STRATEGIC GOAL 3

Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

Objective 3.1

Improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.

Objective 3.2

Provide a level of income that brings eligible veterans and their survivors up to a standard of living that assures dignity in their lives.

Objective 3.3

Enhance the financial security for veterans' families through life insurance and other benefits programs.

Objective 3.4

Ensure that the burial needs of veterans and eligible family members are met.

Objective 3.5

Provide veterans and their families with symbolic expressions of remembrance.

Veterans will have dignity in their lives, especially in time of need, through the provision of health care, pension programs, and life insurance; and the Nation will memorialize them in death for the sacrifices they have made for their country. To achieve this goal, VA needs to improve the overall health of enrolled veterans, provide a continuum of health care (which includes special populations of veterans), extend pension and life insurance benefits to veterans, meet the burial needs of veterans and eligible family members, and make available to veterans and their families symbolic expressions of remembrance.

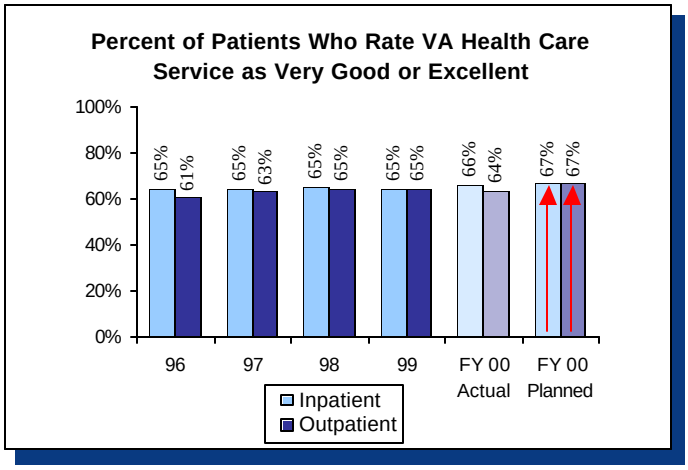
Several key performance measures enable us to gauge progress toward achieving this strategic goal:

- Percent of patients who rate VA health care service as very good or excellent
- Percent of patients who are able to obtain a primary care appointment within 30 days
- Percent of patients who are able to obtain a non-urgent appointment with a specialist within 30 days of referral
- Percent of patients seen within 20 minutes of scheduled appointment at VA health care facilities
- Chronic disease care index (CDCI)
- Prevention index (PI)
- Percent reduction in average cost (obligations) per patient
- Percent increase in number of unique patients treated
- Percent of medical care operating budget derived from alternative revenue streams
- Pension program outcomes
- Insurance program outcomes
- Percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence
- Percent of respondents who rate the quality of service provided by national cemeteries as excellent

Increase the Percent of Patients Rating VA Health Care Service as Very Good or Excellent to 67 Percent

(This measure supports our objective to improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.)

VA's National Performance Data Feedback Center began surveying satisfaction with care among inpatients in 1994 and among outpatients in 1995. During the last 4 years, the share of inpatients and outpatients rating VA health care service as "very good" or "excellent" has remained stable at about two-thirds. The inpatient and outpatient satisfaction levels recorded during FY 2000 were below the performance target of 67 percent. However, the small differences fall within the statistical margin of error associated with the survey sample.



Although the share of patients rating their care as "very good" or "excellent" has remained flat over the last several years, fewer patients now rate their care as "fair" or "poor," while more patients rate their health care service as "good." Considering the significant structural and programmatic realignments VA has implemented to improve access to care, it is gratifying to observe that most veterans approve of the changes and continue to maintain a high level of satisfaction and confidence in VA health care.

In addition to our own surveys, the Department uses other mechanisms to measure patients' satisfaction with VA's health care service. Among the most important of these is information released in conjunction with a nationwide survey commissioned by the National Partnership for Reinventing Government (NPR). The NPR study used the American Customer Satisfaction Index (ACSI) as a national indicator of customer evaluations of the quality of goods and services. This is the only uniform cross-industry/ government measure of customer satisfaction, and it allows benchmarking between the public and private sectors. Data on veterans' satisfaction with their health care service is based on a sample of veterans who used VA outpatient services between April 11 and May 26, 2000.

The 2000 ACSI for VA outpatient care is 78 on a scale of 0 to 100. For the second consecutive year, the satisfaction score for VA outpatient care is above that logged by private sector hospitals, whose ACSI score is 71. In addition, the VA score is higher than the ACSI of 72 recorded by all Americans rating their health care services. VA's index of loyalty (88) remains very high, and is 20 points above the comparable value for private hospitals. This indicates the very high degree to which VA patients state they will use a VA medical center (VAMC) in the future, and the extent to which they would be willing, if asked, to say positive things about VAMCs.

Means and Strategies

VA is constantly seeking feedback from customers on their satisfaction through surveys, focus groups, complaint handling, direct inquiry, and comment cards. This feedback has been used to build a database on what customers expect and experience. Also, it provides information to use in making adjustments to future performance goals and identifying areas that need improvements. As appropriate, specific groups of patients—such as Persian Gulf veterans, minority veterans, and women veterans—are surveyed to determine their special needs and levels of satisfactions.

In FY 2000, Veterans Integrated Service Networks (VISNs, or networks) used a variety of strategies to ensure that veterans were satisfied with their health care service. The following were among the most effective strategies, most of which have been used in previous years as well:

- Enhancing provider/patient communication through education programs; using post-discharge telephone calls, quick cards, and patient representative visits for new admissions; having product line managers in charge to resolve complaints; instituting quarterly awards programs at each facility to recognize outstanding employees and to provide incentives for future positive performance; giving patients the provider treatment roster; and routinely surveying staff and patients to proactively address emerging problems and reinforce positive trends.
- Improving patient access to care. Traditional local strategies include the opening of community-based outpatient clinics (CBOCs), community service centers, and weekend clinics. In addition, VA has continued to use case managers, build permanent clinic screening teams, and make infrastructure improvements, such as a VISN-wide guest services program.

The Department's Performance Plan for FY 2001 will focus on key areas of patient satisfaction, defined as those with the greatest opportunity for improvement: patient education; visit coordination; and pharmacy services.

Beginning in FY 2001, the patient satisfaction survey will be conducted semi-annually. VISNs and medical centers will also conduct more frequent evaluations at the local level. These actions will increase facilities' ability to identify strategies to improve patient satisfaction.

Crosscutting Activities

VISNs constantly seek input from veterans service organizations and cooperate with them to ensure access, reduce friction, and improve quality of care and veteran satisfaction with health care services.

Data Source and Validation

The source of data for evaluating VA performance is the National Performance Data Feedback Center. The satisfaction data are drawn from the results of samples of inpatients and outpatients. The survey results are reported annually on a nationwide and a VISN-specific basis. The inpatient survey targets a random sample of veterans who were recently discharged from inpatient care. The outpatient survey is sent to veterans who had at least one outpatient visit at the general medicine clinic, primary care clinic, or women's clinic. At each clinic in the sample, 175 veterans were randomly selected.

The validity and reliability of the findings are ensured by the application of standardized survey research techniques, i.e., identical methods are used in all settings. This is a notable strength of

the VA survey process. It allows comparison of results at the facility level. In addition, the response rates are high (inpatient survey, 65 percent, and outpatient survey, 74 percent), leading to more reliable information. High response rates leave less room for response bias and minimize the possibility of spurious results. The survey questionnaires are based on well-validated survey instruments. Finally, VA's survey instruments contain many of the same questions as the one used by the Picker Institute in the private sector, therefore allowing valid comparisons with non-VA satisfaction results. The Picker Institute is an international leader in the field of health care quality assessment and improvement.

Percent of Patients Who Are Able to Obtain a Primary Care Appointment within 30 Days
Percent of Patients Who Are Able to Obtain a Non-Urgent Appointment with a Specialist within 30 Days of Referral
Percent of Patients Seen within 20 Minutes of Scheduled Appointment at VA Health Care Facilities

(These measures support our objective to improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.)

The purpose of VA's 30-30-20 strategy is to define how long it takes veterans to obtain appointments for non-urgent care, and how long it takes them to see a provider for a scheduled appointment after arriving at a VA facility. VA's overall service and access goal is to provide personalized care when and where it is needed, in ways that are creative, innovative, and cost-effective. The 30-30-20 goals were incorporated in the FY 2000 and FY 2001 performance agreements between the Network Directors and the Under Secretary for Health. This is intended to ensure a consolidated effort across the VA health care system to accomplish these goals.

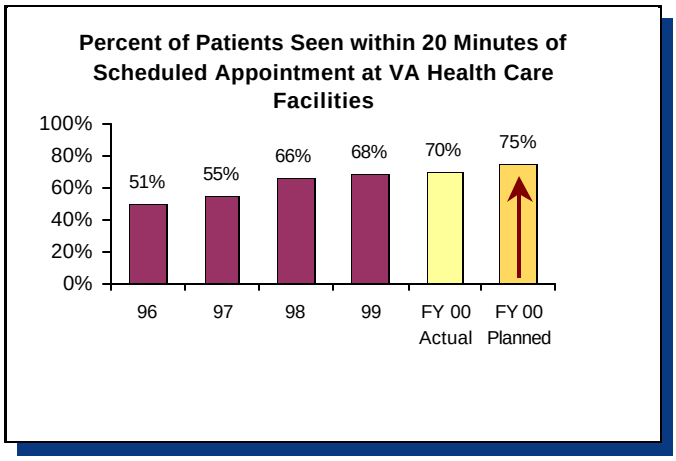
In FY 2000, data on the first two components of VA's 30-30-20 strategy were not collected in a format that provided information on the percentage of patients obtaining an appointment in 30 days. Efforts continue to refine the data collection vehicles required to capture the information in the desired format. A revised version of VA's scheduling software is scheduled for release in FY 2001.

While data on the percent of patients able to obtain an appointment within 30 days are not yet available, the Department did collect information on access to care as measured by the average number of days a patient had to wait to obtain a clinic appointment. These results reveal that the average number of days to obtain a primary care appointment was 60 days. While this value is still well above the strategic target level

(90 percent of patients obtaining an appointment within 30 days), it represents considerable progress compared to waiting times in past years. During the last 9 months of FY 2000 alone, the average waiting time to obtain a primary care clinic appointment fell by over 7 percent. Three VISNs had average waiting times for primary care that were below 40 days, with one network recording an average of only 19 days.

The average number of days to obtain an appointment at a specialty clinic was 62 days in FY 2000. The waiting times for individual clinics were:

Audiology	40 days
Cardiology	45 days
Optometry/Ophthalmology	84 days
Orthopedics	40 days
Urology	69 days



Although the Department did not meet its FY 2000 target that 75 percent of patients would be seen within 20 minutes of their scheduled appointment at VA health care facilities, the actual performance level of 70 percent was an improvement over that registered during FY 1999, when the figure was 68 percent. These data are derived from self-reported information collected on VA's *Annual National Ambulatory Care Satisfaction Survey*.

Means and Strategies

The following strategies were implemented during FY 2000 by way of improving access to, and timeliness of, health care:

- Hired additional staff in critical areas to provide more timely access to care and services.
- Adopted the Boston-based Institute for Healthcare Improvement initiatives and other process improvement efforts to make work and work processes more effective, particularly as they relate to waiting times.
- Provided primary care experts from headquarters to consult with staff at facilities having difficulties meeting the access goals.
- Opened additional CBOCs with improved, convenient access for patients.
- Procured short-term contracts with specialists to provide services to veterans who have been waiting for a significant period of time, as well as improve timeliness of, and access to, specialty services.
- Renovated infrastructure in existing facilities to ensure that at least two exam rooms are available for those providing services on any given day.
- Increased the availability of mental health services, including post-traumatic stress disorder and substance abuse, in facility-based clinics and CBOCs.
- Initiated enhancement/replacement of the scheduling package.
- Developed transplant-sharing agreements to increase access and decrease costs.

- Purchased new, and replaced aging, diagnostic and treatment equipment.
- Replaced aging linear accelerators and cardiac catheterization laboratories.
- Provided Outpatient Medication Dispensing Technology in CBOCs and hospital-based clinics.

VA is making a concerted effort to measure clinic appointment waiting times accurately. In early FY 2000, VA implemented software for measuring the average clinic appointment waiting time experienced by patients needing the next available appointment. The software computes the clinic appointment waiting time by calculating the number of days between the date set for the next available appointment and the date the appointment is made. This method of measurement is considered superior to previous methods because it measures the actual experience of patients rather than a perception of what the experience might be.

Data Source and Validation

The source of waiting time data for primary care and specialty care appointments is the Veterans Health Information Systems Technology Architecture scheduling package. The scheduling package calculates the actual waiting time experienced by patients requesting the next available appointment. In FY 2001, enhancements will be made to the scheduling package, including a patch to allow a distinction between new and follow-up appointments, thus simplifying the prompts displayed to the scheduling clerks and making it easier for them to accurately classify an appointment request as the next available.

To improve accuracy of the data, two other measures of waiting times will be calculated in the FY 2001 version of the software. The first of these is the waiting time experienced by patients new to the clinic. New is defined as not seen at the clinic in the prior 24 months. The second measure is the waiting time experienced by follow-up appointments. The waiting time is computed by subtracting the actual appointment date given from the desired date.

Most new patients will request the next available appointment. The software will calculate the waiting times of these new patients, using both the desired date entered by the clerk and the date the request is made.

All electronic measures of waiting time require the use of the scheduling package. To the extent that a site does not use the scheduling package to schedule appointments, the data from this system will not be accurate. The use of paper waiting lists or other software to bypass the scheduling system will produce inaccurate waiting times in the current measurement system. Therefore, we are exploring the possible use of other external measures of clinic appointment waiting times to check the validity of the waiting times.

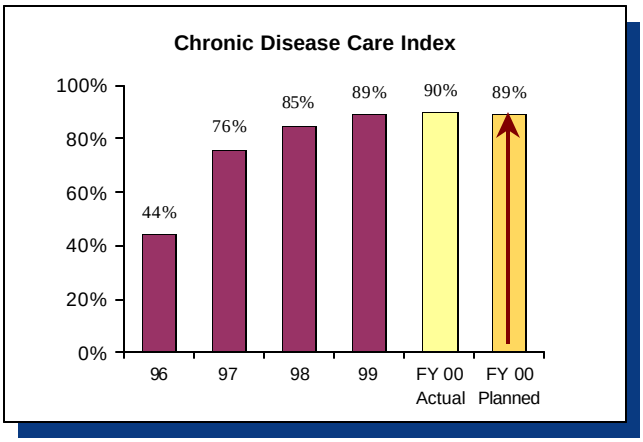
The source of data for the 20-minute waiting time at VA facilities is the *Annual National Ambulatory Care Satisfaction Survey* conducted by the National Performance Data Feedback Center. The numerator is the percentage of outpatients who report they were seen within 20 minutes of their scheduled appointment. The denominator is the universe of patients who respond to the following question: "How long after the time when your appointment was scheduled to begin did you wait to be seen?" A VISN-specific report is produced annually.

Increase the Score on the Chronic Disease Care Index to 89 Percent

(This measure supports our objective to improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.)

Consisting of 13 clinical interventions, the Chronic Disease Care Index (CDCI) measures the degree to which VA follows nationally recognized guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and obesity.

Investment in effective chronic disease management results in improved health of veterans and reduced use of services. Since a large percentage of veterans seek care for one or more chronic diseases, improved management of chronic disease results in reduced inpatient cost, admissions, and lengths of stay.



Data for 1996 through 1998 are based on 3 months of information for each year; data for 1999 and 2000 cover an 11-month period.

The CDCI has more than doubled since FY 1996, increasing to 90 percent in FY 2000. Where comparable data exist, VA consistently outperformed the private sector. For example, VA's rate of beta-blocker therapy for patients following a heart attack was 96 percent, compared to 71 percent of patients included in 1998-1999 data from the Health Care Financing Administration (HCFA) and 85 percent for the 1999 National Committee for Quality Assurance (NCQA) national average. VA's use of beta-blocker therapy has resulted in nearly 500 lives saved since 1996. In addition, patients who received beta-blockers were re-hospitalized for heart ailments 22 percent less often than those who did not get beta-blockers.

Major studies have shown that much of the disability from diabetes—amputations, blindness, renal failure, lower functional status, and death–can be prevented if detected early and managed effectively. In FY 2000, VA achievements in comprehensive diabetes care include:

	VA	NCQA
Annual hemoglobin A1c blood test	94%	75%
Retinal eye exams	67%	45%
Lipid level testing	89%	69%
Lipid level control	76%	37%
Screening for kidney disease	54%	36%

VA's 98 percent rate of aspirin administration following a heart attack continued to exceed private sector performance of 84 percent recorded in HCFA's Medicare fee-for-service program in FY 2000.

Based on VA's success in meeting performance targets for the CDCI, this measure will be

redefined in FY 2001. The measure will now be called the Chronic Disease Care Index II. The modified index will include 20 guidelines to be monitored instead of 13.

Means and Strategies

In FY 2000, VA headquarters continued to promulgate the implementation of managed care strategies. All 22 networks emphasized a number of specific strategies:

- Many VISNs and facilities emphasized patient education and the development of additional patient education programs.
- Networks documented interventions and outcomes to help reinforce quality patient care.
- The expanded use of clinical guidelines ensured that standards of care provided anywhere in the network, or even nationally, are comparable and of the highest quality.
- Staff clinical education programs proved valuable, and networks reported they intend to offer them in the future. Staff education is improved through monthly performance monitoring by peer oversight, such as the Performance Oversight Group, which uses a predetermined checklist.

Networks did not report any serious barriers to achieving the expected performance target during FY 2000. As the number of veterans with chronic medical conditions grows, the implementation of clinical guidelines will require greater attention.

VA continues to measure care provided to patients with chronic disease and will look for strategies to continuously improve the systems supporting the provision of care. In the future, implementation of the automated medical records system, along with a system of clinical prompts and reminders, will facilitate care delivery at the point of patient contact to further ensure that veterans are receiving the appropriate interventions. The new clinical practice guidelines are part of the network directors' performance agreements for FY 2001 and additional increases in system-wide performance are anticipated.

Started in FY 1999 and scheduled for completion in FY 2001, VA's comprehensive evaluation of cardiac care programs will address the full range of treatment, from prevention through acute and long-term care. Also, it will focus on bypass and transplant procedures, as well as on ischemic heart disease.

Crosscutting Activities

In conjunction with the Agency for Health Care Policy and Research, VA developed and implemented clinical practice guidelines. Clinical practice guidelines are recommendations for the performance or exclusion of specific procedures or services derived through rigorous methodological approaches.

Data Source and Validation

VA's External Peer Review Program (EPRP) is the source of data for the CDCI. EPRP is a contracted review of care, specifically designed to collect data for improving the quality of care delivered throughout the system. It serves as a functional component of the facility, VISN, and headquarters quality management program by:

- Providing real-time information for use in VA's continuous quality improvement program;
- Identifying opportunities for improvement in care;
- Establishing a database for analyzing and comparing patterns of care at all levels.

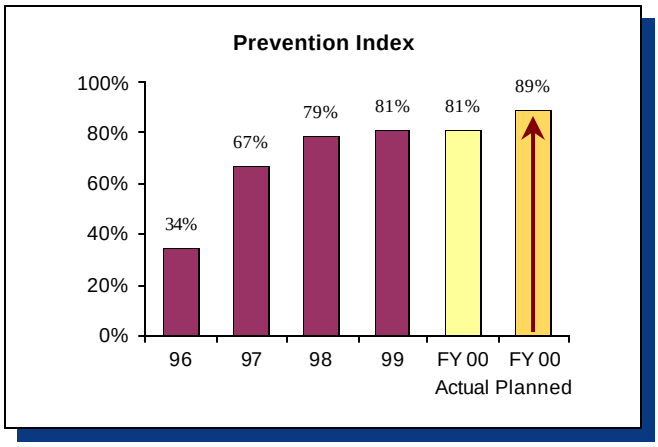
Data are abstracted monthly. The West Virginia Medical Institute conducts measurements of performance through medical record abstraction. They statistically evaluate the data to ensure validity and reliability. For each abstractor involved in the review process, the West Virginia Medical Institute uses inter-rater reliability assessments to further ensure validity and reliability of the data. A sub-contractor generates data files and performance reports for each quarter of the fiscal year and transmits this information electronically to VA.

Increase the Score on the Prevention Index to 89 Percent

(This measure supports our objective to improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.)

The majority of diseases that cause disability or death among Americans could be prevented or delayed through screening, education, and counseling aimed at risk-factor identification and behavior modification. Through its education programs and screening tests, VA urges veterans to become aware of ways to promote good health and encourages each person to assume individual responsibility to achieve this objective. The goals of preventive medicine are to maintain health and achieve early detection of disease, thereby easing the burdens associated with cost, suffering, and resource availability in chronic disease management.

VA has designed several specific quality of care indices that allow a comparison of VA and private sector health care outcomes. One of these is the Prevention Index (PI). The PI charts the outcomes of eight medical interventions to measure how well VA follows national primary-prevention and early-detection recommendations for eight diseases or health factors that significantly determine health outcomes: pneumococcal pneumonia, influenza, tobacco consumption, alcohol consumption, and screenings for colorectal cancer, breast cancer, cervical cancer, and prostate cancer. VA provides primary, secondary, and tertiary preventive interventions that are important for a population of healthy veterans, as well as severely ill and disabled veterans. Data contained in the PI are estimates of the average percentages of patients receiving appropriate medical intervention for these diseases, whether in the form of immunization, screening, or counseling. These measures were initially reported only for primary care clinics. Over time, both the implementation and reporting of such measures have been expanded to include related specialty clinics.



Data for 1996 through 1998 are based on 3 months of information for each year; data for 1999 and 2000 cover an 11-month period.

Although VA did not meet the performance target of 89 percent, the PI has more than doubled in recent years, growing from 34 percent in FY 1996 to 81 percent in FY 2000. Improvements during the last 2 years have been limited, due in part to reaching what we consider to be a maximum level of performance on some indicators. For example, the screening rate for substance abuse was 96 percent. Significant improvement above this already high level is unlikely. Furthermore, medical standards and guidelines have become stricter for certain conditions. Medical evidence continues to evolve in the area of colorectal screening, and the previously accepted digital rectal exam and single stool sample are no longer considered viable screening interventions. National authorities on flexible sigmoidoscopy and colonoscopy now place increased emphasis on the use of these diagnostic techniques.

Where comparable data exist, VA outperformed the private sector for all indicators in health promotion and disease prevention. This pertains to NCQA national averages, performance goals presented in *Healthy People 2000* (Department of Health and Human Services), and HCFA data.

	VA	NCQA	HCFA	*Healthy People 2000* (Goals)
Colorectal cancer screening	68%	------	------	50%
Breast cancer screening	90%	73%	56%	60%
Cervical cancer screening	93%	72%	------	85%
Immunization for pneumonia	81%	------	46%	60%
Immunization for influenza	78%	------	66%	60%

For patients with hypertension, counseling about lifestyle issues of weight and exercise reached 95 percent and 93 percent, respectively. Aggressive treatment of high blood pressure reduces mortality from heart disease, stroke, and renal failure. Data for FY 2000 show that 46 percent of VA patients who previously had higher than normal blood pressure now have the condition adequately controlled. Although this rate shows room for improvement, it compares favorably with the performance of private sector Health Maintenance Organizations (HMOs) or managed health care organizations. The 1999 NCQA national average performance was 39 percent.

In FY 2001, the PI will be enhanced through the addition of hyperlipidemia (cholesterol or low-density lipoproteins) screenings. This "new" PI will be referred to as "Prevention Index II."

Means and Strategies

Using the PI, VA evaluates progress toward improving systems that support preventive care delivery. For example, the automated medical record system and a system of clinical prompts and reminders facilitate care delivery at the point of patient contact to ensure that veterans receive appropriate interventions. To implement prevention services effectively, VISNs employed a variety of strategies in FY 2000:

- Continued implementing new clinical guidelines and refining existing guidelines;
- Used patient and staff education programs to stress the importance and benefits of prevention;
- Monitored local performance monthly using checklists to ensure that preventive activities for patients were accomplished as scheduled;
- Charged primary care teams with responsibility and accountability for local PI measures.

To emphasize the importance of continuous improvement in quality of care as measured by the PI, the Under Secretary for Health once again

included this performance measure in the 22 network directors' individual performance plans.

Data Source and Validation

VA's External Peer Review Program (EPRP) is the source of data for the PI. EPRP is a contracted review of care, specifically designed to collect data for improving the quality of care delivered throughout the system. It serves as a functional component of the facility, VISN, and headquarters quality management program by:

- Providing real-time information for use in VA's continuous quality improvement program;
- Identifying opportunities for improvement in care;
- Establishing a database for the analysis and comparison of patterns of care at all levels.

Data are abstracted monthly. The West Virginia Medical Institute conducts measurements of performance through medical record abstraction. They statistically evaluate the data to ensure validity and reliability. For each abstractor involved in the review process, the West Virginia Medical Institute uses inter-rater reliability assessments to further ensure validity and reliability of the data. A sub-contractor generates data files and performance reports for each quarter of the fiscal year and transmits this information electronically to VA.

The OIG's Office of Audit conducted an initial evaluation of the accuracy of the CDCI and PI data. Focusing primarily on the data accumulation process for both performance measures from data input to output, the evaluation assessed the appropriateness of the sampling methodology employed by VA to determine the patient sample used in computing the two performance measures. Also, the OIG evaluated the system controls at each point in the data flow.

The principal findings of this audit were:

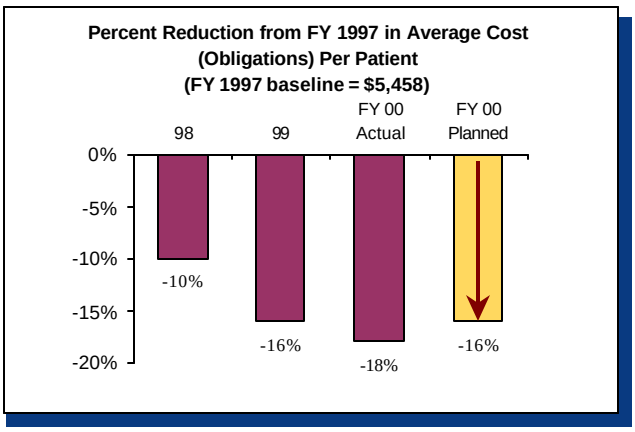
- Procedures used by VA to compute the CDCI and PI indices were adequate;
- The sampling methodology was appropriate;
- Reliability controls, edit checks, and other controls were adequate and functioned properly;
- Security controls over data maintained in computers need to be strengthened;
- Disclosure should be made concerning the fact that prior to FY 2000, the CDCI and PI data were based on less than 12 months of information.

VA has taken appropriate action to address the two areas needing improvement. The OIG's Office of Audit plans to conduct a follow-up audit of VA's quality of care indices, focusing in particular on the validity of the data.

Maintain the 16 Percent Reduction in Average Cost (Obligations) Per Patient (FY 1997 baseline = $5,458)

(This measure supports our objective to improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.)

At the beginning of FY 1998, VA developed an objective and associated strategies to increase the efficiency of the health care system. Three long-term performance goals were established to gauge progress toward meeting this objective: (1) reduce the average cost per patient by 30 percent from the FY 1997 baseline of $5,458; (2) increase the number of unique users of the health care system by 20 percent over the FY 1997 baseline of 3,142,000; (3) increase the share of the medical care operating budget derived from alternative revenue streams to 10 percent, with the FY 1997 value amounting to 0.4 percent. These performance measures will no longer be tracked as key measures in future Departmental plans and reports.



By reducing the average cost (obligations) per patient to $4,470 in FY 2000, VA exceeded its FY 2000 performance target. To eliminate the impact of inflation, the reduction in average cost per patient, or unique social security number, is measured in constant dollars. This better-than-expected performance resulted from the application of a complex set of improvement strategies.

Means and Strategies

The primary strategy used to reduce the cost per patient in FY 2000 was to continue the reengineering of the health care delivery system, by shifting health care resources and patient treatment modalities from inpatient care to outpatient care. This shift impacts physical plants, clinical staff needs, and almost all aspects of the health care delivery system. Hospital utilization was minimized whenever therapeutically possible; inpatient services were converted to outpatient services and extended into the community.

Consolidation and integration eliminated redundancy, improved economies of scale, and brought service levels and workload up to minimum levels to assure clinical quality and cost effectiveness. The restructuring effort continues to address consolidation, integration, right sizing of facilities, and realignment of services and programs within facilities.

The 22 VISNs reported that the following strategies were often employed successfully to reduce the average cost per patient:

- VISNs reduced excess beds and inpatient days of care, and further succeeded in shifting inpatient care to various ambulatory locations. Patients transferred to residential care included long-term psychiatric patients. Resource savings from inpatient care were used to expand outpatient treatment programs.

- Consolidation of duplicative services helped networks expand and improve the quality of care for veterans, while reducing unit costs. Also, VISNs reduced per-patient costs by contracting for certain services that VA facilities chose not to provide in-house. Numerous networks were able to enter into blanket purchase agreements for medical services that were previously bought on a fee-for-service basis.
- In general, networks continued to refine the use of managed care techniques, use drug formularies, employ clinical pharmacists and other physician extenders, and market and share excess VA services such as laboratory tests. In short, VA has become more skillful in managing care that provides value and satisfaction to patients.

Crosscutting Activities

VA collaborated with the Health Care Financing Administration to develop VA benchmarks for bed days of care. We obtained data on ambulatory procedures from the National Center for Health Statistics. We also collaborated with DoD on enhancing VA's Parametric Automated Cost Engineering System in order to partner on real property assets, and to acquire and co-locate VA facilities with excess property available through the closure of military bases. Additionally, VA participated in joint design and construction projects with the Department of Agriculture, Indian Health Service, Public Health Service, National Park Service, and Merchant Marine Academy.

VA provided laundry services to State Veterans Homes and Job Corps programs. The Department collaborated with the General Services Administration in a Government-wide Real Property Information Sharing program on use of Government-owned and Government-controlled real property in the Northeastern United States, and in the acquisition of lease-hold interests in real property for clinical and administrative purposes in various regions across the country. VA partnered with a private sector panel to identify enhanced-use lease initiatives at various VA medical centers for the purpose of lowering utility and energy services, thus making more resources available for direct patient care.

Major Management Challenges

A March 1999 GAO report concluded that VHA could significantly reduce the funds used to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets. In response to the GAO report and a subsequent Congressional hearing on July 22, 1999, VHA initiated development of the Capital Asset Realignment for Enhanced Services (CARES) program—a strategic planning process to improve health care access and quality by realigning capital assets.

The CARES process involves the objective assessment of future veterans' health care needs within each network; the identification of service delivery options to meet those needs; and the strategic realignment of capital assets and related resources to better meet veterans' health care requirements. Through CARES, networks will develop plans for enhanced services based on objective criteria and analysis, cost effectiveness, and potential capital asset restructuring. These plans will take into account future directions in health care delivery, demographic projections, physical plant capacity, community health care capacity, and workforce requirements. Using a structured decision methodology, VHA will evaluate and rank network capital asset realignment proposals. All savings generated through implementing CARES will be used to provide quality health care to veterans. A CARES pilot study, involving VISN 12 in the Chicago area, is scheduled to be completed in May 2001.

Data Source and Validation

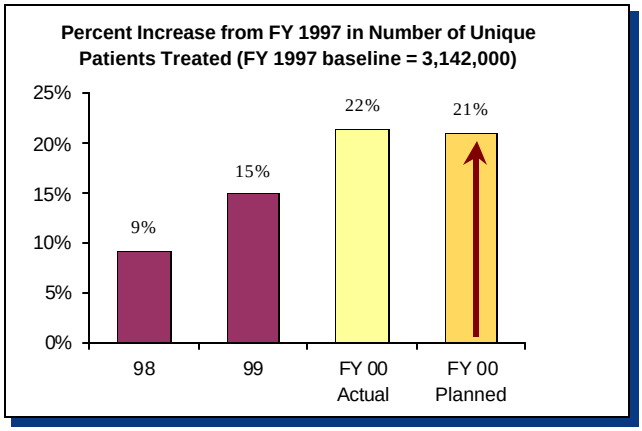
Data for calculating the cost of per-patient care are derived from the National Patient Care database and the various network plans. These databases contain the relevant workload, unique social security numbers, and dollars spent on providing health care for VA patients.

Audit programs, as mandated in the Chief Financial Officers Act and the Federal Financial Managers' Integrity Act, help to ensure the validity and reliability of these figures.

Increase the Number of Unique Patients Treated in the Health Care System by 21 Percent (FY 1997 baseline = 3,142,000)

(This measure supports our objective to improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.)

VA treated 3,817,300 unique patients in FY 2000, exceeding the performance target of 3,794,900. Between FY 1997 and FY 2000, the 21.5 percent increase in the number of unique patients treated is the result of continuing demand for care and more skillful management of VA resources.



The eligibility reform and enrollment provisions of Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, represent the most important factors in creating the necessary conditions for veterans to have improved access to VA medical care.

The Department plays a critical role in providing health care to patients throughout the country. VA operates the largest health care system in the United States, and has a long tradition of sharing agreements, partnerships, and other alliances. For example, VA has hundreds of sharing arrangements with DoD medical facilities, and more than 100 VA medical centers are affiliated with medical schools. Also, VA has sharing arrangements with local and state government health agencies, the Indian Health Service, and private providers.

VA's mission to provide contingency support to DoD and the Public Health Service during times of disaster or national emergency has a national benefit. In fact, VA is one of the Federal Government's assets for responding with medical assistance for large-scale natural disasters.

VA's health care system provides care to millions of patients who have no other viable health care option. More than 40 percent of the patients treated in VA's health care system are veterans with low incomes. Without the availability of VA health

care, many of these veterans would have to rely on Medicaid. In addition, VA provides medical services and other support for homeless veterans. VA is the largest direct care provider for homeless persons in the country, a critically important element in the Nation's public safety net.

Means and Strategies

During FY 2000, VA's primary strategy to increase the number of unique patients, has been a gradual transfer of patient care and corresponding resources to ambulatory care programs. The following specific means were used to implement the primary strategy:

- Implementing primary care policies in all VISNs. The fundamental principle of primary care is to identify and intervene in disease processes and medical problems as early as possible. Early detection often allows for curative care or care that prevents or delays acute and chronic problems. A healthier patient requires fewer resources, thus freeing resources to provide care to more people.
- Increasing the number and types of access points for medical care services, especially community-based outpatient clinics (CBOCs). During FY 2000, 79 CBOC proposals were endorsed and approved by Congress. The Health Services Research and Development office completed a three-year evaluation of CBOCs and concluded they are generally meeting the goals and objectives for which they were established.
- Expanding panel sizes of primary care teams (adding clinical specialists in mental health and other medical specialties, as appropriate) to improve access to a greater variety of services, even in community-based settings.
- Integrating telemedicine technologies into ambulatory care delivery systems.
- Increasing outreach through mobile vans and participation in health fairs and other community events.
- Strengthening liaison with Vet Centers, shelters, veterans service organizations, and other stakeholders.
- Initiating telephone or mail contact with veterans who have used VA care, but not within the past 12 months.

Crosscutting Activities

VA and DoD have numerous sharing agreements that provide veterans with increased access to quality medical care closer to where they live. Many of these collaborative agreements include important patient groups, such as veterans with spinal cord injury, acute traumatic brain injury, and Gulf War illnesses, as well as those in need of prosthetic services.

Major Management Challenges

OIG audits show resource allocation (i.e., VHA funding patterns) continues to be a major public policy issue. VHA management addressed staffing and other resource allocation disparities as part of various initiatives to restructure the VA health care system. Some of the most significant initiatives include the Veterans Equitable Resource Allocation (VERA) model, improved management information and performance measurement, and staffing reductions and adjustments.

In response to this challenge, VHA has taken the following actions:

- Continued to monitor complex care workload relating to VERA funding allocations on a quarterly basis. Complex care patients are those who generally require the services of VA's special emphasis programs, and receive significant high-cost inpatient care.

- Established a basic non-vested patient class (i.e., those who use some VA health care services, but are less reliant on the VA system than fully vested patients who rely on VA for their care). This new patient class replaces the basic single outpatient class.

- Completed an analysis of the three-year, basic non-vested workload as a percent of the total basic workload for FY 1997-1999. VHA will continue to monitor basic and basic non-vested workloads on an annual basis.

- Issued a directive establishing that the allocation of resources at all levels within the Administration be guided by principles that move the organization toward accomplishing its system-wide goals and objectives.

During FY 2000, VHA essentially completed work on a directive that defined the extent to which medical centers were to standardize the basic structure of their Decision Support System (DSS). This standardization will allow DSS to achieve its full potential as VHA's first automated, cost accounting and clinical information tool used to assess and manage the delivery of medical care across facilities. It will provide VHA managers with comparable expense and clinical information to use in determining clinical decisions, managing workload, and controlling medical care costs. (The directive was signed in early FY 2001 (October 5, 2000); OIG recommendations for amending it are under consideration.)

GAO reviews recommended that VA improve the accuracy, reliability, and consistency of information used to measure the extent to which: (1) veterans are receiving equitable access to care across the country; (2) all veterans enrolled in VA's health care system are receiving the care they need; (3) VA is maintaining its capacity to care for special populations.

VA has taken several actions to address these recommendations:

- Continued to place emphasis on planning and opening new CBOCs within the network strategic planning framework;

- Issued an annual geographic access report based on distance to VA facilities;

- Held data summits that specifically addressed the development of uniform definitions;

- Improved enrollment procedures for gathering and updating information on employment, insurance, and service-connected disabilities;

- Implemented procedures to make the principle of funding allocations consistent with eligibility requirements and priorities;

- Established a workgroup to evaluate allocation principles and processes to ensure that network allocations to facilities are fair and equitable.

For more information, refer to pages 100-101.

Data Source and Validation

The source of these data is the VERA database at the Boston Allocation Resources Center (ARC). A comprehensive report detailing the number of unique patients is produced annually and is available at the national level and for each VISN. At the end of each fiscal year, the ARC evaluates all data sources and checks for validity and reliability.

There are many automated procedures throughout VHA data collection systems to make sure that the social security number of each patient is accurately recorded and that it is entered into the local and national patient count only once during a fiscal year. Due in part to OIG recommendations stemming from an independent evaluation of the

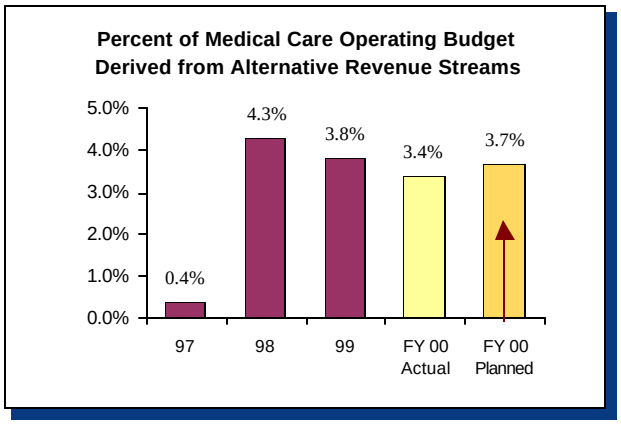
data systems, VHA implemented edit checks in automated data processing systems to correct input errors and improve the quality of data used to report the number of unique patients. In addition, a major enhancement to the Veterans Health Information Systems and Technology Architecture is a primary VHA initiative to eliminate input errors identified in the OIG audit.

Since patient information is contained in over 140 databases in medical centers nationwide, VHA developed the Master Patient Index (MPI), a component of the Clinical Information Resources Network (CIRN). The MPI maintains a central index to track each patient individually across these multiple databases. The CIRN/Patient Demographics (CIRN/PD) module provides the necessary tool to match potential patient duplicates, and requires each facility to correct errors before processing can be completed. The MPI/CIRN/PD system allows access to patient information across the 22 VISNs, while providing the clinical component of the information systems supporting managed care.

Alternative Revenues Will Total 3.7 Percent of the Medical Care Operating Budget

(This measure supports our objective to improve the overall health of enrolled veterans, including special populations of veterans, through a health care system characterized by convenient access, high quality, satisfied patients, and cost efficiency.)

One of VA's long-term performance goals was to increase the share of the medical care operating budget derived from alternative streams to 10 percent by FY 2002. This was predicated on receipt of Medicare monies as a major source of non-appropriated funds. However, Congress has not yet approved a Medicare subvention pilot that would allow VA to bill Medicare for the cost of providing health care to certain Medicare-eligible veterans. As a result, this long-term goal is not achievable, and this measure will no longer be included in future plans and reports.



Means and Strategies

VA actively pursued various revenue strategies, including improvements in medical cost recoveries. In FY 2000, receipts in VA's Medical Care Collection Fund totaled $573 million, and revenues from sharing agreements and other direct reimbursements to the medical care account totaled $109 million.

In FY 2000, networks continued to use local strategies for increasing alternative revenue streams. For example:

- A number of networks continued to use Network Alternative/Revenue Team/ Coordinator positions. This strategy ensures

that collection objectives are regularly monitored and persistent problems receive timely management attention.

- A number of the networks designed locally possible collection strategies: they acquired billing software, increased insurance policies, conducted pre-registration, entered into agreement with other networks for telephone triage services, hired a collection agency to follow-up on bills greater than 90 days past due on a network-wide basis, and designated a site-specific insurance expert to clean up insurance files.
- Selling excess capacity is still a popular strategy to supplement appropriated funds. Several networks participated in joint ventures or entered into enhanced-use contracts.
- Implementation of reasonable charges, accomplished in September 1999, allowed for private practice recoveries for actual services provided.
- We continued to better inform veterans, employees, and veterans service organizations about third-party billing, and developed training for physicians and coders.

Data Source and Validation

The source of data is the General Ledger maintained by VHA's Office of Financial Management and the Automated Allotment Control System. The measure for this goal is calculated from revenue figures recorded in each VISN's general ledger compared against VISN current year availability without unobligated balances from the prior year.

Audit programs, as mandated in the Chief Financial Officers Act and the Federal Financial Managers' Integrity Act, help to ensure the validity and reliability of these figures.

Pension Program Outcomes

(This measure supports our objective to provide a level of income that brings eligible veterans and their survivors up to a standard of living that assures dignity in their lives.)

VA is in the process of developing pension program outcomes and performance measures for the veterans and survivors pension program. As a result, there were no performance targets for FY 2000.

Means and Strategies

In September 2000, staff from the C&P Service consulted with VA field employees about the purpose and outcomes of the pension program. Following these discussions, a team of representatives from throughout the Department was formed in October 2000 to address these issues. The team's discussions formed the basis for consultation sessions with our stakeholders.

The first meeting between program experts and stakeholders took place in December 2000. The second meeting occurred in January 2001. As a result of these meetings, the following statements have been drafted for final presentation to the stakeholders:

VA Pension Program Purpose

Our wartime veterans served us during times of national need. In civilian life, some of these veterans—because of severe disability unrelated to their military service—find themselves in financial need. Similarly, survivors of veterans may face financial hardships.

The purpose of the pension program is to provide a basic income, according to family need, for these disabled veterans and their families and for the surviving family of any wartime veteran, when the family has financial hardship.

A VA pension is intended to afford a reasonable measure of security so these wartime veterans and their families can live their lives in dignity.

VA Pension Program Outcomes

Access

Veterans and their families get the information and help they need to access, understand, and participate in the pension program and related health care options.

Income

VA pension provides entitled wartime veterans and survivors the income they need to afford the basic necessities for themselves and their families.

Security

Pensioners and their families can rely on the financial continuity and stability of VA pension in time of need.

Dignity

VA pensioners are accorded the dignity and respect earned through the veteran's service to our Nation during wartime.

The pension program purpose and outcomes will be presented to the Under Secretary for Benefits for approval by the spring of 2001. Program outcome performance measures will be developed by the end of FY 2001. Data collection is scheduled to begin in FY 2002.

Data Source and Validation

VA does not currently have data to measure how veterans and survivors perceive the pension program or the impact this program has on the quality of their lives. Data validation procedures will be established at the time the data collection vehicles are developed.

Insurance Program Outcomes

(This measure supports our objective to enhance the financial security for veterans' families through life insurance and other benefits programs.)

During FY 2000, insurance program managers led a process with stakeholders from Congress, OMB, and veterans service organizations to determine the most appropriate outcomes for the program. As a result of that process, the program's outcome goal is to provide parity with the average American's ability to purchase adequate amounts of life insurance at competitive rates. To measure our effectiveness, we compare the VA insurance program's policy coverage and premium cost against what the average American purchases in coverage amounts and pays in premiums. This comparison helps determine how VA insurance programs compare with what the average

American can purchase in life insurance, and what improvements are needed to make the VA programs more competitive.

Completion of the Survivors Benefits Study, a program evaluation that is currently underway, may provide us better benchmarks for use in the future. With the important exception of the Service-Disabled Veterans Insurance, VA insurance programs generally compare well with those available to average Americans.

Means and Strategies

There are four VA insurance programs open to new policies for which outcomes have been developed:

1. **Service-Disabled Veterans Insurance (S-DVI) —** Our goal is to provide insurance protection to veterans who have lost their ability to purchase commercial insurance at standard (healthy) rates because of their service-connected disabilities. Participants receive a subsidy equal to the difference between the premiums that they pay—which account for age but not disabilities—and actual costs of the coverage. S-DVI coverage is the maximum amount available for our standard policy. S-DVI coverage is the maximum amount available for our standard policy. S-DVI premium cost is the average premium rate that current S-DVI policyholders are paying.

2. **Servicemembers Group Life Insurance (SGLI) —** Our goal is to provide insurance protection to active duty and reserve members of the uniformed services that are commonly provided by large-scale civilian employers.

3. **Veterans Group Life Insurance (VGLI) —** Our goal is to provide insurance protection to individuals discharged from the uniformed services (some of whom are disabled) that is comparable to what is available in the private sector. VGLI provides a guaranteed conversion of the SGLI coverage the individual carried in the uniform service.

4. **Veterans Mortgage Life Insurance (VMLI) —** Our goal is to provide mortgage insurance protection to severely disabled veterans who have lost their ability to purchase commercial mortgage insurance at standard (healthy) rates because of their service-connected disabilities.

Data Source and Validation

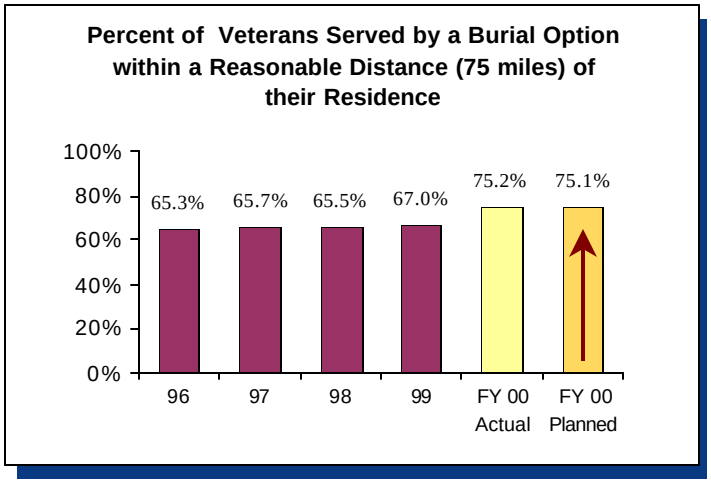
An evaluation of the insurance programs is currently underway. The results of the program evaluation will be used to assess the appropriateness of our interim outcomes, and as a source of additional information about the impact of the programs on veterans and their families. This evaluation of the insurance programs, which also studies the DIC program and the way insurance and DIC benefits assist the survivors of disabled veterans, will be completed during FY 2001.

Increase the Number of Veterans Served by a Burial Option within a Reasonable Distance (75 Miles) of their Residence to 75.1 Percent

(This measure supports our objective to ensure the burial needs of veteran and eligible family members are met.)

VA provides interment of veterans and eligible family members upon demand. From FY 1996 to FY 2000, annual interments increased 15 percent, from 71,786 to 82,717. With the aging of World War II and Korean Conflict-era veterans, veteran deaths are increasing each year. Based on the 1990 census, the annual number of veteran deaths should peak at 687,000 in the year 2006 before beginning a gradual decline. This progressive increase in veteran deaths results in a corresponding increase in the number of interments in national cemeteries.

According to National Cemetery Administration (NCA) data from recent years, about 80 percent of persons interred in national cemeteries resided within 75 miles of the cemetery at time of death. As the annual number of interments and total gravesites used increases, cemeteries deplete their inventory of space and are no longer able to accept full-casketed or cremated remains of first family members. As a result, veterans may lose access to some of VA's burial options.



At the end of FY 2000, of the 119 existing national cemeteries, only 61 contained available, unassigned gravesites for the burial of both casketed and cremated remains; 31 accepted only cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member; and 27 only performed interments of family members in the same gravesite as a previously deceased family member.

Means and Strategies

To meet the burial needs of veterans and the FY 2000 performance target, VA opened three new national cemeteries; expanded four existing national cemeteries; acquired additional land to continue burial options at four national cemeteries; and developed more effective use of available burial space.

Three new national cemeteries—Abraham Lincoln National Cemetery in Illinois, Dallas-Fort Worth National Cemetery in Texas, and Ohio Western Reserve National Cemetery near Cleveland—opened in FY 2000. These cemeteries provide a burial option to approximately two million veterans who were not previously served. In FY 2000, VA continued to make progress in developing new national cemeteries in the areas of Atlanta, Georgia; Detroit, Michigan; Fort Sill, Oklahoma; Miami, Florida; Pittsburgh, Pennsylvania; and Sacramento, California. These locations were identified in a May 2000 report to Congress as the six areas most in need of a new national cemetery, based on previous demographic studies.

The Veterans Millennium Health Care and Benefits Act directs VA to contract for an independent demographic study to identify those areas of the country where veterans will not have reasonable access to a burial option in a national or state veterans cemetery, and the number of additional cemeteries required to meet veterans' burial needs through 2020. This study is underway and the contractor's report is due in the fall of 2001.

VA monitors gravesite usage and projects gravesite depletion dates at open national cemeteries that have land for future development. As those cemeteries approach their gravesite depletion dates, VA ensures that construction to make additional gravesites or columbaria available for burials is completed. In FY 2000, VA completed projects at Fayetteville, Florence, Florida, and Salisbury National Cemeteries.

Appropriate land acquisition is a key component to providing continued accessibility to burial options. In FY 2000, VA acquired an additional 209 acres to continue burial operations at Beaufort, Calverton, Dayton, and Salisbury National Cemeteries. VA will continue to identify national cemeteries nearing depletion of grave space, and will determine the feasibility of extending the service life of those cemeteries, by acquiring adjacent or contiguous land or by constructing columbaria. These actions, which depend on such factors as the availability of suitable land and the cost of construction, are not possible in every case. Efforts to acquire additional land are currently underway at nine national cemeteries.

In FY 2000, NCA continued a pilot project in which closed national cemeteries, in areas not served by an open national or state veterans cemetery, are used to provide committal services for eligible individuals, with subsequent interment in a more distant national cemetery. This allows families the comfort of having the committal service for loved ones performed at a national shrine, while avoiding travel to a distant cemetery. There has been limited interest in this option; however, veterans, their families, and funeral directors recognize its value as an alternative burial option.

Crosscutting Activities

To complement our system of national cemeteries, VA administers the State Cemetery Grants Program (SCGP), which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving veterans' cemeteries that are owned and operated by the states. In FY 2000, 4 new state veterans cemeteries opened; over 14,000 interments were performed; and funds were obligated to establish, expand, or improve 12 cemeteries in 10 states. To date, 42 operating state veterans cemeteries have been established, expanded, or improved through the SCGP.

Data Source and Validation

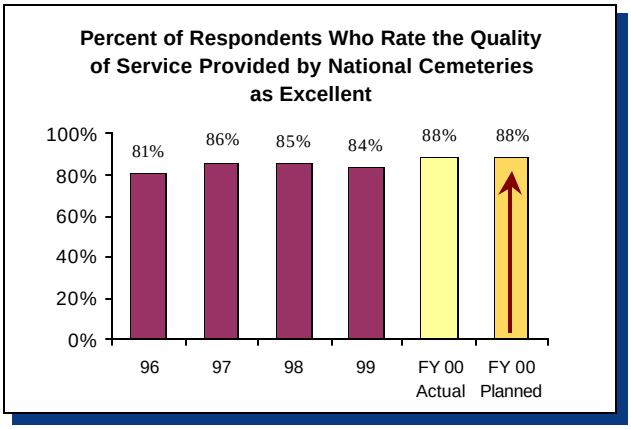
The percent of veterans served by a burial option within a reasonable distance of their residence was determined by analyzing census data, the number of new national or state veterans cemeteries opened, and changes in the service delivery status of existing cemeteries. Multiple counts of the same veteran population are avoided in cases of service-area overlap.

Results of an OIG audit completed in 1999 showed NCA personnel generally made sound decisions and accurate calculations in determining the percent of the veteran population served by the existence of a burial option within a reasonable distance of their residence. Although some inconsistencies in NCA's estimate of the percent of the veteran population served by a burial option were identified, they did not have a material impact, and no formal recommendations were made. VA has addressed these inconsistencies, and the adjustments are included in the data contained in this report.

Increase the Number of Respondents Who Rate the Quality of Service Provided by National Cemeteries as Excellent to 88 Percent

(This measure supports our objective to ensure the burial needs of veterans and eligible family members are met.)

VA's goal is to make sure that the Nation's veterans and their families are satisfied with the quality of service provided by national cemeteries. The Department strives to provide high quality, courteous, and responsive service in all of its contacts with veterans and their families. In one of many letters of appreciation VA received in FY 2000, a family member wrote, "My concerns were handled with compassion and a sense of importance." Another letter noted the "caring and professional way" in which the cemetery staff dealt with the family.



Satisfaction with the quality of service provided by national cemeteries remained at a very high level. Cemetery service goals are set in keeping with the high expectations of the families of individuals who are interred and of other visitors.

Means and Strategies

In order to improve service to veterans and their families, VA provides weekend scheduling of the interment in a national cemetery for a specific time in the ensuing week. In FY 2000, VA provided weekend scheduling for over 5,600 interments.

Kiosk information centers assist cemetery visitors in finding the exact gravesite location of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about the National Cemetery Administration. By the end of FY 2000, VA had installed 24 kiosks at national cemeteries.

Veterans and their families have indicated that they need to know the interment schedule as soon as possible in order to finalize necessary arrangements. The amount of time it takes to mark the grave after an interment is also extremely important to the veteran's family members. To meet these expectations, VA strives to schedule committal services at national cemeteries within 2 hours of the request, and to mark graves at national cemeteries within 60 days of the interment. Data collection instruments, using modern information technology, were developed to measure the timeliness of interment scheduling and marking graves at national cemeteries. NCA established a quality improvement team to assess data collection procedures and make recommendations to make sure the data collected for these two measures are accurate, valid, and verifiable. As a result of weaknesses identified in the test data collection instrument, the team had to develop new parameters for data collection. The quality improvement team will continue to collect, review, and analyze these data in FY 2001.

During FY 2000, Corporal Jesse T. Barrick, awarded the Congressional Medal of Honor for his actions May-June 1863, was disinterred from

Cityview Cemetery in Pasco, Washington, and interred at Tahoma National Cemetery near Seattle. Cemetery staff organized a military funeral honors service. The Veterans of Foreign Wars provided the chaplain, and the U.S. Army provided pallbearers and presented the flag.

A special interment service for unknown soldiers from Wilson's Creek Battlefield, the first major Civil War engagement west of the Mississippi River, was held at Springfield National Cemetery in Missouri.

To ascertain how our customers and stakeholders perceive the quality of service provided by national cemeteries, VA annually seeks feedback from them through visitor comment cards and focus groups. This information is used to determine expectations for service delivery as well as specific improvement opportunities and training needs. VA is developing a nationwide mail-out survey to better measure the public's perception of the quality of NCA services. The information gathered will be used in the NCA strategic planning process to develop additional strategies for improving service. VA will continue to conduct focus groups to collect data on stakeholder expectations and their level of satisfaction with the quality of service provided by national cemeteries.

Crosscutting Activities

VA continued to work closely with components of DoD and veterans service organizations to provide military funeral honors at national cemeteries. While VA does not provide military funeral honors, national cemeteries facilitate the provision of funeral honors ceremonies and lend logistical support to funeral honors teams. Veterans and their families have indicated the provision of military funeral honors for the deceased veteran is important to them.

VA continued to work with funeral homes and veterans service organizations to find new ways to increase awareness of benefits and services. Funeral directors and members of veterans service organizations participated in focus groups to identify not only what information they need, but also the best way to make sure they receive it.

Data Source and Validation

The source of data to measure the quality of service provided by national cemeteries is the NCA Visitor Comment Card. Data are collected annually for a period of 90 days. The measure for quality of service is the percentage of respondents who rate the quality of interaction with cemetery staff as "excellent."

VA headquarters staff oversees the data collection process and provides an annual report at the national level. Memorial Service Network (MSN) and cemetery level reports are provided for NCA management use.