VA health care. During the past year 132,583 veterans enrolled for VA health care within the network. All enrolled veterans are eligible for a comprehensive health care benefits package of inpatient and outpatient services.

Alignment to a patient service line organizational structure will promote consistent and predictable health care along the entire continuum of care. The four patient service lines are: 1) Primary Care, 2) Specialty Care, 3) Mental and Behavioral Health Care, and 4) Extended Care and Rehabilitation.

Each of the patient service lines is responsible for ensuring their care is accessible, cost-effective and meets quality and customer service standards. The patient service line organization will be fully implemented in 2001.

Caring for special populations of veterans is at the center of VA health care. Veterans with spinal cord injuries, blindness, traumatic brain injury, amputations, post traumatic stress disorder and serious mental illness will continue to receive compassionate care from employees who use state of the art technology.

### **Assessing the Financial Outlook**

The budget depends upon the Congressional appropriation each year. Since Congress implemented the flat line budget for fiscal years 1997 - 2002, it has supplemented VA's budget each year to meet inflationary costs. Additional funds are expected in FY 2000 as well. External collections from third party insurance next year may exceed \$23 million. The collections can be retained and used within the network.

We expect a deficit of \$1.4 million in FY 2000 resulting in a loss of 31 staff through attrition. A patient service line operating budget will be adopted using a phased-in approach in FY 2000.

### **Setting Year 2000 Priorities**

We will focus efforts in three areas during the next year: 1) improving customer service, 2) continuously improving how we provide care to veterans, and 3) striving to become an employer of choice.

#### **Customer Service**

Veterans will have the opportunity to complete customer satisfaction surveys more frequently and directly after their health care visit or inpatient stay. Employees will learn how veterans feel about their interaction and health care provided. As a result, they will be able to change behaviors to better serve veteran patients.

Veterans will be able to obtain clinic appointments on a more timely basis as we implement strategies to reduce clinic waiting times.

Access to care will improve for veterans in the Sioux City, Iowa and southeastern Minnesota areas when community based outpatient clinics are opened.

#### **Performance Improvement**

In all aspects of caring for veterans, we will continually strive to improve performance, provide better and more compassionate care and find new ways of diagnosis and treatment. We intend to systematically improve our systems and processes through a process improvement framework.

#### **Employer of Choice**

Employees are the most valuable resource within the organization. Their products and efforts contribute to the overall quality of service provided. Being an employer of choice will enable the network to retain quality employees and attract new team members to fill vacancies as they occur.

We intend to increase employee knowledge about patient service line implementation and leadership. Leadership at all levels will empower employees and create a sense of ownership of the service delivery process with the training, tools, and information needed to skillfully participate in the decision making process at the appropriate level. Leadership abilities will be strengthened throughout the organization.

Employees will serve as members of functional teams working in a collaborative environment. Engaging employees in continuous improvement efforts will facilitate this movement.

We will utilize "higher than step one" rate setting, retention bonuses, and special rates, when indicated, to recruit quality employees. Compensation problems will be analyzed to determine special problems.

#### **Achieving Our Vision**

More and more veterans are seeking VA health care than ever before. Since 1997, the number of veterans in the network receiving care has grown by 10% to nearly 97,000. We expect this trend to continue even though the veteran population will decline by nine percent over the next five years.

We are taking steps to gain additional efficiencies in operations, generate external revenues and obtain approval to treat veterans under the Medicare program. Supplementing our VA appropriations in this manner will enable us to continue to maintain services to our current veterans plus treat additional veterans seeking VA health care.

We will accomplish all of the above strategies and many more as presented in the following plan by seeking the constant involvement and interaction of those we serve: veterans.

*Department of Veterans Affairs*



**Central Plains Health Network**  
*A Veterans Integrated Service Network (VISN 14)*

# **STRATEGIC PLAN**

**Fiscal Year 2000  
to  
Fiscal Year 2005**

**October 1, 1999**

## Executive Summary

The transformation of the VA Central Plains Health Network (VISN 14) from a hospital-centered service model to a patient-centered health care management model which was begun in FY 1999 continues. This systems renovation is being driven by the need to enhance quality, improve access, lower costs, and increase the number of patients served. These demands require a significant investment in the development of primary and ambulatory care and a re-focusing of resources away from hospital-based and specialty care. More and more, VISN 14 is incorporating service delivery sites outside the "four walls" of our medical centers into the continuum of care in an attempt to garner maximum clinical benefit from our limited financial, physical and human resources.

These changes support the goals of the VA Central Plains Health Network to promote the health and well being of the veterans we serve and to become their provider of choice. To fulfill our mission to provide health care services to a geographically dispersed population with special needs, VISN 14 must continue the pursuit of new and progressive approaches to providing health care in a manner that:

- ◆ improves access to care
- ◆ enhances quality of care
- ◆ increases patient satisfaction and health outcomes
- ◆ maximizes utilization of limited resources

A number of challenges have impact upon VISN 14's ability to provide predictable care that is of a consistently high level of quality. These include:

- ◆ maximizing operating efficiencies despite precipitous budget challenges
- ◆ evaluating the need for, and optimum location of, VA sites of care based on current and projected patient demographics
- ◆ increasing access to care to veterans living in rural areas
- ◆ evaluating the impact of existing infrastructure on our ability to provide high quality care to the greatest number of patients
- ◆ changing the focus of care from hospital system to health care system
- ◆ changing the focus of care from episodic to a continuum
- ◆ remaining current with medical and technological advances
- ◆ eliminating duplicative and unnecessary services
- ◆ providing cost effective care to meet budget limitations

By the year 2003, nearly half of VISN 14's veteran population will be over the age of 65. This age group is expected to consume health care services at a greater rate along with an increasing demand for extended care services such as nursing home care, residential care, home based care, adult day care, and palliative care. Complicating the challenges presented by this aging population is the fact that the total number of eligible veterans residing within VISN 14's service area is decreasing rapidly.

In order to attract new and retain current veteran users, VISN 14 must provide a comprehensive and accessible array of services that meet the majority of our patient's health care needs. These services must be provided in a consistent, predictable manner across all sites of care within the network in order to build successfully upon our current patient base.

Failure to do so would result in the loss of patients to private sector providers and a continued deterioration in the network's funding base through third party reimbursement and the Veterans Equitable Resource Allocation (VERA) system. Likewise, failure to ensure fiscal accountability and provide services in the most efficient and cost-effective manner will accelerate the depletion of money available for patient care services.

The future of the VA Central Plains Health Network as an integrated delivery system will be dependent upon the maximization of clinical and administrative efficiencies and the successful implementation of creative alternatives to current operations. VISN 14's success will have a significant impact upon the ability of the VA to support the needs of an aging veteran population that is expected to use services at a greater rate and require more chronic care.

To improve the likelihood of success, the VA Central Plains Health Network has established the following strategic goals for Fiscal Year 2000 through Fiscal Year 2005 planning cycle:

- ◆ Patient Care: Enhance quality of and access to patient care services in Nebraska, Iowa, and Western Illinois
- ◆ Quality: Continuously improve quality outcomes in the delivery of health care
- ◆ Customer Service/Satisfaction: Enhance customer service/satisfaction
- ◆ Human Resources: Improve the delivery of patient care through innovative utilization of human resources
- ◆ Staff Education: Improve access to educational services
- ◆ Research/Medical Education: Increase research opportunities and enhance relationship with affiliates
- ◆ Marketing/Communication: Enhance marketing/communication initiatives
- ◆ Revenue: Aggressively pursue alternative revenue generation and cost savings/cost avoidance opportunities
- ◆ Infrastructure: Maximize the utilization of VA-owned infrastructure and land while minimizing maintenance cost
- ◆ Integration/Consolidation: Continue the integration and consolidation of activities supporting the VISN 14 health care delivery system
- ◆ Emergency Preparedness: Maintain the integrity of VISN 14 health care delivery systems while continuing to provide backup to the Department of Defense and support to Federal Disaster Response plans

Strategic Initiatives have been developed in support of these goals. Although a number of these initiatives are evaluative in nature, it should not be inferred that VISN 14 is not taking active steps toward its future. The evaluation of clinical and administrative functions to be completed during the course of Fiscal Year 2000 are a proactive approach to dealing with the challenges and opportunities that lay before us. The thorough and thoughtful review of options and alternatives will ensure that future action taken by VISN 14 to change the systems for providing VA health care in Iowa, Nebraska and Western Illinois are in the best interests of the veteran.

In order to assign and monitor accountability for the completion of individual initiatives, a Strategic Plan Matrix has been developed. This document tracks initiatives by Network Goal, State Strategies, Tactics, Measures, Operational Plans, Timelines and Responsibility. A copy of the Strategic Plan Matrix is included as an attachment to our Plan.

The active participation of VA clinical and administrative staff; medical school affiliates; state and national veterans organizations; Union Partnership; representatives of the Veterans Benefits Administration and the National Cemetery System; and our veteran patients will be critical to the successful implementation of this Strategic Plan and the continued success and viability of the VA Central Plains Health Network. To assure the participation of these vitally important stakeholders, a formal strategic planning process will be developed for implementation during Fiscal Year 2000. This process will include continuous review and monitoring of veteran demographics, patient care needs; clinical outcomes, VA care capacity, comparative cost data, opportunities for collaboration, and other pertinent information to guarantee that the network achieves the maximum patient care benefit for the resources expended.



**M**aximum  
**V**eteran  
**B**enefit

## VA Heartland Network

**VISN 15  
Strategic Plan**

**Fiscal Years  
2000-2005**



**Kansas City  
VA Medical Center**



**Harry S. Truman  
Memorial Veterans' Hospital**



**John J. Pershing  
VA Medical Center**



**St. Louis VA Medical Center  
John Cochran Division**



**Marion  
VA Medical Center**



**St. Louis VA Medical Center  
Jefferson Barracks Division**



**Eastern Kansas Health Care System  
Colmery-O'Neil  
VA Medical Center**



**Wichita VA  
Medical/Regional  
Office Center**



**Eastern Kansas Health Care System  
Dwight D. Eisenhower  
VA Medical Center**

## Executive Summary

Health care in America continues to transform into a system of lower cost, greater accountability, and higher quality while revenue opportunities are reduced and competition is increased. The VA Heartland Network (VAHN) began its journey to meet the challenges of modern health care in fiscal year 1997. This strategic plan will continue the course set in 1997, support *Journey of Change, Vision for Change, Prescription for Change* and guide the VA Heartland Network into the 21<sup>st</sup> Century.

The VA Heartland Network provides services to veterans in Kansas, Missouri, Southern Illinois and Indiana as well as portions of western Kentucky and northeastern Arkansas. A full continuum of care is provided to approximately 147,000 veterans at its seven medical centers, CBOCs, and outreach clinics. With an emphasis on the primary care concept, the VA Heartland Network facilities are estimated to provide approximately 1.4 million outpatient visits in the coming year.

In taking care of 147,000 veterans, the VA Heartland Network is proud of its many accomplishments, which demonstrates a firm commitment to the improved quality of care and customer satisfaction of the veteran population to which it serves. A few of the outstanding accomplishments include:

- ◆ The VA Heartland Network has dramatically improved local access of care to veterans through 15 Community-Based Outpatient Clinics, 10 Medical Outreach Clinics, and 1 Mobile Clinic and more CBOCs are in the making.
- ◆ The VA Heartland Network has received national recognition for its Telemedicine/Teleradiology system, which allows for highly-technological, and immediate consultation for veterans throughout our network.
- ◆ For the last two years, the network has been ranked #1 and #2 in the nation among Veteran Integrated Service Networks (VISN) on Performance Measures, which include clinical, safety, and administrative monitors.
- ◆ The VA Heartland Network is the only network in the country to have earned a one-year accreditation from the prestigious National Committee for Quality Assurance (NCQA).

It is the policy of the VA Heartland Network (VISN 15) to facilitate the provision of high quality health care to each patient, in a timely manner. The Quality Improvement Program (QI) consisting of quality management and improvement strives to achieve excellence in the delivery of health care services. The VA Heartland Network is a comprehensive integrated delivery system providing health care services to veterans along the entire continuum of care. A segment of the accomplishments noted from the FY 1999 Performance Measures system include:

- ◆ Compliance with the Chronic Disease Indicators has increased from 85% in FY 1997 to 86% in FY 1998 and to 91% in FY 1999
- ◆ The network has the lowest Lost Times Claims Rate (LTCR) at 1.8, significantly below the national rate of 2.9
- ◆ An overall increase in unique patients treated of approximately 18% since FY 1997

In keeping with the commitment to provide consistent quality care to veterans, Clinical Practice Guidelines are in use across the network. These guidelines include: Ischemic Heart Disease, Diabetes Mellitus, Hypertension, Major Depressive Disorder, Smoking Cessation, COPD, Psychoses, and Congestive Heart Failure. Additionally, in a patient focused effort, the VA Heartland Network has also established Patient Safety Redesign Initiatives. Results of monitoring activities are reviewed at the facility level and at the network level through the Performance Oversight Group to ensure continuity of care.

Effective communication is central to any organization. The VA Heartland Network has taken the necessary steps to address this important issue as Senior Management continues to conduct semi-annual Town Halls at all Medical Centers for the purpose of having all-employee forums. Stakeholder communications at the network level have included: interaction with members of area Management Advisory Councils including Veteran's Service Organization officers, state and local congressional representatives, state veteran commission staff, consumers, and other stakeholders. At the recent 100-Year Anniversary celebration of the National Veterans of Foreign Wars Convention in Kansas City, the VA Heartland Network was recognized for organizing and staffing a health fair, while providing other educational and health care services at this important event.

The VA Heartland Network takes pride in the fact that it has provided our veterans uninterrupted high quality care within the network's operating budget in the past. All indications are that the Heartland Network will close out FY 1999 in a solvent state. Looking ahead FY 2000 and beyond will without a doubt, become more challenging in balancing revenues and expenditures without infringing on the quality and/or the services currently provided to our veterans.

There is a strong commitment within the network to provide high quality care to special veteran disability populations, in accordance with Public Law 104-272. Across the network, these populations are served in a variety of settings. This care is either being provided at the local medical center, by transfer to another VA hospital, or by contracting in the community or with other government agencies. The care of patients in this category is coordinated very closely with the patient and their families.

The VA Heartland Network maintains academic affiliations with a large number of educational institutions, helping to educate Physicians, Nurses, Pharmacists, and numerous other Medical Personnel. The network currently has 336 residents in training of which 61% are Primary Care and 39% are in Specialty Care and Surgery. The funding for this training is not sensitive to budgetary fluctuations.

The VA Heartland Network facilities maintain emergency preparedness plans across the network and participate regularly in local community disaster drills. These plans result in the network facilities being prepared for a wide range of disasters or emergencies that can disrupt the environment of care, as well as providing back up for the Department of Defense.

The VA Heartland Network supports the Department of Veterans Affairs' mission of Research and Development (R&D). Most of the R&D initiatives are conducted at the network's tertiary care and affiliated medical centers, and to a lesser degree in the small rural centers. A variety of studies are underway including low vision, heart disease, osteoporosis, aging, and drug development.

The VA Heartland Network is responsive to the growing long-term needs of its aging veteran population. As part of the continuum of care, veterans are served either on VA medical center premises, through contracts with the community, or when possible, in their home. As the health care environment continues to change and the veteran population ages, the network is positioned to continue to meet veterans needs and expectations, although the manner in which care is delivered, may change.

A key component of the organization, is the department of Human Resources. There is a consistent and ongoing effort to field the right employee, for the right job, at the right time. The VA Heartland Network currently employs approximately 7,100 clinical and administrative personnel and expects to finish FY 1999 with approximately 7,117 dedicated and patient focused employees.

The mission of the VA Heartland Network Acquisition and Logistics Section is to leverage the combined purchasing power of the VA Heartland Network, and strategic partners of other networks, to obtain the highest quality products and services at the lowest possible costs. Logistics will improve the inventory process, control all inventories at the facilities, reduce inventory costs and reduce the FTE requirements to perform the Acquisition and Logistics functions. This work will assure that the VA Heartland medical centers will be able to maximize services and quality of care by having the tools and financial resources to provide the Maximum Veteran Benefit.

Each of the facilities in the VA Heartland Network has individually developed a long history of excellent service to our nation's veterans. The VA Heartland Network wishes to continue this tradition of excellence through the ongoing development of primary care medicine. Primary care medicine and the development of lasting relationships between patient and physician/provider, will serve as a guiding principle for the delivery of high quality health care well into the future.



**VISN 16  
JACKSON, MS**

**STRATEGIC PLAN  
FISCAL YEARS 2000 – 2005**

## Executive Summary

The fundamental method of operation for VISN 16 is to 1) Satisfying our Patients and Other Customers (employee and stakeholder), 2) Delivering High Quality Care and Improving the Continuity of Care, and 3) Becoming a Financially Healthy Organization thus *Patient Focused, Performance Based, and Outcomes Oriented*. This direction is the driving force that will take us into the new millennium and beyond. Nationwide, VISN 16 ranked as a top performer under the FY 1999 network performance contract. Throughout all sections of the following narrative description of VISN 16's accomplishments and strategic direction for FY 2000 and beyond, these three factors (*Patient Focused, Performance Based, Outcomes Oriented*) will become evident as the key drivers of the network.

### **Internal/External Assessment**

The structure of VISN 16 was designed to insure continuous internal assessment of the management process. The Executive Leadership Council (members include VISN management, all ten medical center Directors, two Chiefs of Staff, one Associate Director, Product Line Managers, and one Nurse Executive) and its committees automatically assess local and network-wide impact when establishing initiatives and reviewing past practice. Sound decision making by this governing body has been the cornerstone of VISN 16's success.

External changes in health care and our political environment cannot be controlled, but can be monitored. VISN 16 actively promotes external reviews and utilizes results and findings to gauge success and assess potential areas to improve/develop. VISN 16 continues to reinforce the external stakeholder's role in the management and direction of the health care network through inclusion at all levels in the shared decision making process. With the inception of our Business Office, the network will continue to develop new contacts and increase our stakeholder base.

### **Performance and Quality**

A key driver of the network is to be a Performance Based operation. Initiatives and strategies identified for FY 1999, FY 2000, and beyond are measurable ways to assist the local medical centers and VISN committees accomplish their objectives. As previously mentioned, VISN 16 continues to rank as one of the top performers in meeting and exceeding national performance measures.

Following are a sampling of VISN-wide FY 1999 accomplishments that will be carried through to FY 2000 and beyond. These initiatives and accomplishments focus our attention on bringing the network closer to achieving the VISN 16 goals of 1) Satisfying our Patients and Other Customers (employee and stakeholder), 2) Delivering High Quality Care and Improving the Continuity of Care, and 3) Becoming a Financially Healthy Organization:

- ◆ Led the nation in the Mental Health 30-day follow-up performance measure, while also achieving the lowest national readmission rate within 30 days of discharge improving continuity of care.
- ◆ Implemented single VISN-16 primary care provider for each enrolled patient.
- ◆ Implemented VISN 16 provider profiling reports.
- ◆ Reduced mental health bed days of care by 25% and converted inpatient mental health beds to residential treatment beds, reducing cost while improving patient access.
- ◆ Established a Mental Illness, Research, Education and Clinical Center (MIRECC), one of only six nationwide, in Little Rock, Arkansas.
- ◆ Established a Diagnostics Product Line that during the initial start-up generated a net savings VISN-wide of over a million dollars, with savings projected into the future.
- ◆ Led in performance measure results relating to the Chronic Disease Index and Prevention Index, reporting the highest rate of intervention.
- ◆ Implemented fourteen guidelines and two special emphasis guidelines to improve the quality and continuity of patient care.
- ◆ Reported a total estimated savings of \$4,288,670 through the newly established Business Office by consolidating, contracting, and other volume buying.

- ◆ Developed and implemented an in-depth Home Care Business Plan for VISN 16 facilities.
- ◆ Identified a single point of contact for 100% of all seriously mentally ill (SMI) patients to improve the quality and consistency of care.
- ◆ Developed and implemented the Mystery Shopper program at all medical centers, focusing on all aspects of Customer Satisfaction.
- ◆ Applied for national accreditation to sponsor continuing medical education activities for physicians.

## **Human Resources**

As with all major actions impacting either one or all ten facilities of VISN 16, staffing initiatives are reviewed and decided upon by the Executive Leadership Council (ELC). With the success of the Mental Health and Diagnostic Product Lines, VISN 16 is currently focusing attention on other high cost high usage areas, and realignment of staff is being accomplished to establish VISN-wide management in the areas of Pharmacy benefits, Prosthetics, and Informatics. This realignment will enhance veteran access and improve customer service in the area of waits and delays.

As is evidenced in our Strategic Goal to Satisfy our Patients and other Customers, several network initiatives are under way that reinforce our commitment to employee education and training and becoming the Employer of Choice. VISN 16 recently applied for national accreditation to sponsor continuing medical education for physicians. Once approved, VISN 16 will be the first network to receive national accreditation. National accreditation will greatly enhance the educational opportunities offered to our physicians, while providing a cost effective approach to meeting employee needs. Future plans for network accreditation are in the areas of Nursing and Pharmacy.

The ELC has tasked the Staff Education Council (SEC) to identify and implement employee needs and training activities that will positively impact customer service. Several of the on-going VISN-wide training programs identified by the SEC are:

- ◆ Bayer Training - physician training geared toward improving customer/care-giver relationships.
- ◆ CARE Training – similar to Bayer training geared toward non-physician relations with veteran customers.
- ◆ Learning Maps – highly interactive sessions where employees expand their knowledge base of Becoming One VA, The Changing Healthcare Environment, The Economics of Providing Care, Delivering Care/Customer Service, and VHA’s Journey of Change.
- ◆ High Performance Development Model – encompasses six areas for employee development including core competencies, performance based interviewing, continuous learning, continuous assessment, coaching and mentoring, and performance management.

## **Communications/Marketing**

As previously mentioned, changes in health care and our political environment cannot be controlled; however, the VISN can insure communication of these changes with management, patients, stakeholders, and employees. Stakeholder involvement at all management levels within the VISN is evident in our management structure that includes stakeholders on all major network committees. Medical Centers have embraced the town-hall meeting concept of sharing information with our veteran customers. Union partners are kept up-to-date on network direction by being included in the decision making process through the Joint Cooperative Council and by maintaining a presence on all VISN-wide committees. The network has established a variety of means to promote communication between our academic affiliations that enhance our methods of informing, listening, and sharing information.

VISN 16’s Internet website address is <http://199.227.52.91/>. This address directs the public to the VISN VOICE, VISN 16’s quarterly newsletter, along with information on health. “Disease specific information” is the most popular area on the VISN website. The health information on the website is provided by the Patient Education Committee to assist the patient (and family) to partner with their physician and share in the decision-making processes of health care.

The VISN Business Office continues to expand the stakeholder base by opening lines of communication and establishing joint ventures with insurance companies and the film industry. The Business Office is developing training and training tools for the revenue generation coordinators to use in the development of new contracts, and is reviewing expansion in the areas of VA/DOD, TRICARE, and CHAMPVA. Medical Centers are encouraged to use the team approach in selling health care resources.

## **Financial**

With the current funding allocation model, VISN 16 has fared very well; however, that has not stopped us from reviewing options. Rather, it has given us the margin needed to step back and examine different scenarios, and become creative and innovative in our planning process. VISN 16 has initiated numerous cost efficiency initiatives; but considering our aging population and the demand for extended care options that will continue to increase, the network is concerned with facing potential shortfalls in the years FY 2002 and beyond.

## **Special Populations**

VISN 16 continues to address the direction and provide care for special populations, spinal cord dysfunction, blindness, traumatic brain injury amputations and non-stroke neurologic loss of limb, PTSD, and serious mental illness (SMI) including SMI related to substance abuse and homelessness as well as other special emphasis programs. VISN 16 continues to excel in performance measures relating to these areas.

Due to the large geographic distribution, VISN 16 does not propose any mission changes. The network will continue to work on strengthening management relations and improving quality and access of care for all patients through joint projects.

## **Network Strategic Direction**

One of VISN 16's goals is to continue providing high quality clinical care while emphasizing access as a priority to our veteran customer. The successful realignment to Product Lines in the areas of Diagnostics and Mental Health provided the impetus to pursue centralization of other high cost high usage areas such as prosthetics, pharmacy benefits, and informatics.

The VISN 16 Waits and Delays teams are compiling data and monitoring areas to identify possible system redesigns.

Compliance and reasonable charges are two areas that challenge VHA and VISN 16. A VISN 16 Compliance Team is being developed to maximize revenue and minimize legal liability. The areas of coding and medical documentation are being enhanced through extensive training.

## **Capital Plans**

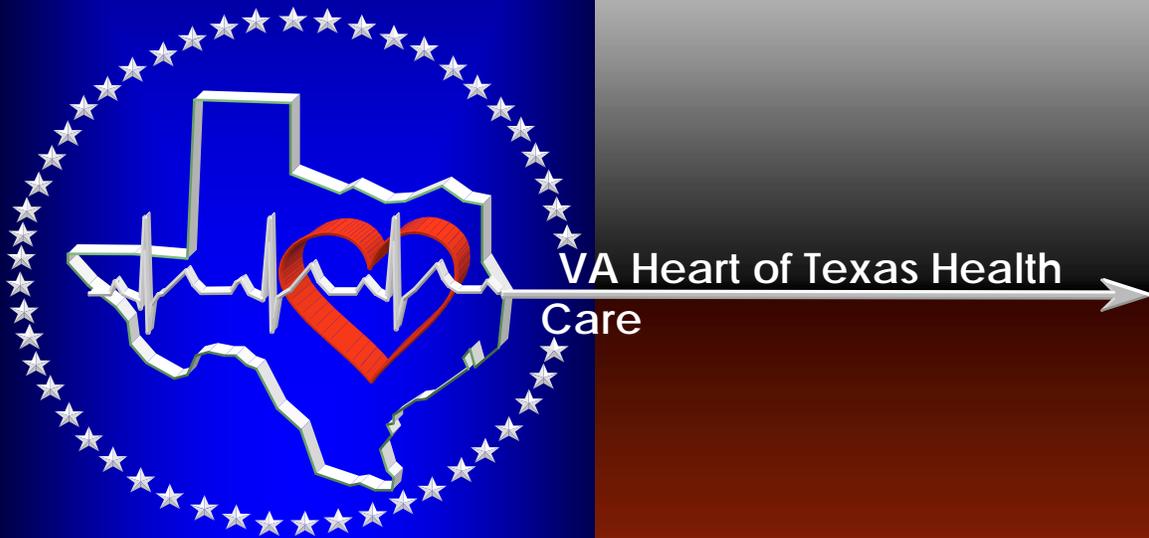
At the current time, VISN 16 does not have any major construction planned. Our NRM/MINOR construction initiatives are directed toward improvements in infrastructure, expanding and enhancing inpatient areas to meet customer service/patient privacy standards.

VISN 16 is also reviewing energy conservation areas for improvement and has initiated a joint venture with the Corps of Engineers and VIRON, Inc. The initial area of focus will be lighting and water conservation projects.

VISN 16 appointed a Capital Asset Management work group to review the current capital related processes with the network. Underutilized space and the potential for conversion to long term care activities and/or the possibility for disposal will also be reviewed.



DEPARTMENT OF VETERANS AFFAIRS  
Veterans Health Administration



VA Heart of Texas Health  
Care

# NETWORK PLAN FY 2000-2005:

*A Road Map To Health Care  
for Veterans*

## Executive Summary

As a leader in the Department of Veterans Affairs, Veterans Health Administration, the VA Heart of Texas Health Care Network (VISN 17) will strive to meet the needs of veterans now and into the future. The network will become an even more veteran-focused organization, functioning as a single comprehensive provider of seamless health care. Together the VA North, Central and South Texas Health Care Systems comprise the network in providing a continuum of care for veterans residing in the 134 counties served. In the quest for excellence, the network will continuously benchmark the quality and delivery of service with the best in nation and use innovative means and high technology to deliver improved service. The network will foster partnerships with veterans and other stakeholders making them part of the decision-making process. The network will also cultivate a dedicated work force of highly skilled employees who understand, believe in, and take pride in its vitally important mission.

### **Network Mission Statement**

*The mission of the VA Heart of Texas Health Care Network 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, the Network needs to be a comprehensive, integrated health care system that provides excellence in health care 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.*

### **Network Vision Statement**

*Health care Value begins with VA. The VA Heart of Texas Health Care Network supports innovation, empowerment, productivity, accountability, and continuous improvement. Working together, the network provides a continuum of high quality health care in a convenient, responsive, caring manner---and at a reasonable cost.*

### **Network Strategy Statement**

*VA Heart of Texas Health Care Network's strategy is to provide excellent health care 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 health care delivery focused on continuous quality improvement.*

Strategic planning is critical in defining the network's resource requirements and supporting stakeholder relations. The FY 2000-2005 Network Plan is a "roadmap" that details the directions the network intends to take to meet the short and long-term health care needs of the veteran population. The Network Plan will be used for a variety of purposes but will be especially important in communicating future strategies and actions to Congress, the Office of Management and Budget, Veteran Service Organizations and employees. The need for the Network Plan has become compelling as the network is called upon to defend program expenditures and to explain the continued restructuring of its health care systems. The Network Plan addresses the network's approach to three critical strategic issues: 1) providing a full continuum of care, 2) providing a predictable and consistent level of care, and 3) assuring implementation and accountability. The network's strategic plan is also integral to VHA's corporate reporting and offers direct evidence of the progress made at the local level to implement national goals and strategic targets. In providing strategic initiatives and supporting documentation, the Network Plan is used to build VHA's annual budget and performance plan and the Department's five-year strategic plan.

The Network Plan is organized into eight chapters encompassing an external environmental assessment, internal environmental assessment, performance and quality, human resources, communications and marketing, financial management, capital plan and alternatives, and summary of strategies. Supporting appendices follow the chapter presentations and include a summary of network strategies to address fifteen VHA national performance measures and other high priority issues (Appendix A of our Plan), supporting financial statements and documentation

(Appendix B of our Plan), and capital asset tables (Appendix C of our Plan). The Network Plan embraces the four overarching goals of Care, Cost, Compliance and Communication that will drive the operations and actions of the network for the planning period FY 2000-2005. Accomplishments and continuing opportunities for improvement are interwoven throughout the related sections and appendices of the plan.



The *External Assessment* combines data analysis and qualitative information to formulate an accurate profile of the Texas marketplace in which the network operates. The assessment provides a review of demographic, economic, and health status trends and forecasts; reviews health care delivery, reimbursement and regulatory trends; analyzes the Texas hospital industry as a competitor; and assesses market forecasts and implications. The State of Texas and the network face many of the same issues with initiatives underway to meet the growing needs of the elderly, expand health promotion/disease prevention, promote Texas-Mexico border health programs, increase access to care particularly for the special needs populations, and address the maldistribution of health professionals in rural counties. The Texas hospital industry and the network face similar budget challenges that reinforce the need to aggressively manage cost while continuing to shift from inpatient to outpatient care. Increasing marketplace competition and consumer mistrust of managed care organizations and hospitals has fueled a renewed focus on customer satisfaction that will require providers, insurers and consumer to bridge their differences in redefining a health care delivery system that is quality-driven, customer-oriented and cost-effective.

The *Internal Assessment* provides an analysis of veteran demographic trends. Veterans aged 55 to 64 represent the fastest growing segment of the network’s veteran population with racial/ethnic group composition mirroring Texas’s general population. Health care delivery is based on “hub-and-spoke” referral patterns within each of the three health care system’s with referrals directed between hubs for highly specialized services. As veteran population declines, enrollment and actual users are increasing under the network’s provision of a uniform health benefits package to ensure a full continuum of care is delivered in a predictable and consistent manner. Veteran health characteristics and service utilization patterns are comparable to like age groups in Texas’ general population with cancer, pulmonary disease and heart disease representing the leading causes of death. Significant progress has been achieved in improving health care value to veterans as measured by cost/price, access, technical quality, functional status and

customer service. In reducing costs, the network continues to shift its resources from inpatient to outpatient care as reflected in hospital bed closures and increases in ambulatory procedures and community based outpatient clinics (CBOCs). Additional cost/price strategies include systematic program reviews and increasing use of the Decision Support System as an analytical tool with revenue generation initiatives offsetting the need for more aggressive cost reduction actions. The network has improved access to care through CBOC expansion, the Telenurse Program, and expanded home and community based alternatives to institutional care with current efforts directed at improving follow-up after hospitalization for mental illness and participation in the Institute for Healthcare Improvement Initiative. Achievements in technical quality are evidenced through network-wide accreditation by the Joint Commission on Accreditation of Healthcare Organizations, mammography program accreditation by the American College of Radiology, spinal cord injury program accreditation by the Rehabilitation Accreditation Commission, designated VA Clinical Programs of Excellence and accomplishments in palliative care. Continuing efforts will focus on the management of chronic diseases, preventive health and implementation of clinical practice guidelines. Also covered in the *Internal Assessment* are the missions of education, both graduate medical education and employee education; research, relative to the Mental Illness Research, Education and Clinical Center proposal, Cardiovascular Research Institute partnership and New Investigators Award Program; and emergency preparedness, in the areas of VA emergencies, VA/DoD contingency planning, National Disaster Medical System, Federal Response Plan, Weapons of Mass Destruction and the Disaster Emergency Medical Personnel System.

To ensure continuous improvements in health care value with an emphasis on improving quality of care, the network manages performance along a ten dimensional framework as presented in *Performance and Quality*. The strategic framework includes the dimensions of personnel, clinical care strategies, care monitoring through performance monitoring, internal review, external review and oversight, technology management patient reported outcomes, education, research and management. With an emphasis on quality in adapting to a rapidly changing environment, the network depends upon the collective insight, creativity and energy of the workforce as its most important asset. In "Putting Veterans First," the network has built a workforce that is well regarded by customers and ranks highly when compared to national standards. *Human Resources* reflects a relatively stable workforce with programmed staffing reductions offsetting increases tied to major construction activations. Language and cultural barriers are also minimized by network providers who are more racially/ethnically diverse than the state's overall provider population. While importance will continue to be placed on ethics in the workplace and labor-management partnerships, improving employee communications will become a major focus of the network in facilitating performance feedback and acceptance of change. Other human resource initiatives include ensuring a safe work place with reductions in Office of Workers' Compensation Program lost time claims rate and expenditures, continuing implementation of the High Performance Development Model, and possible design of an employee survey instrument in the absence of a national "One VA" Employee Survey.

*Communications and Marketing* provides an assessment of current veteran outreach activities at the federal, state and local level as well as focused efforts to: improve the joint separation/compensation and pension examination process in collaboration with the Veterans Benefits Administration and Austin Automation Center in the spirit of One VA; expand CBOCs; and improve border health under the Lower Rio Grande Valley Initiative. To provide additional outreach to veterans, the network will restructure its Marketing and Public Affairs Program, establish five additional CBOCs, pursue Blue Cross/Blue Shield of Texas preferred provider organization status, and develop a veteran's health magazine. *Financial Management* examines network performance as defined by the Financial Indicator Report Card, Cost Distribution Report, Government Purchase Card usage, and the Medical Care Cost Fund and Compliance Programs. A new network resource allocation methodology will be applied in distributing the FY 2000 Veterans Equitable Resource Allocation (VERA) budget to the three health care systems with actual allocations based on prorated patients, seriously mentally ill adjustment, incentive performance, VERA based education and research, and Medical Care Cost Funds. Future areas of emphasis include network-wide compliance training; a focused independent review to identify cost reduction opportunities in Pharmacy Service and Supply, Processing and Distribution (SPD); providing reimbursable services to three State Veterans Homes; and marketing the Dallas Central Dental Laboratory on a national basis. An overview of financial scenario planning is provided with specific reference to the mandated reporting requirements summarized in Appendix B of our Plan.

*Special Populations* address the six special disability programs of Spinal Cord Injury and Disorders (SCI&D); Blindness; Traumatic Brain Injury (TBI); Amputation; Serious Mental Illness (SMI); and Post Traumatic Stress Disorder (PTSD) as well as nine other Special Emphasis Programs and populations. In general, the network has

expanded capacity across-the-board in these programs with increases in individuals treated and expenditures from FY 1998 to FY 1999. Commitment to these special populations will be maintained with additional expansions contingent upon potential resource realignments within the network and future budget appropriations.

While the network continues to consider potential future changes in health care system missions, staffing and bed levels, there are no definitive plans identified in *Capital Plans and Alternatives*. In managing its capital assets, the network continues to consider expanded alternatives to institutional care and contracting with local community health care organizations based on the results of cost/benefit analysis. An overview of the capital baseline assessment, potential conversion of unused space to long-term care, summary listing of CBOCs, capital investments for minor and non-recurring maintenance accounts, and five capital investments that exceed VA Capital Investment Board thresholds are also presented with particular reference to Appendix C of our Plan. The network's five capital investment proposals are not included in the Network Plan given the detailed nature of each application covering: the project's description; project phase; location of proposed/actual asset; scope; project goals and objectives; investment size; total acquisition cost; total recurring cost; total present value life cycle costs; performance-based management; special requirements for major construction, major leases, and major GSA space assignments; and population basis. Capital investment proposals include two major construction proposals (Mental Health Enhancements at the North Texas Health Care System and Ambulatory Care Center at Central Texas System), one capital lease for the Austin Satellite Outpatient Clinic at Central Texas, and two capital equipment items at North Texas (replacement tunnel washer and an additional linear accelerator). While these applications are provided to VHA Headquarters as a separate submission, they are available through the Network Office upon request.

As a final section, *Summary of Strategies* provides a preface to Appendix A of our Plan that summarizes the network's FY 2000-2005 strategies to address fifteen VHA national performance measures and high priority network issues of information technology and work place safety. While these strategies are referenced in relevant sections of the Network Plan, Appendix A of our Plan provides a consolidated overview of FY 1999 accomplishments, means and strategies used to effect the accomplishments, identification of FY 2000-2005 strategies, Network goals supported by the strategy, potential impact on veterans, alternative strategies and rationale for the preferred strategy, and estimated resource requirements. Resource requirements associated with FY 2001 strategies are also carried over to Appendix B of our Plan, Fiscal Year 2001 Financial Projection and Operational Strategies, Required Fiscal Year 2001 Operational and Financial, Strategies and Actions Summary, and Required Fiscal Year 2001 Strategy and Action Justifications.

In summary, the network's senior leadership and employees are fully committed to achieving the strategic goals and near-term priorities contained in this document. This commitment exemplifies "VA Heart of Texas Health Care Network – People Who Care" and the virtues of communication, cooperation, mutual respect, integrity, loyalty, selflessness and dedication it embraces.



# **Network Strategic Plan FY 2000**

**October 1999**

# Executive Summary

## **Introduction**

Veterans Integrated Service Network 18 (VISN 18), also known as the “VA Southwest Health Care Network” was established in November 1995. With distances sometimes exceeding 400 miles between facilities, the missions of VISN 18’s VA Health Care Systems encompass a comprehensive range of primary, secondary, tertiary, and long term health care services providing a full continuum of care. The VA Health Care Systems are the backbone of the network and include many remote Community Based Outpatient Clinics (CBOCs) and several Vet Centers. As the network develops and integrates, it is anticipated that the number of inpatients will continue to decline, while outpatient services will enjoy continued growth. One major reason for the decline in inpatient workload is the ongoing emphasis on innovative approaches to managed care. In aggregate, VISN 18 facilities provide health care services in all major bed sections and provide the most sophisticated treatments and procedures with world-class technology. Along with improved access to network health care programs, VISN 18 patients may expect a consistent level of high quality care as outlined in our Plan’s chapter on Performance and Quality. The strategies listed in the Summary of Strategies shows how the network plans to implement and provide accountability for our health care services. Specific measures and a target timeframe have been developed for each strategy. Geographically, the network encompasses over 361,000 square miles in 6 states with nearly 800,000 veterans. VISN 18 provides health care services to 176,000 unique patients per year and maintains 1,270 inpatient beds, treating nearly 26,000 inpatients annually. The network also provides 1,600,000 outpatient visits a year.

## **Mission**

VISN 18 provides a continuum of high quality health care services to all eligible veterans. The network is built on a foundation of primary care and is accountable for community health, joint-venture initiatives with Department of Defense (DoD), major research initiatives, and educational affiliations.

## **Internal/External Assessment**

During the past year, many of the health care facilities in the network were redesignated as VA Health Care Systems to reflect the ever-widening system of CBOCs attached to the parent facilities. As access is one of the important network strategic targets, VISN 18 has activated 30 CBOCs and plans to establish 10 additional CBOCs by the end of FY 2001. While we expect the number of unique veterans served to continue increasing, we believe that the rate of increase will drop from nearly 7% in 1998 to 4% per year by FY 2001. At the same time, VISN 18 is anticipating the rate of growth for the frail elderly (75+) will increase to over 22% from FY 1999 to FY 2005. Our strategy of supporting an increase in State Veterans Homes is intended to help address this need. As the enrollment process evolves, VISN 18 will vastly increase the use of cybertechnology to improve the movement of patient information between parent facilities and their ever-expanding web of remote CBOCs across the network. This technology will assist in further integrating the health care services provided to our veteran patients and make patient transfers more efficient. Our network is fully prepared to handle any Y2K contingency as part of its successful Emergency Preparedness program. Future challenges facing VISN 18 include recruitment and retention of health care providers in an evermore competitive health care manpower marketplace and meeting the rapidly changing health care needs of an aging and increasingly more diverse veteran population.

## **Performance and Quality**

VISN 18 strives to continually improve the quality of veteran health care and network performance through achievement of VHA mission goals, strategic targets, performance measures, performance monitors, and requirements of various regulatory and accrediting bodies. Key areas of emphasis include chronic disease intervention, preventive medicine, palliative care, implementation and compliance with clinical guidelines, customer satisfaction, and patient safety. In the FY 2000 VISN 18 strategic plan, all targets and strategies are linked to improving the national/network performance.

Total quality improvement techniques are employed to facilitate improvement in each key area through the establishment of VISN 18 work groups and action teams. These groups have broad staff representation to maximize employee involvement and establish courses of action that achieve optimal results.

Validation of our strategic planning is in part evidenced by the success of our 1999 Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) surveys. All facilities received full accreditation with exceptional Hospital Accreditation Program (HAP) scores ranging from 93 to 95.

## **Human Resources**

VISN 18 considers its over 6,600 employees as its single greatest resource. Many innovative employee incentive programs have been designed to recognize and reward deserving employees. In addition, countless educational opportunities are provided to assist employees in meeting their educational needs and the 36-hour minimum requirement established by the network. Another important aspect in managing our valuable human resources is insisting upon frontline manager accountability. Some of the methods used to accomplish this include performance appraisals, High Performance Development Model (HPDM) core competencies integrated into performance plans at some facilities, competency assessments, training/education requirements, internal and external customer satisfaction survey results, management briefings, monthly report cards, and progress reports relevant to established performance measures, service-level goals and objectives, and other measurable outcomes.

## **Communications**

VISN 18 uses its three Management Assistance Councils (MACs) as a forum not only for marketing its services, but also to facilitate two-way communications with its stakeholders. Our MACs enjoy broad representation and include members from veterans service organizations, medical school affiliates, congressional offices, labor organizations, State Department of Veterans Affairs, State Veterans Homes, local government, VA Regional Offices, Vet Centers, and the National Cemetery Administration. Patient and employee newsletters are published quarterly, providing information on health care topics and VA activities. The Network Director also hosts frequent town hall meetings at each facility so that every employee in the VISN has an opportunity to share concerns with VISN management.

## **Financial**

Historically, VISN 18 has been the most efficient network in the VHA system when comparing cost and workload. VISN 18's budget has increased 22% since FY 1996 as a result of the Veterans Equitable Resource Allocation (VERA) and alternative revenues. Additionally, the number of veterans using VISN 18 facilities has increased by 17% which has translated into a 30% increase in outpatient visits and a 24% decrease relative to inpatients treated. As VISN 18's budget has increased, the network continues to be efficient. FY 2000 will present certain challenges. For example, the VISN will be facing a 5% projected increase in the number of veterans treated, an estimated 4.8% inflationary increase, an increase in prosthetics and pharmacy costs above normal inflation, testing and treating Hepatitis C, and providing emergency and reproductive care. It is expected that in FY 2001 and beyond VISN 18 will continue to see an increase in the number of veterans seeking care, although at a more moderate pace, and will strive to improve timeliness of care. It is the VISN's goal to meet these additional challenges and demands and maintain the practice of being efficient without affecting the provision of quality care.

## **Special Populations**

VISN 18 provides necessary health services to meet the needs of veterans with the six disabling conditions that are identified in the *Veterans Eligibility Reform Act of 1996* (PL 104-262) including: Spinal Cord Injury/Dysfunction, Blindness, Amputation, Seriously Mentally Ill, Traumatic Brain Injury, and Post Traumatic Stress Disorder (PTSD). VISN 18 has maintained or increased its treatment capacity for these disability programs as compared to FY 1996 levels. Substance Abuse, as a subset of Seriously Mentally Ill, declined slightly. The Mental Health Work Group will examine this issue to determine the cause and make recommendations. Waiting times for specialized programs continue to be within the national goals, with the average waiting time for admission to the SCI Center of one day and the waiting time for a routine appointment being one day. Veterans wait an average of 17 weeks for admission to the Blind Rehabilitation Program, while the national average is 33 weeks. This is also the largest program in the system, serving six states.

## **Network Strategic Direction**

VISN 18's approach to clinical care is to utilize five executive policy and planning boards designed to foster the integration of clinical activities within the network. Progress has been made in many areas such as patient quality of care and transfers and referrals. Continuous improvement is anticipated as the network's strategies unfold. Increased cooperation amongst network facilities will maximize medical educational opportunities and significantly increase research grants attracting world-class researchers. Strategies will expand access to care, identify and treat high risk populations, improve the coordination and quality of care, achieve better program integration, reduce patient waiting times, and improve patient satisfaction. In addition, the network will reap the benefits of capital investments, alternative revenue generation, and improved financial analysis and forecasting. Investments will be made in technology and human resources. In the execution of the strategic plan, VISN 18 will be advantageously poised as we enter a new millennium.

## **Capital Resources/Alternatives to Institutional Care**

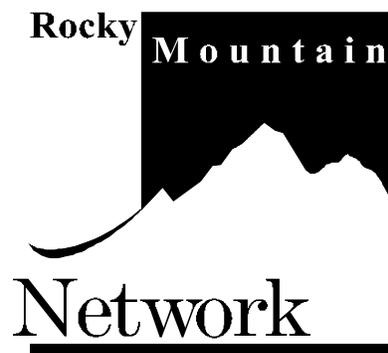
The 1997 Capital Asset Review Process (CARP) space survey provided a ratio of space to workload ranging from 26.2 to 67.6, with a national average of 45.4. VISN 18 has the lowest ratio of 26.2, which means that we have less space for the amount of work accomplished than any of the other networks. Upon completion of the Outpatient Addition at the Southern Arizona VA Health Care System at Tucson, every facility in VISN 18 will have undergone an outpatient renovation or addition. We are now focusing our Minor Construction Program funds on improving the inpatient environment. Nine new CBOCs are planned in addition to replacing the Lubbock Outpatient Clinic via lease. We have been systematically replacing obsolete diagnostic medical equipment with state of the art digital imaging equipment. Completion of the Telecommunications Infrastructure Project (TIP) and the addition of Local Area Networks (LANs) at all facilities supports many new business and information processing needs including telemedicine, standardized multimedia e-mail, and Decision Support Systems. Implementation of the Computerized Patient Record System (CPRS) and Bar Code Medication Administration (BCMA) will require an enhancement to the LANs in FY 2000. Plans are being developed to pilot Veterans Health Information Systems and Technology Architecture (VistA) Imaging and implement a private Wide Area Network to increase inter-facility data transfer.

The network is committed to supporting innovative and viable initiatives regarding alternatives to institutional care. Services currently available are: Ambulatory Surgery, Home Care, Residential Care, Day Care, Halfway Houses, and Hoptel/Lodging.

## **Conclusion**

As VISN 18 executes the 26 strategies outlined in this plan, (1) access to and quality of health care services will be enhanced; (2) the highest level of patient satisfaction will be achieved; (3) revenues will be increased along with improvements in management structures; (4) patient care will be enhanced through more accurate data capture and improved cybertechnology; and (5) investment in human resources will yield continuous benefits to the network. By achieving these five Strategic Targets, our network will gain an enormous edge towards meeting the coming challenges in the new millennium.

# Department of Veterans Affairs



# Network Strategic Plan

## FY2000

## Executive Summary

The Rocky Mountain Network continues to be dedicated to its original mission: Provide excellence in health care value, excellence in services as defined by customers, excellence in research and education and be an organization characterized by exceptional accountability and be an employer of choice.

To carry out this mission, the network has adopted VA Headquarters strategic targets (slightly modified) for FY 2002 under which specific objectives can be delineated and accomplished. These targets include:

- ◆ increasing the number of users of our system by 20% (This target has been reached and additional patient users are being added);
- ◆ increasing the percent of the operations budget obtained from non-appropriated sources by 10%;
- ◆ redistributing health care services in the network to serve veterans closer to their homes;
- ◆ establishing primary care as the means to coordinate care;
- ◆ providing care at an equal or lower cost than other providers;
- ◆ meeting or exceeding national VA quality outcome measures and community standards for quality in what we provide where we serve;
- ◆ increasing the proportion of patients reporting VA health care as very good or excellent and as good or better than other providers;
- ◆ increasing employee training in quality improvement, customer service and other VHA priorities to 40 hours per year;
- ◆ providing excellence in research and education;
- ◆ establishing an information system that meets HQ requirements and supports network strategies.

The predominant objectives for the FY 2000-2001 period include determining the future of the Fort Lyon campus, developing an health care access plan for VA Montana, establishing new community based clinics, integrating clinical and informational functions and implementing cost reduction measures to meet budgetary demands.

The network and local southeastern Colorado community leaders have met frequently to consider various options for the future of the Fort Lyon campus. One of the options being considered is the Colorado Department of Corrections (CDOC) proposal that they acquire the Fort Lyon campus for use as a correctional institution. Both the network and the community support this option as best for both patients and the future of the community. There are several compelling reasons for supporting this option: 1) the campus is 25 miles from emergency services, which does not meet criteria for quality care, is a threat to patients and a concern to physicians; 2) due to the isolation of the campus, recruitment and retention of qualified clinical staff is a continuing problem; 3) closure of the Fort Lyon campus will allow the network to place many patients in care centers closer to their homes; 4) savings acquired from eliminating high campus operating costs will allow the opening of three new outpatient clinics in La Junta, Lamar and Alamosa, thus providing treatment for more veterans; and 5) the CDOC proposal promises the opportunity for continued employment and economic growth in that region. The CDOC need for staff anticipates many job matches with current VA employees at Fort Lyon.

An opportunity exists at the Miles City campus for more efficient use of partially occupied buildings. A plan will be developed to acquire tenants in the building to reduce operating costs so that more resources can be used in treating patients.

The network plan includes opening/expanding five new community based outpatient clinics in Colorado, Montana and Nebraska. These clinics will allow more patients to be treated and to be treated nearer their homes. Clinics would be located in La Junta, Lamar and Alamosa, Colorado; Sidney, Montana; and Sidney, Nebraska. Clinics in Gillette and Big Horn, Wyoming could also open pending available funding.

The network plans to more fully integrate clinical services at some sites in the network. This plan redirects funds to continue clinical services to patients, but provide them more efficiently. Patient care beds would be increased at Denver to accommodate some inpatient medical, surgical and psychiatry needs for patients coming from Cheyenne

and Southern Colorado who previously would have received care from private sector providers at more cost. Part of this plan includes providing additional subspecialty services at the Colorado Springs community based clinic. Also, a pilot orthotics lab at Denver and a pilot orthotics insole service at Salt Lake City would be established. If the pilots work out as planned, then the services would be available as a network wide resource. Other VISNs could potentially purchase services from these sites.

A plan to integrate network databases is also part of the network strategy. This would begin with data viewing, retrieval and in updating connections between all medical centers and community based clinics in the network.

Expected funding for FY 2000 and thereafter will require significant cost reduction efforts in the network. Increased efficiencies will be undertaken in several areas. Lengths of stay in acute mental health will be reduced to the network goal of an average of 12 days or less. Contract clinic rates are being renegotiated at several sites. Use of more home health contracts and additional use of Medicare for more home health services will be required. Educational/training materials will be centrally purchased. Patient travel costs may be reduced through a network-wide air charter contract. In addition, individual medical centers will be required to appropriately plan for anticipated budget contingencies. This may include reduction in force.

As part of a long-range plan, the network is working actively with the University of Colorado to determine the feasibility of co-locating selected functions at the now vacated Fitzsimons Army Medical Center site in Aurora, Colorado.



**VISN 20  
NORTHWEST NETWORK**

**Strategic Plan  
FY 2000-2005**

**October 1999**

## Executive Summary

Visit the VISN 20 Website at <http://152.131.133.4/visn20/index.html>

### **Who Are We:**

VISN 20, the Northwest Network, includes the states of Alaska, Washington, Oregon and most of the state of Idaho. This equates to approximately 23% of the United States land mass. The network includes six medical centers (the tertiary sites – Portland and Seattle – have two divisions that were previously consolidated), one independent outpatient clinic, one independent domiciliary, six community based outpatient clinics and one mobile clinic covering several sites. In support of the VISN education mission are two major academic affiliations, the University of Washington, and Oregon Health Sciences University, and over 290 affiliations with both regional and national academic institutions. Other services operated in VISN 20 are 7 nursing home care units, three homeless domiciliaries, and 15 readjustment counseling centers.

### **Budget and Research:**

The network has an operating budget of approximately \$652 million and employs 7,300 people. It has a research budget of greater than \$30 million. Research involvement includes national agreements with the Northwest Health Systems Research & Development program in Seattle, the Environmental Hazards Research Center (Gulf War Veterans illnesses), the Office of Regeneration Research and the newly awarded Center for Rehabilitative Auditory Research at Portland, Oregon. Further, research, education and clinical care in Mental Health, Geriatrics, and Epidemiology are enhanced by a Mental Illness Research, Education, and Clinic Center (Boise, Portland, and PSHCS), a Geriatric Research, Education and Clinical Center GRECC (PSHCS), and the Epidemiologic Research and Information Center (PSHCS). In support of the education mission, network facilities have a total of 292 affiliation arrangements with both regional and national academic institutions.

### **Whom We Serve:**

Since FY 1997, VISN 20 has grown approximately 16% in veteran users, which is slightly less than the national average increase. VISN 20 anticipates a demand to treat approximately 150,000 veterans in FY 2001--a 27% increase from FY 1997. In FY 1998, VISN 20 served 130,000 veterans; the tertiary facilities and Anchorage served proportionally more veterans under 65; secondary facilities served the largest proportion of elderly veterans. Between 2000 and 2010, the VISN veteran population overall will decrease, and the composition will continue to shift to those who are elderly, the age groups most likely to need health care. Workload at all facilities is continuing to move from inpatient to outpatient care and to non-institutional alternatives.

### **Malcolm Baldrige Criteria:**

VISN 20 has begun using the Malcolm Baldrige criteria as the primary model for planning and improvement. This includes linking all improvement efforts to the strategic plan by developing tactics at the Alliance/Facility/Committee levels that are designed to meet the objectives and goals of the network.

### **Alliances:**

Consistent with the VHA mission statement articulated in the Vision for Change, the Northwest Network established a five year vision of becoming an integrated health services delivery system (FY 1997 Network Strategic Plan). In its 3+ years of existence, the network has refined and improved its organizational structure to facilitate movement in that direction. The current organization consists of 2 geographically compatible health care Alliances and a more accountable committee structure. The two alliances are: (1) the South Cascade Alliance includes all Oregon facilities - a tertiary referral facility at Portland, a secondary VAMC at Roseburg, and a Domiciliary at White City; and (2) the Northern Alliance is comprised of five facilities, covering three states. These include a tertiary referral facility (VA Puget Sound Health care System – Seattle/American Lake); three secondary VAMCs at Boise, Spokane and Walla Walla; and a VA Medical and Regional Office Center (VAMROC) in Anchorage.



**Rewards and Recognition:**

In June 1999, Dr. Kizer presented the network with an Honorable Mention Award for the 1998 Quality Achievement Recognition Grant competition.

For the second year, VISN 20 provided funding for each site to recognize employees who contributed to network-wide initiatives. This year, facilities distributed over \$109,000 to 376 employees through this recognition program.

**Special Populations:**

VISN 20 is committed to maintaining the capacity of programs to serve 6 special populations of veterans: spinal cord injury and diseases; blindness; traumatic brain injury; amputation; seriously mentally ill, including the chronically mentally ill, substance abuse, and PTSD; homeless.

The plan addresses services for women veterans and those with multiple sclerosis.

# Excellence by Design

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## Strategic Plan FY 2000-2004

*Veterans Integrated Service  
Network 21  
October 1999*

## Executive Summary

Over the next five years, the VA Sierra Pacific Network will continue its strategic journey for success. The chosen course is in concert with the corporate goals and objectives of the Veterans Health Administration (VHA), and supports the strategic plan for the Department of Veterans Affairs (VA). The framework and title for the Strategic Plan, *Excellence by Design*, emphasizes the network's commitment to actively develop outstanding clinical and business services for veterans.

The VA Sierra Pacific Network is one of 22 Veterans Integrated Service Networks (VISN) in VHA. The VA Sierra Pacific Network (VISN 21) serves 1.3 million veterans residing in northern and central California, northern Nevada, Hawaii, the Philippines, and several Pacific Islands (e.g., Guam, American Samoa). The network provides comprehensive services to more than 140,000 veterans each year. Major VA facilities include:

- VA Central California Health Care System (HCS), Fresno
- VA Medical and Regional Office Center (VAMROC), Honolulu
- VA Regional Office/Outpatient Clinic (VARO/OC), Manila
- VA Northern California HCS, Martinez
- VA Palo Alto HCS
- VA Medical Center (VAMC), San Francisco
- VA Sierra Nevada HCS, Reno

### **Mission, Vision, and Values**

The mission of the VA Sierra Pacific Network is to improve the health and functional status of veterans

The vision of the VA Sierra Pacific Network is to be widely recognized for excellence in patient care and high customer satisfaction.

The network will fulfill its mission and realize its vision by developing a fully integrated health care system that delivers outstanding clinical services, cultivates effective educational programs and conducts leading-edge research activities.

The core values of the VA Sierra Pacific Network are trust, respect, excellence, compassion, and commitment.

### **Network Strategic Direction**

The network's central strategy for delivering services to enrolled veterans is development of an integrated system of care sites. Across these sites, veterans will have timely and convenient access to a full continuum of coordinated, high quality care. Outstanding customer service will be a cornerstone of this system. The network is committed to providing enrolled veterans with the benefits package defined by law. The network will continue to improve access to a full continuum of care, with particular attention given to special programs. Primary care will be available within 30 miles of the homes of 80 percent of the network's veteran population, and provision of services will be timely. Each primary care patient will be assigned a provider or team responsible for managing the patient's care, including access to regionalized specialty care.

The network will facilitate integration of care across the network by fostering alliances between facilities with complementary missions (e.g., San Francisco VAMC and Northern California HCS), developing hub and spoke models for highly specialized services (e.g., spinal cord injury), and linking information systems across sites to enable sharing of clinical information and resources (e.g., teleradiology).

The central strategy will be accomplished through the following goals and objectives:

***Be a provider of choice for veterans***

- Improve geographic access to care
- Improve timeliness of care delivery
- Improve coordination of benefits
- Improve customer service
- Improve marketing and public relations

***Be an employer of choice***

- Provide employees with the education and training necessary for high performance
- Improve employee satisfaction
- Recognize and reward employees for contributing to the mission and strategic goals of the network
- Provide employees with a safe work environment
- Sustain effective labor relations and EEO program

***Be a fully integrated health care network providing an extensive continuum of high quality care to veterans***

- Ensure appropriate access to a full continuum of care
- Integrate special emphasis programs in the continuum of care
- Ensure coordination of the care of each patient by a single provider or team
- Sustain an environment of continuous quality improvement
- Provide high quality educational experiences for residents and trainees
- Sustain strong research programs
- Ensure access to accurate management and clinical information across the network

***Be operationally efficient and increase external revenues***

- Optimize potential revenues
- Organize administrative functions for maximum efficiency
- Optimize clinical efficiencies
- Leverage network purchasing power
- Meet compliance expectations

***Be a leader in capital asset management***

- Demonstrate comprehensive, data-driven strategic planning with linkages to budget and capital asset planning
- Provide a safe, functional cost-effective environment
- Plan for timely replacement of equipment and keep pace with advances in technology
- Coordinate network planning and resources for standardization of information technology ventures and efficiencies

The network will evaluate progress toward implementing the strategy along the dimensions of access, quality, cost, and stakeholder relations.

## **Environmental Assessment**

Major external factors influencing strategic direction for the VA Sierra Pacific Network include the impact of eligibility reform legislation on enrollment and provision of a basic benefits package, identification of the network by the General Accounting Office (GAO) as one of eight VA markets having high potential for realignment of capital assets, and the number of buildings identified as exceptionally high risk during a seismic event. In addition, the network faces national performance expectations and budgetary challenges.

Internally, the network has assessed how well it is positioned to achieve its goals by evaluating strengths, weaknesses, opportunities, and threats. The Northern California Study represents a plan for improving access to inpatient and outpatient services in a large segment of the network's service area.

## **Performance and Quality**

The quality management process in the network ensures that facilities provide a predictable and consistent level of high quality care through systematic and ongoing evaluation, monitoring and trending of patient outcomes. The network utilizes a balanced scorecard approach and produces regular report cards for the network and individual facilities. Performance on a variety of quality measures demonstrates that health care services are improving and compare favorably with the private sector. Initiatives underway in the network include:

- ◆ Performance agreements between the Network Director and facility directors
- ◆ Quarterly quality visits to each facility by the Network Director and Quality Management Officer
- ◆ Network Committee on Prevention Index and Chronic Disease Index
- ◆ Clinical Practice Guidelines Committee
- ◆ Hypertension Project

Customer satisfaction surveys for ambulatory care show the network performs better than the national average in all areas, and significantly better in patient involvement in the treatment process, emotional support and education/information. Inpatient surveys show opportunity to improve in some areas.

The VA Sierra Pacific Network's resident satisfaction survey represents a best practice. The survey was created in 1998 as a means for obtaining feedback about what residents consider to be the strengths and weaknesses of the training they receive at VA facilities.

The VA Sierra Pacific Network fully supports education and research missions, recognizing their contributions to high quality patient care. These programs are integral to the network's ability to implement its strategic plans, given the impact on advances in patient care, recruitment of highly qualified clinical staff, and management of workload.

## **Special Populations**

The VA Sierra Pacific Network established a baseline for evaluating special populations, including a clinical inventory and national capacity measures for selected programs. The inventory shows the network to have a wide range of services in place to meet the needs of special populations. Network facilities have identified a number of best practices or monitors that are in use, including customer satisfaction surveys, performance and quality monitors, follow-up processes, and participation in national projects. Future initiatives under consideration for these patients include special program accreditation, telemedicine capabilities, improved access and care coordination, community partnerships, and program enhancements.

## **Communications and Marketing**

Stakeholder relations in the VA Sierra Pacific Network are overwhelmingly positive, with numerous mechanisms in place to solicit stakeholder involvement in network activities.

The network committee structure provides a mechanism for communication between internal and external stakeholders, care sites, and the network corporate office. The Management Assistance Council (MAC) is made up of representatives from veteran service organizations, state and county veterans departments, medical school affiliates, Department of Defense, community health organizations, employee unions, and other VA administrations. In addition to the MAC, the network solicits stakeholder feedback through numerous forums, including an annual

briefing of Congressional delegations, meetings with county service officers in California and Nevada, and deans committee meetings. The network also publishes its newsletter *Veterans' HealthMatters* and maintains a Web page. The network's Marketing and Planning Council has oversight responsibility for communications and marketing, and will publish a Network Communication Plan in FY 2000.

## **Human Resources**

Employees are the network's greatest asset. The network is committed to developing its workforce to meet future challenges. Human resources strategies include education and training opportunities, recruitment and retention initiatives, performance management systems, and reward and recognition programs. The network also places high priority on maintaining effective labor relations and upholding the principles of equal employment opportunity. A major initiative for the network involves implementation of the high performance development model.

## **Financial Plan**

In FY 2000, the VA Sierra Pacific Network may receive a five percent increase over the FY 1999 budget allocation. Even so, the network faces a number of financial challenges. On top of overall inflation, the most significant challenges arise from unfunded mandates, including:

- ◆ treatment of Hepatitis C
- ◆ pay raises
- ◆ new facility activation
- ◆ increased pharmaceutical costs
- ◆ prosthetic costs

Implementation of inpatient services in the Sacramento area will add new recurring costs, as will support for the Center for Aging in Honolulu, Hawaii and continued operation of CBOCs. Infrastructure technology requirements and system replacement projects will also add to the cost structure over time. Areas of emphasis include a wide area network/local area network project, disk storage needs, computerized patient record system (CPRS), telemedicine applications, and videoconferencing.

In order to effectively meet these challenges, the VA Sierra Pacific Network must streamline clinical and business practices and generate new revenues. Cost reduction strategies include standardization of medical supplies, energy savings, CBOC efficiencies, provider profiling, program realignment, staffing mix adjustments, and pharmacy cost containment.

Revenue generation is a major priority for the network. In the arena of third party reimbursement, the implementation of reasonable charges is expected to increase Medical Care Collection Fund (MCCF) collections. In addition, the network has opportunities for revenue generation in the areas of TRICARE, sharing agreements, enhanced use, and contractual arrangements.

Reengineering business practices will reduce costs as well. The establishment of the Consolidated Contracting Authority for Bay Area facilities has resulted in substantial savings. The network also participates in the Western States Business Opportunities (WSBO), a consortium of five networks created to leverage purchasing power and identify sharing opportunities.

## **Capital Plan**

The VA Sierra Pacific Network is faced with numerous facilities management challenges, the most significant being the number of facilities designated as exceptionally high risk during a seismic event. The projected cost to correct all seismic issues for these buildings is \$50.8 million. In addition, the GAO identified the San Francisco Bay Area as one of eight market areas within the country that are strong candidates for consolidation of programs or facilities. The network will likely be in the first round of studies that are proposed for FY 2000. The network will continue to address capital requirements necessary to increase access to inpatient and outpatient care in northern California.

## **Summary of Strategies**

The network's goals, objectives and tactical actions are summarized in Chapter IX of our Plan.

# California and Nevada



## **Desert Pacific Healthcare Network**

**FY 2000 – 2005 Network Strategic Plan**

# Executive Summary

The VA Desert Pacific Healthcare Network is a fully integrated, comprehensive health care system that provides a continuum of care for America's veterans. One of twenty-two Veteran's Integrated Service Networks (VISNs) in the Department of Veterans Affairs, the network is solidly grounded on the principles set forth in the Malcolm Baldrige criteria for quality, highly effective organizations. As such, the strategic planning process, strategic goals and council structure were created and aligned using the Baldrige Healthcare Criteria (refer below to the seven criteria which also are the "Network Strategic Goals").

## **Network Mission Statement**

Quality Healthcare, research and education for America's veterans exemplified by outstanding customer service.

## **Network Vision Statement**

We envision a health care system that realizes continued user growth, is responsive to veterans' needs and serves as a benchmark for health care value.

## **Network Values**

The network embraces the VHA core values of trust, respect, excellence, commitment and compassion in an environment of continuous improvement.

## **Network Strategic Goals**

Enhance the following network-wide (based on the seven Baldrige Healthcare Criteria):

1. Leadership
2. Strategic planning
3. Focus on patients, other customers and markets
4. Information and analysis
5. Staff focus (employee learning, well-being, satisfaction and motivation)
6. Process management (how key processes are designed, implemented and improved)
7. Organizational performance results

Because Baldrige "Excellence" organizations focus on all seven criteria to drive organizational quality and excellence, the network places equal weight and importance to each of the seven network goals. All FY 2000 strategies are listed under one of the seven network goals in Table 6 on page 32 of our Plan).

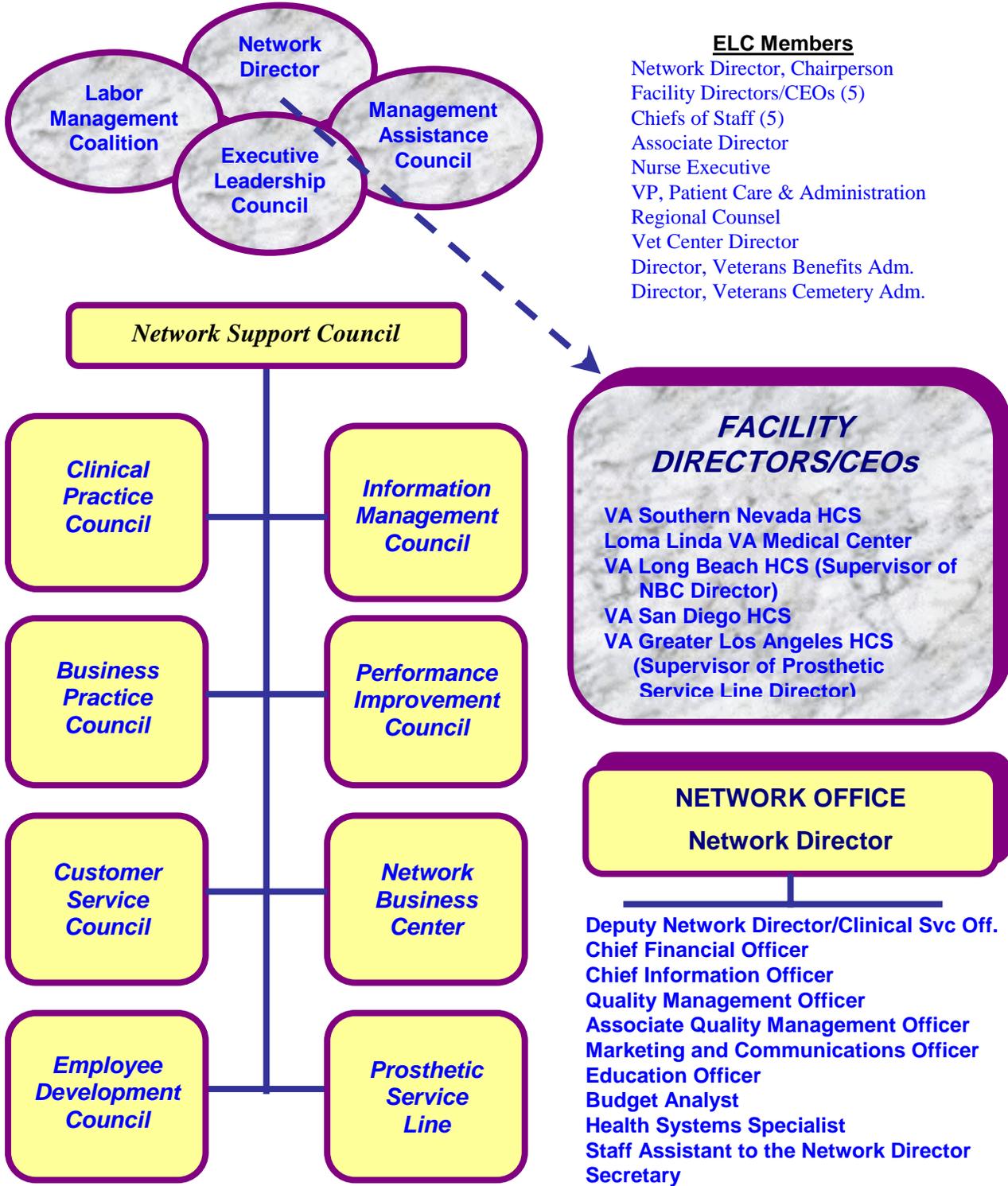
## **Planning Assumptions**

The network functions as the central business unit for all affiliated facilities. As such, it engages in planning, fiscal control and provides operations support for the network. The network is supported by an Executive Leadership Council (the primary governing board) and committees. It also is supported by a Management Assistance Council that includes external stakeholders and a Labor Management Coalition that provides a forum for addressing all network-wide labor management issues. Refer to Table 1, "VA Desert Pacific Healthcare Network Organizational & Functional Model" for a breakdown of the leadership and planning councils, which comprise the Network.

Membership of the ELC consists of all Facility Directors, Chiefs of Staff, Regional Counsel, a Nurse Executive and an Associate Director. The Veterans Benefits Administration Director and National Cemetery Director are also members to assure that a "One-VA" focus is maintained and fostered.

Table 1

VA Desert Pacific Healthcare Network  
Organizational & Functional Model



**ELC Members**

- Network Director, Chairperson
- Facility Directors/CEOs (5)
- Chiefs of Staff (5)
- Associate Director
- Nurse Executive
- VP, Patient Care & Administration
- Regional Counsel
- Vet Center Director
- Director, Veterans Benefits Adm.
- Director, Veterans Cemetery Adm.

The main councils include the Clinical Practice, Business Practice, Information Management, Customer Service, Performance Improvement and Employee Development councils. Each network council also has multiple sub-councils, taskforces and work groups, which are chartered to accomplish time-limited implementation projects or carry out council initiatives. In addition, a Network Business Center (NBC) provides contracting and construction planning support and a Prosthetic Service Line provides centralized coordination of prosthetic programs and purchases.

## **INTERNAL AND EXTERNAL ASSESSMENTS**

The internal assessment provides the network with an overview of the demographics of its veteran patients, the competitors in the private health care environment and the current status of resources that are available to support health care delivery.

The network is comprised of five medical centers and twenty-four community-based outpatient clinics (CBOCs). The network spans approximately 110,000 square miles of southern California and southern Nevada. Inpatient facilities are located in the major markets served by the network: Los Angeles, Long Beach, San Diego, Loma Linda, and Las Vegas. The Los Angeles facility has recently integrated with the Southern California System of Clinics to form the VA Greater Los Angeles Healthcare System. CBOCs include Los Angeles, East Los Angeles, Gardena, Culver City, Hollywood, Antelope Valley, Bakersfield, Santa Barbara, Sepulveda (also has a Nursing Home Care Unit), Port Hueneme, Lompoc, San Luis Obispo, Santa Ana, Anaheim, Mission Valley, Vista, Chula Vista, El Centro, Victorville, Sun City, Palm Desert, Henderson and Las Vegas. Additional CBOCs are either approved or planned for FY 2000, including Glendale, Cabrillo, Pahrump, Las Vegas (Vet Center collocation), Corona and Whittier.

The network has 1,987 operating beds, including 999 inpatient acute, 637 nursing home, 321 domiciliary and 30 psychiatric residential beds. In FY 1999, the network cared for a projected 198,650 unique veteran users (based on July 31, 1999 actual users projected to the End of Fiscal Year [EOFY]). Also, the network had 24,000 inpatient stays and 1.8 M outpatient visits (refer to the workload graphs on pages 8-9 of our Plan). The cumulative, end-of-year actual FTEE level has decreased from 11,968 in FY 1993 to 9,776 (Pay Period #18) in FY 1999 (-18.3%), of which approximately 900 (680 FTEE) are physicians.

The overall national and local California and Nevada health care environment is similar to that which existed during the FY 1999 Network Strategic Planning cycle. However, the network patient population has continued to experience phenomenal growth. These markets remain progressive, dynamic, and extremely competitive. Driven by the high managed care market penetration rate and a large and diverse population, this market frequently serves as a barometer for national health care industry trends (overall market trends include major integrated delivery system providers, such as Tenet and Columbia/HCA, expanding operations to broaden geographic coverage concurrent with smaller, specialized providers targeting specific patient populations; i.e. females, rehab, mental illness, etc.) to create niche markets. Pending legislation threatens to have a major impact on health care processes, costs, utilization, etc. For example, new initiatives are being debated to allow lawsuits against HMOs, direct access to specialists, second opinions within a health plan (or external), minimum nurse staffing ratios and minimum hospital stays for specific conditions (delivery, etc.).

### **Implications of the External and Internal Assessments on the VA Desert Pacific Healthcare Network**

The implications of the assessments are conclusive. Strategies have been developed (refer to Table 6, page 32 of our Plan) to increase market share (veteran users) in an environment of constricting budgetary pressure and declining appropriations. The network must also provide for the unique health care needs of veterans in a cost-efficient manner relative to alternative competitor services and pricing. The cost per patient of network services, particularly administrative overhead, must decrease to a competitive market level. Multiple strategies have been included in Table 6 of our Plan to address cost-savings. Examples of two network strategies designed to deal with this reality are the 366 employee Reduction in Force (RIF)/Staffing Adjustments (SA) at the Greater Los Angeles Healthcare System and a smaller RIF of 64 employees at the Long Beach Healthcare System. Congress is still considering the possibility of approving VHA "Buyout Authority," which would help the network deal with the need to reduce costs through appropriate right-sizing of employment levels.

## **FINANCIAL/CAPITAL PLAN**

The total amount of funds anticipated to be available in FY 2000 for the network is extremely uncertain. The FY 2000 VA Appropriation is still under debate by Congress. Possible VHA funding levels vary significantly. In addition, VERA is still undergoing methodological changes. Due to this uncertainty, it is impossible to define the methodology that will be used to fund the facilities within the network at this time. More current and optimistic VHA appropriation funding levels would require little change in the FY 2000 facility funding allocation model from that historically employed by the network. The network has in the past used a facility resource allocation methodology that closely approximated VERA, with some modifications. It, like VERA, can be characterized as a partial or modified capitation model.

The ultimate intent is to have an equitable resource allocation methodology that helps ensure that the five "Domains of Value": access, technical quality, customer satisfaction, efficiency (cost/price) and functional status, are achieved to the greatest extent possible within the funds made available to the network. To offset the impact of a fairly constant overall funding level, inflation, additional funding needs for new CBOCs and other new initiatives, a series of cost cutting, reduction and avoidance actions will be implemented. A significant portion of these cost cutting and cost avoidance actions will focus on employment (FTEE) levels, since salaries comprise approximately 70% of total operating costs. Continued FTEE reductions will be accomplished through a combination of actions: attrition (turnover); buy-outs (if approved and authorized by Congress) and Reduction in Force/Staffing Adjustments.

## **NETWORK STRATEGIC DIRECTION**

The network's strategic direction is set forth in Table 6 (refer to page 32 of our Plan). The seven network goals are broken down into objectives and specific strategies. For example, under Goal #1, "Enhance Leadership," the network will focus on strategies to strengthen the "One VA" initiative. Under Goal #2, "Enhance Strategic Planning," the network is now utilizing a Baldrige format for planning and the ELC council structure. Goal #3, "Enhance Focus on Patients, Other Customers and Markets," includes strategies to improve customer service survey results, coordination of care and continuity of care. Under Goal #4, "Enhance Information and Analysis," the network will finalize roll-out of computerized medical records (CPRS) and implement electronic clinical reminders to enhance patient care. Goal #5, "Enhance Staff Focus," includes strategies to implement the "High Performance Development Model," employee safety initiatives and an Employee Needs Assessment. Under Goal #6, "Process Management," the network will focus on consistency in clinical treatment processes related to the performance measures (such as clinical practice guideline training, establishment of a palliative care work group to standardize end-of-life treatment planning, etc.). Goal #7, "Enhance Organizational Performance," will include strategies focusing on an increase in the number of unique patient users and Category A users (market share), an increase in alternative revenues and a decrease in the cost per patient (cost savings strategies, including Reductions in Force at the Greater Los Angeles and Long Beach Health Care Systems). All other strategies throughout the document relate back to these key seven Network Strategic Goals.

The network is faced with several significant challenges. Following the general direction of private sector health care, the network continues to transition from a hospital-based provider of care to a community-based health care provider with a focus on primary and preventive care. Two specific factors are driving this transformation: 1. Implementation of a Uniform Benefits Package for all veterans; and, 2. Opening of Community Based Outpatient Clinics to provide care closer to veteran's homes.

Budgetary considerations are also a continuing issue for the network. The flat-line budget, combined with unfunded mandates and wage inflation, is forcing the network to improve efficiency and generate new sources of non-appropriated revenue. This will drive the network toward resource sharing and partnering arrangements with other health care providers, social service entities and government agencies.

Substantial opportunity to work closely with Department of Defense (DoD) health care facilities to provide expanded care to active duty military and retired veterans should be aggressively pursued over the next 3-5 years.

The shift in delivery pattern and budgetary constraints parallel the non-VA health care industry. Similar to non-VA systems, the network must model operations after demonstrated best practices to recognize cost efficiencies and optimize treatment outcomes. Included in these models must be an openness to explore non-traditional treatment modalities and practices.

Finally, the network needs to utilize and align its capital assets (buildings, land, space, etc.) more effectively to assure VA patients are taken care of and excess assets are used to generate alternative revenues to re-invest in health care services.