

Department of Veterans Affairs

FY 1997 Performance Measures and Results Presentation

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VA MEASURING UP.. *Results*

The Department of Veterans Affairs (VA) directly touches the lives of millions of veterans every day through its health care, benefits, and burial programs. VA's complex mission is accomplished through partnerships between and among the Veterans Health Administration, the Veterans Benefits Administration, the National Cemetery System, the Board of Veterans' Appeals, and the Departmental staff organizations by integrating the related activities and functions of the following lines of business, or programs:

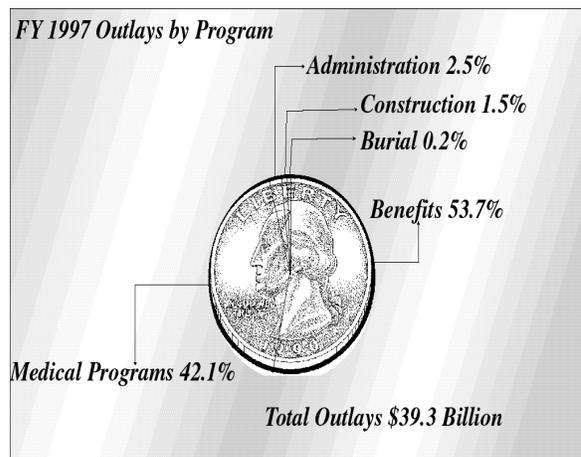
Mission

"To administer the laws providing benefits and other services to veterans and their dependents and the beneficiaries of veterans (38 U.S.C. (301(b),1997)."

To serve America's veterans and their families with dignity and compassion and be their principal advocate in ensuring that they receive medical care, benefits, social support, and lasting memorials promoting the health, welfare and dignity of all veterans in recognition of their service to this Nation.

- Medical Care
- Medical Education
- Medical Research
- Compensation
- Pension
- Vocational Rehabilitation and Counseling
- Education
- Loan Guaranty
- Insurance
- Burial

The Veterans Health Administration (VHA) operates three of the Department's lines of business. VHA ensures that the **Medical Care** needs of America's veterans are served by providing primary care, specialized care, and related medical and social support services. VA's 172 hospitals, 131 nursing homes, 439 ambulatory clinics, 40 domiciliaries, 206 readjustment counseling centers, 75 home health programs, and various contract treatment programs, have been organized into 22 Veterans Integrated Service Networks (VISNs or Networks). The VISNs are now the system's basic operating unit. In addition to providing medical care, VHA is the Nation's largest trainer of health care professionals. VA's **Medical Education** and training programs help to assure an adequate supply of clinical care providers for veterans and the Nation. The **Medical Research** program contributes to the Nation's knowledge about disease and disability. This integration of the health care system enables VA to maximize the health of our veteran patients, to strive



In FY 1997, VA spent \$39.3 billion on these programs. Nearly 96 percent of this sum went directly to veterans in the form of monthly payments of benefits or for direct services, such as medical care.

for health care value, excellence in service, education and research, and to be recognized as an organization characterized by exceptional accountability to veterans, their advocates, and the American taxpayer.

Benefits or Services	
<i>Medical Care</i>	
<i>Unique Patients</i>	3,142,000
<i>Compensation</i>	
<i>Veterans</i>	2,256,700
<i>Survivors/children</i>	305,200
<i>Pension</i>	
<i>Veterans</i>	409,300
<i>Survivors</i>	319,200
<i>Education</i>	
<i>Veterans and Servicepersons</i>	299,400
<i>Reservists</i>	77,400
<i>Survivors/dependents</i>	42,400
<i>Vocational Rehabilitation</i>	
<i>Veterans receiving services</i>	55,600
<i>Loan Guaranty</i>	
<i>Loans Guaranteed</i>	238,800
<i>Insurance</i>	
<i>Administered policies in force</i>	2,300,100
<i>Supervised policies in force</i>	2,465,000
<i>National Cemetery System</i>	
<i>Interments</i>	73,000
<i>Occupied graves maintained</i>	2,203,100
<i>Headstones and markers ordered</i>	269,900

Number of individual veterans or dependents receiving benefits or services during FY 1997.

Through the Veterans Benefits Administration (VBA), VA ensures the delivery of benefits and services to veterans and their families in a responsive, timely, and compassionate manner.

The **Compensation** program provides monthly payments and ancillary benefits to veterans, in accordance with rates established by Congress, in recognition of the average potential loss of earning capacity caused by a disability or disabilities or disease incurred in or aggravated during active military service. The Compensation program also provides monthly payments, as specified by law, to surviving spouses, dependent children and/or dependent parents in recognition of the economic loss caused by the veteran's death during active military service or, subsequent to discharge from military service, as a result of a service-connected disability. In addition, this program provides allowances and in some cases reimbursement of funeral and burial expenses for eligible veterans.

The **Pension** program provides monthly payments, as specified by law, to needy wartime veterans who are permanently and totally disabled as a result of a disability not related to military service. The program also provides monthly payments to needy surviving spouses and/or dependent children of deceased wartime veterans.

The **Vocational Rehabilitation and Counseling** program helps service-disabled veterans achieve independent life skills and employment, providing all services and assistance necessary to enable veterans with service-connected disabilities to achieve maximum independence in daily living and, to the maximum extent feasible, become employable and obtain and maintain suitable employment.

The **Education** program provides educational assistance to men and women of the Armed Forces to adjust to civilian life after separation from the service; extends the opportunity for higher education to those who might not otherwise be able to afford it; restores lost educational opportunities and vocational readjustment to service members who lost these opportunities as the result of their active military duty; aids in the recruitment and retention of the Armed Forces, Selected Reserve, and National Guard; and enhances our Nation's competitiveness through the development of a highly educated and productive work force.

The *Loan Guaranty* program provides housing credit assistance to veterans and service persons to purchase and retain homes through the use of the Government's partial guaranty of loans made by private lenders.

The *Insurance* program provides the same or better life insurance benefits and service to veterans, service members and beneficiaries commonly made available to private citizens by their employers, and insurance protection to veterans who have lost their ability to purchase commercial insurance at standard rates because of service-connected disabilities.

VA's *Burial* program is administered through the National Cemetery System (NCS). VA ensures that the military service of our Nation's veterans is honored by providing dignified burials and lasting memorials for veterans and eligible family members; maintaining all veterans' cemeteries as national shrines; providing aid to states in establishing, expanding, or improving state veterans' cemeteries; providing headstones and markers for graves of veterans in national, state, and private cemeteries; and providing Presidential Memorial Certificates to family and friends of deceased veterans.

In addition to VA's ten lines of business, final decisions are rendered for the Secretary of Veterans Affairs on all appeals for entitlement to benefits administered by the Department. This process is administered through the Board of Veterans' Appeals (BVA).

Honor, Care and Compensate Veterans in Recognition of Their Sacrifices for America

VA is dedicated to serving the needs of more than 25 million men and women living today who have served in the Nation's Armed Forces, and their dependents. In FY 1997, VA continued shifting its emphasis from a process-focused system to a strategically-driven, performance-based, outcome-oriented delivery system. To determine whether its programs are serving the purposes for which they were created and whether they are improving the quality of life for veterans and their families, VA measures its performance in achieving the following general goals and objectives.

General Goal 1: Improve the overall health care of veterans

One of the Department's most critical outcome goals is to improve the overall health care of veterans. During FY 1997, the Department made substantial progress toward meeting this key goal. Health care services were provided to more veterans, particularly those who are VA's highest priority (service-connected and low income veterans); the quality of care provided dramatically improved in the areas of prevention

Vision

As the Department of Veterans Affairs heads into the 21st Century, we will strive to meet the needs of the Nation's veterans today and tomorrow.

We will become a more customer-focused organization, functioning as "One VA" and delivering seamless service to our customers.

We will benchmark our service with the best in business. We will use innovative means and high technology to deliver "World Class Customer Service." We will foster partnerships with our customers and stakeholders, making them part of the decision-making process.

and chronic disease; the use of clinical practice guidelines became much more widespread throughout the health care system; end-of-life care plans were in place for two-thirds of the patients with a terminal diagnosis or a condition in the final stages of illness; about nine of every ten inpatients received care in accordance with externally set and accepted standards; and over three-quarters of VA's patients knew there was one provider or team in charge of their health care needs.

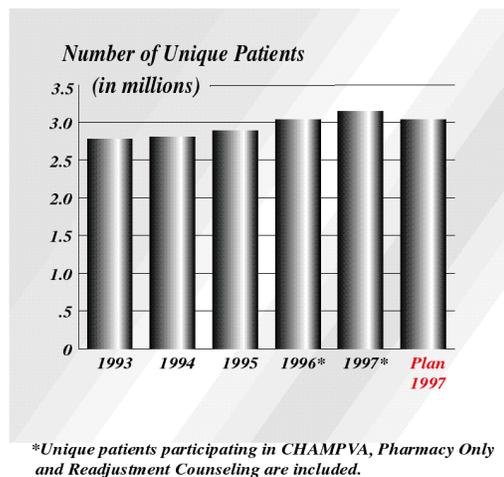
While the Department did not meet all of the performance targets associated with this goal, the improvements in program performance were still quite dramatic. Many of the target levels of performance were set intentionally high so as to emphasize their importance and stretch the organization to achieve the best outcomes possible.

One of the driving forces behind these very significant performance advancements from FY 1996 to FY 1997 was the fact that the Under Secretary for Health established performance agreements with the directors of each of the 22 Networks. The executive level focus on, commitment to, and accountability for achieving specified levels of performance was the main reason that VA was able to record such noteworthy performance in the delivery of health care.

Objective 1.1: Increase number of unique patients of the veterans health care system

The shift in health care in the United States from the basic system of hospital-centered care to the delivery of managed patient-centered primary care and necessary specialty care is affecting institutions in the public as well as the private sector. To respond to these dramatic changes, health care providers everywhere are realigning, restructuring, and reducing costs to improve their position. Likewise, VA is responding, in part, by pursuing sustained program growth and by ensuring greater access to services.

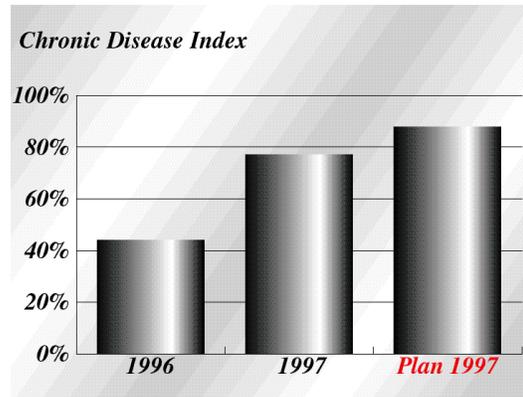
A principal aspect of VA's strategy in the delivery of health care calls for increasing the number of patients of the veterans health care system by 20 percent from FY 1997 to FY 2002. Over a five-year time span, this represents an average 4 percent growth per year. The 3 percent growth achieved in FY1997 is slightly under the needed growth rate for the next five years. Two performance strategies underpin the growth in unique patients—implementation of primary care and the growth of ambulatory care, both of which permit treatment of more patients. Specific field strategies to increase unique patients have included partnering with VA regional offices to identify potential patients from the compensation and pension files, and formation of marketing work groups.



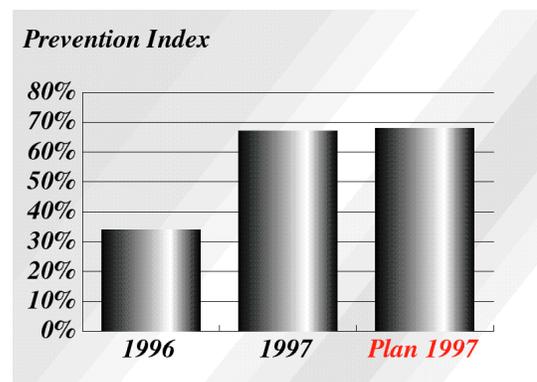
Objective 1.2: Exceed the proportion of patients of other health care providers who achieve maximum functional potential

VA aims to ensure the consistent delivery of health care by implementing standard measures that are based upon the provision of evidence-based care. Technical quality of care increased substantially during FY 1997 based on several key performance measures, including the Chronic Disease Index (CDI) and the Prevention Index (PI).

The CDI is a group of measures that reflect the quality of services provided to VA outpatients in five high volume, high cost diagnostic categories – ischemic heart disease, chronic obstructive pulmonary disease, diabetes, obesity, and hypertension. The individual disease-specific measures track the degree to which VA is following nationally recognized clinical guidelines. The national CDI average achieved was 76 percent, a figure which was moderately below the 88 percent target, but substantially above the FY 1996 figure. Specific achievements within this measure include aspirin administration (92 percent) and beta blocker administration (83 percent) for ischemic heart disease, both of which continue to exceed FY 1997 private sector performance of 76 and 62 percent, respectively. VA's 69 percent rate of retinal eye exams for diabetics exceeds the FY 1997 HMO national average of 38 percent.



The PI assesses how well VA follows nationally recognized approaches for primary prevention and early detection recommendations related to diseases with major social consequences such as influenza, pneumococcal infection, and several cancers. Thirteen Networks achieved the stretch goal of doubling the PI from 34 percent in FY 1996 to 68 percent in FY 1997. Specific achievements within this measure include more than doubling immunization for pneumococcal disease and influenza to 61 percent, both of which now exceed the U.S. goal of 60 percent for the year 2000. Breast, cervical, and colorectal cancer screening rates (87, 90, and 62 percent, respectively) exceed FY 1997 HMO national average performance (70, 70, and 55 percent, respectively).



Specific field strategies used to increase both CDI and PI scores included development of various encounter forms and electronic mechanisms to document medical interventions.

Clinical guidelines are recommendations for the performance or exclusion of specific procedures or services that are derived through rigorous methodological approaches such as determination of appropriate criteria and literature reviews to determine strength of evidence in relation to these criteria. VA's FY 1997 performance goal was for Networks to implement twelve new nationally developed Network-wide clinical practice guidelines, two of which were to be for special emphasis populations, such as veterans with spinal cord injuries, homeless veterans, and those suffering from post traumatic stress disorder. All of the 22 VISNs achieved this goal.

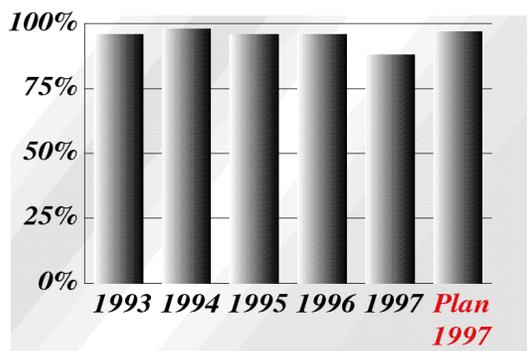
In FY 1997, VA began to collect data on the percent of patients with terminal diagnoses who have end-of-life (palliative) care plans. Palliative care refers to the comprehensive management of the physical, psychological, social, spiritual, and existential needs of patients with incurable, progressive illnesses. The goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs, and practices. The Department's FY1997 goal was to document admission to a community hospice program, VA hospice program, VA home-based primary care program, or the development of an individualized plan for at least 95 percent of those patients with incurable, end-stage illness. VA did not achieve its goal; however, the FY 1997 goal was set at an extremely ambitious level. The actual performance (67 percent) is a reasonable level of achievement. VA received a Commendation from Americans for Better Care of the Dying for its achievements in end-of-life care.

The 88 percent result achieved in FY 1997 was skewed somewhat downward by oversampling in a known problem area—care provided to psychiatric patients. In past reviews, 18 or more clinical conditions were reviewed. In FY 1997, the number of topics reviewed was limited to four high risk or known problem areas. Care provided to medical and surgical patients met or exceeded community standards 96 percent of the time. The data also demonstrate a sustained high level of performance for patients with acute myocardial infarction and coronary artery bypass surgery. In FY1997, 65 percent of the sample consisted of patients suffering from major depressive disorder (MDD). Their care met or exceeded community standards 84 percent of the time.

Although VA recognizes continued improvement is needed, this result for MDD represents an 11 percent improvement in the quality of care provided over the previous year.

No Network achieved the stretch goal of 85 percent for this measure, which suggests that the goal was set at an extremely ambitious level. Nonetheless, the value of such a goal can be seen in the 5 percent actual improvement experienced in FY 1997 which approximated the improvement rate of the previous year.

Percent of Patients Receiving Care In Accordance with Externally Set and Accepted Standards



Specific field strategies to promote primary care and patients' awareness of their primary care team include toll-free centralized access to primary care, increasing the number of primary care resident positions, and patient education in primary care.

General Goal 2: VA medical research programs meet the needs of the veteran population and contribute to the Nation's knowledge about disease and disability

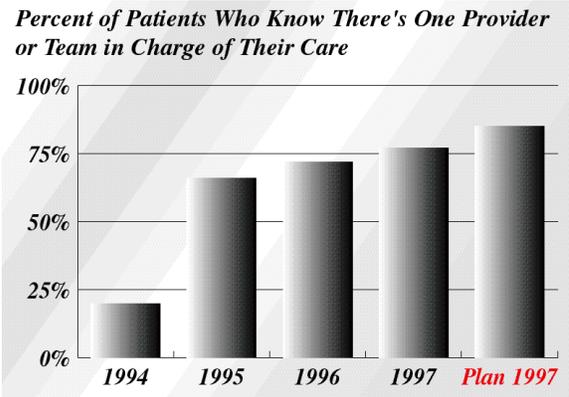
VA is linking medical research with veteran patient needs and has identified a variety of actions to focus research on the priority health care needs of veterans. The 22 Network research programs are engaged in locally initiated as well as multi-center and nationally directed efforts. Some of the locally initiated projects address the organization of veteran medical care delivery (primary care, service-line organizations) in addition to such traditional, clinical problems as the diagnosis and treatment of chronic disease, post traumatic stress disorder, spinal cord injury, and assistance for the infirm and aged.

Objective 2.1: 100 percent of VA medical research projects are demonstrably related to the health care of veterans or to other Departmental missions

The primary purpose of VA's medical research program is to contribute to the Nation's knowledge about disease and disability and to create innovations to improve the health care of veterans. The following table presents information on current trends within the research area.

<i>VA's Intramural Research Program</i>	<i>1993</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>Plan 1997</i>
<i>Projects Funded</i>	2,003	1,870	1,771	1,666	1,693	1,644
<i>New Projects Funded</i>	172	261	334	192	240	200
<i>Projects Receiving Funding from Extra-VA Sources</i>	56%	58%	58%	57%	59%	59%
<i>Funds Coming From Extra-mural Sources</i>	55%	54%	54%	62%	68%	61%

The increase in the total number of projects funded in FY 1997 was due to internal efficiencies which resulted in the release of new funds for VA medical research projects. The total number of projects funded is partly a function of budget size and partly a function of the type of projects that are submitted. As in the total number of projects, the increase in new projects funded during FY 1997 was also due to additional monies becoming available because of internal efficiencies.



VA's intramural research program has been restructured, and while the program's funding increased only 2 percent from FY1996 to FY 1997 (\$256 million to \$262 million), 30 percent more merit review projects have been funded, 15 new cooperative studies were begun in FY 1997, and many new studies and health services research projects have been initiated.

A number of notable advances in VA medical research occurred during FY 1997. For example, the VA Cooperative Studies Program, which conducts multi-hospital clinical trials of medical therapies, found that: an implantable insulin pump offers patients with adult onset diabetes the prospect of eliminating daily injections; smokers are five times as likely as non-smokers to develop abdominal aortic aneurysms; and a non-invasive approach of testing and medication is at least as effective as invasive strategies in treating a common type of heart attack.

The Department's Medical Research Service supports basic and clinical studies designed to improve prevention, diagnosis, and treatment of disease and disabilities. Among the major findings in FY 1997 are: the use of laser surgery to remove excess tissue from enlarged prostate glands is safe and effective; an experimental vaccine consisting of a synthetic peptide boosts the body's ability to produce white blood cells that control and regulate disease causing cells; the Kaposi's sarcoma-associated herpes virus, which causes cancer in AIDS patients, may also cause multiple myeloma; an anti-cancer drug protects patients with sickle cell anemia from

the severe crises that characterize the illness; a major part of the risk for schizophrenia appears to be linked to a gene that helps filter information and can be stimulated by nicotine; and identical changes in three specific chromosomes are related to inherited forms of Alzheimer's disease. In addition, researchers perfected a breath test for identifying the organism responsible for 90 percent of peptic stomach ulcers. The new test is more accurate than blood tests and is expected to reduce the need for expensive endoscopies.

Finally, VA medical researchers found that clot-dissolving drugs are as effective as balloon angioplasty in opening blocked arteries. Drug therapy spares patients the risk associated with the invasive procedure and costs about \$3,000 less per patient than surgery.

<i>Medical Research</i>	1993	1994	1995	1996	1997	Plan 1997
Number of Cooperative Studies	NA	28	31	35	38	37
Number of VA Funded Studies Involving VA Patients or VA Databases	NA	972	854	786	746	786
Percent Increase from FY 1996 Network-Level Total VA and Non-VA Peer Reviewed Research Funding	NA	NA	NA	NA	9%	5%
Number of Investigators	NA	4,044	4,027	3,782	4,393	3,650
Percent of Proposals in Designated Research Areas (DRA)	NA	NA	NA	87%	97%	90%
Number of Collaborative Agreements	NA	NA	NA	8,400	12,097	NA
Number of Publications by VA Investigators	NA	9,901	10,997	10,157	13,334	5,300
Number of Publications or Special Events Produced or Arranged by Research Communications Service	12	21	27	57	129	80

The continuing decrease in FY 1997 in the number of VA-based studies reflects an overall decrease in competitive clinical research proposals and the difficulty in obtaining patient consent for research.

VA has established Designated Research Areas (DRAs) of particularly high relevance to veterans' health care needs as the organizing principle for VA research. Different kinds of research can be conducted in each of the designated areas, ranging from very basic biochemical laboratory research through tests of new drugs or other treatments in individual patients, to analyses of the cost effectiveness of different treatments in large populations.

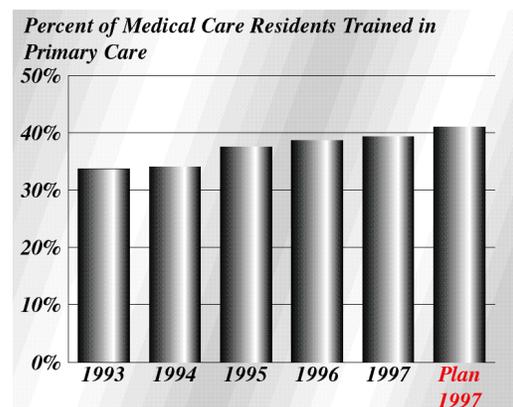
Standards and guidelines to achieve an appropriate balance between basic and applied outcome research are in place. The Department is constantly seeking new ways to expand collaboration with other government and non-government organizations to maximize research opportunities and enhance the value of research dollars available to investigators.

The significant increase in the number of publications or special events produced or arranged by VA's Research Communications Service is due to a number of factors. First, the staff was increased by one FTE. Secondly, the service has worked more closely with veterans' service organizations to get articles and news releases printed. Finally, the performance reflects a conscious effort by the Under Secretary for Health and the Department's Research and Development office that VA has an impressive story to tell that is relevant and important not only to the veteran community but to the entire Nation.

General Goal 3: VA's health care education and training programs help assure an adequate supply of clinical care providers for veterans and the Nation

Objective 3.1: Realign the academic training program and update the curriculum with a greater emphasis on primary care to better meet the needs of VA, its patients, students, and academic partners

To enhance the quality of care provided to veterans, VA provides assistance in the education and training of medical, dental, nursing, and associated health professions students, residents, and fellows. Current efforts have been directed toward increasing primary care training. The Primary Care Education Program (PRIME) funds trainee awards to those facilities demonstrating provision of primary and managed care to a population of veterans using a multidisciplinary team approach.

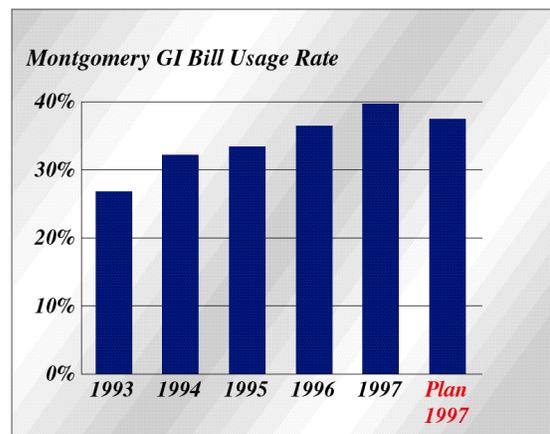


General Goal 4: Assure the education support programs meet the needs of veterans and their families

The Montgomery GI Bill serves as a valuable tool used by the military to support recruitment and retention in the Armed Forces. Furthermore, implicit in each education benefit program is the premise that monetary benefits provided by VA will assist an eligible individual in achieving educational or vocational goals to subsequently obtain stable employment.

Objective 4.1 Improve the educational opportunities provided to veterans

One measure of program success is the extent to which eligible beneficiaries use their earned benefit. Greater use results in a more highly educated and productive workforce, thus enhancing the Nation's competitiveness and supporting one of the purposes of this program. As the Montgomery GI Bill (MGIB) veteran population grew, so too did the usage rate. It has grown from less than 20 percent in 1992 to almost 40 percent in 1997. Usage is expected to continue this upward trend. Because this program has been embraced by the military services as an excellent recruiting tool, the Department of Defense is very interested in seeing full utilization.

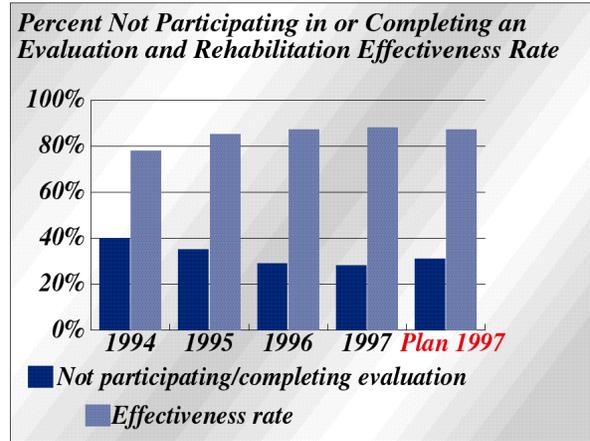
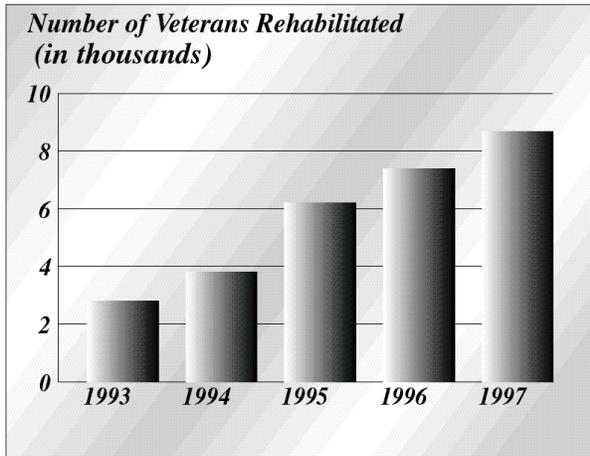


General Goal 5: Assure the vocational rehabilitation program is meeting the needs of veterans

VA strives to provide all necessary services and assistance to enable veterans with service-connected disabilities to achieve maximum independence in daily living, and to the maximum extent feasible, become employable and to obtain and maintain suitable employment. In FY 1997, VA saw improvements both in the number of veterans rehabilitated and in the number of program applicants completing an initial evaluation. The rehabilitation effectiveness rate remains positive at 88 percent.

Objective 5.1: Increase the number of disabled veterans who acquire and maintain suitable employment and are considered to be rehabilitated

VA continues to see improvement in the number of veterans rehabilitated (a 17 percent increase over FY 1996) due to an emphasis on employment and the specialized assistance in employment services provided by contract service providers. In addition, we have received valuable support from our partners at the Department of Labor (DOL). DOL's Disabled Veterans Outreach Program staff has assisted in finding employment for many vocational rehabilitation program participants.



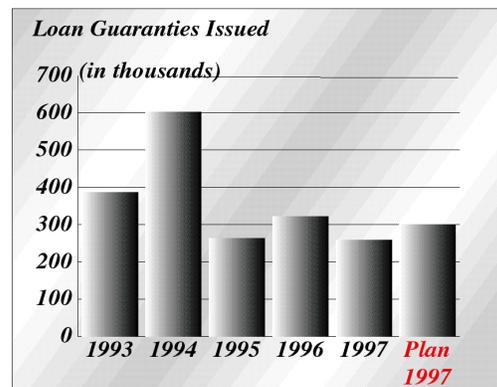
All veterans filing a claim for vocational rehabilitation benefits and meeting basic eligibility criteria are entitled to an evaluation to determine their entitlement to vocational rehabilitation services. The Department has heightened its efforts to motivate program applicants to complete an initial evaluation. Increased access points have made it easier for disabled veterans to attend evaluation appointments. In FY 1997, the Vocational Rehabilitation and Counseling program revised its performance measures and will no longer track the percent not participating in or completing an evaluation. The revised measure will focus on the percentage of participants who successfully complete the evaluation process.

General Goal 6: Assure the loan guaranty program meets the needs of veterans

In recognition of their service to the Nation, VA helps veterans and active duty personnel purchase and retain homes. Assistance is provided through the use of the Government’s partial guaranty of loans made by private lenders, in lieu of the substantial downpayment and other safeguards applicable to conventional mortgage transactions.

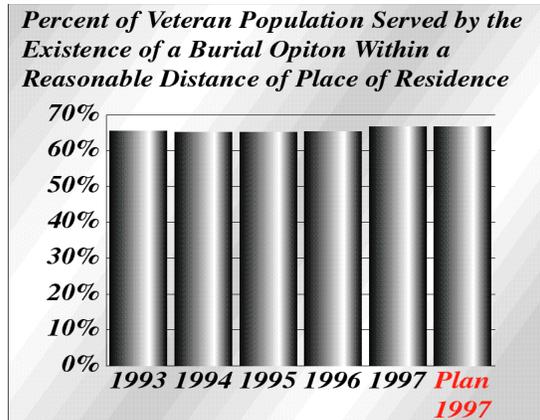
Objective 6.1: Improve the abilities of veterans to obtain financing for purchasing a home and the terms under which the financing can be obtained

VA issued guaranties on 19 percent fewer loans in FY 1997 than in FY 1996. Loan volume fluctuates from year to year, largely due to interest rates and economic conditions. Because interest rates increased early in the calendar year, the loan volume was lower than expected.



General Goal 7: Assure that all eligible veterans have reasonable access to a burial option

Experience and recent historical data show that almost 80 percent of persons interred in national cemeteries resided within 75 miles of the cemetery at time of death. Based upon this experience, reasonable access to a burial option means that an option, whether for casketed or cremated remains, is available within 75 miles of the veteran's place of residence. To achieve this goal, the Department needs to complete the development of new national cemeteries in selected heavily populated metropolitan areas that currently lack a national or state veterans cemetery within a reasonable distance; continue phased development of burial areas in open cemeteries with undeveloped land; acquire land that can be developed for cemeterial purposes adjacent to cemeteries that will soon exhaust the supply of available gravesites; develop more effective use of available burial space; and encourage use of the State Cemetery Grants Program.



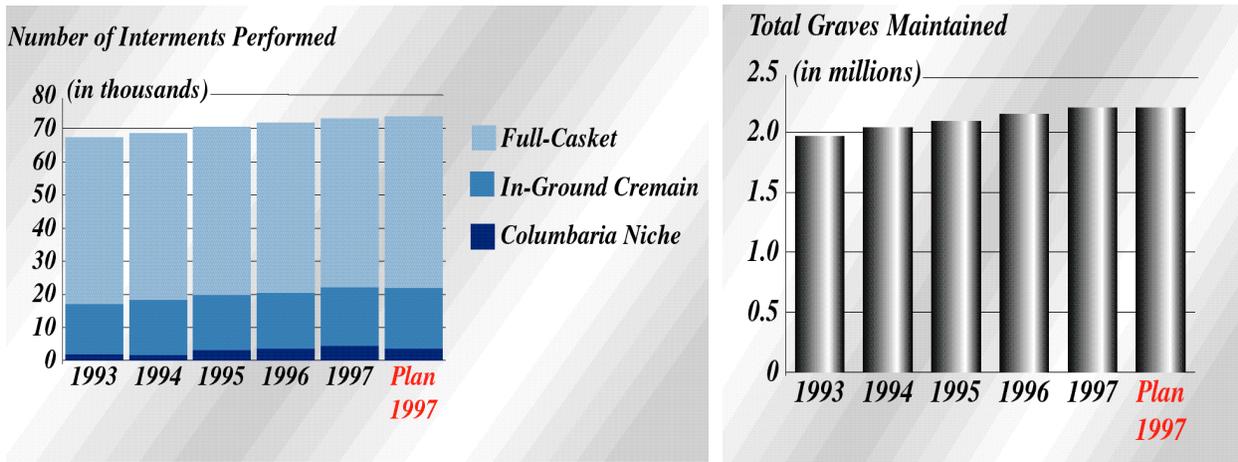
Objective 7.1: Increase the number of veterans served by a burial option within a reasonable distance of their residence

In September 1997, NCS opened the Tahoma National Cemetery near Seattle. This is the 115th national cemetery operated by VA, and the first in the State of Washington. The first phase of construction, covering 43 acres of the 160-acre site, will allow for more than 10,000 gravesites and 4,000 niches for cremated remains. With more than 600,000 veterans living in Washington State, including 400,000 in the Puget Sound area, it is anticipated that Tahoma will quickly become one of VA's busiest national cemeteries.

During FY1997, additional burial space was made available as expansion projects were completed at eight national cemeteries. For example, Willamette National Cemetery in Oregon added 25,000 gravesites and two new columbaria with a total of 5,000 cremation niches. This cemetery serves over 250,000 veterans. More than 1,400 new gravesites were added at Fayetteville National Cemetery in Arkansas. Also in Arkansas, an expansion project at Fort Smith National Cemetery yielded 3,600 gravesites. These two cemeteries provide service to over 200,000 veterans. Houston National Cemetery, serving over 350,000 veterans, completed an expansion project that added 20,000 gravesites and 5,000 columbaria niches.

In FY 1997, the State Cemetery Grants Program awarded eleven grants totaling over \$4.8 million to assist in establishing several new state veterans cemeteries and to expand and improve other existing state-owned cemeteries for veterans. With the help of this program, Virginia established its first state veterans cemetery in Amelia County. The Virginia Veterans Cemetery was dedicated May 28, 1997. This 129-acre cemetery will serve approximately 435,000 veterans residing within a 75-mile radius.

At the end of FY 1997, only 57 national cemeteries contained available, unassigned gravesites for the burial of both casketed and cremated remains; 36 national cemeteries had exhausted the supply of unassigned gravesites for the interment of casketed remains, but were still able to accommodate requests for burial of family members in the same gravesite as a previously deceased family member and could also accommodate cremated remains; and 22 national cemeteries were able to accommodate only subsequent family members in previously occupied gravesites. As annual interments and the number of total gravesites used continue to increase, cemeteries deplete their inventory of space and are no longer able to provide full service, thus reducing the burial options available to veterans.



General Goal 8: Assure that the unique needs of special veteran populations are met

VA has a number of clinical and administrative programs that are designed to meet the special needs of specific subsets of the veteran population.

Objective 8.1: Maximize the functional potential of special populations of veterans, assess their needs, improve the quality of their care, and ensure that access to VA programs and benefits is equitable

Substance Abuse

The Addiction Severity Index (ASI) is a widely used assessment tool of functional status in the field of substance abuse and treatment developed to assess the multiple problems often seen in alcohol and drug dependent persons. It is administered as a structured clinical interview combining both objective and subjective data to give ratings of severity in seven functional areas: medical; employment and support; drug use; alcohol use; legal status; family/social relationships; and psychological status. VA's FY 1997 goal was to use the ASI to assess and record at least 90 percent of those inpatients and outpatients who have received a primary diagnosis of substance abuse. While VA's actual performance level (60 percent) was well below the FY 1997 goal, the Department noticeably exceeded the private sector benchmark of 50 percent in the extent to which substance abuse patients were evaluated using a standardized clinical assessment instru-

ment. Performance was variable among the Networks. Only one Network achieved the performance target of 90 percent.

Spinal Cord Injury/Dysfunction

In an effort to determine the level of customer satisfaction from those patients in a special emphasis area, spinal cord injury/dysfunction (SCI/D) patients were surveyed. While over one-half of both SCI/D inpatients and outpatients reported their care as very good or excellent, performance on this measure demonstrates that SCI/D patient satisfaction represents a significant opportunity for improvement. The satisfaction levels for SCI/D patients are significantly lower than for the veteran population as a whole. This data is best regarded as a baseline measure of national SCI/D performance. Comparable data is available in the private sector for general medical, surgical, and psychiatric samples, but a comparable data set is *not* available for SCI/D. To increase SCI/D patients' satisfaction with care, VA has initiated several measures in the Networks. The changes include identification of SCI/D Primary Care Teams, increased networking between the SCI/D Centers and longstanding catchment areas, improved access to specialty care providers, training of staff, and development and distribution of clinical practice guidelines in managing autonomic dysreflexia and prevention of thromboembolism in SCI/D patients.

Women Veterans

In FY 1997, a Women Patient Privacy Survey was conducted and demonstrated that two-thirds of health care facilities do not have deficiencies relating to women veteran privacy issues in the outpatient setting. VA strengthened the Women Veterans Coordinator program in each regional office by appointing a coordinator in each Area Office and a full-time coordinator in St. Petersburg, Florida.

AIDS

VA is the Nation's largest single provider of health care services for patients with Human Immunodeficiency Virus (HIV) infection and/or Acquired Immunodeficiency Syndrome (AIDS). By the end of FY 1997, VA had treated more than 27,700 patients since the beginning of the epidemic. During FY 1997, clinical care efforts were directed toward the development of clinical guidelines and recommendations for the promising new anti-retroviral drug treatment and viral load measurements. Attention was also directed toward the post-exposure prevention treatment of health care workers occupationally exposed to HIV, using Public Health Service provisional recommendations.

Seriously Mentally Ill

Under Public Law 104-262, section 335, a Committee on Care of Severely Chronically Mentally Ill Veterans was established to assess the needs of seriously mentally ill (SMI) patients, evaluate their care within VA, identify system-wide and facility-specific problems and model programs, and report their findings and recommendations to the Department's Under Secretary for Health. This report, along with com-

ments from the Under Secretary, was submitted by the Secretary to the Committees on Veterans' Affairs of the Senate and House of Representatives on April 1, 1997. Major recommendations include: assessing the need for mental health services in new Community Based Outpatient Clinics; assessing obstacles to the use of the new atypical antipsychotic medications; establishing additional intensive community case management teams where indicated; assessing the provision of and access to mental health care for women veterans with a serious mental illness; and increasing both educational and research efforts to reflect the high prevalence and costs of treating SMI veterans. The Committee has been working successfully with Network directors to accomplish these goals. In addition, VA has published and distributed Treatment Guidelines for Psychosis, and has implemented the Major Depressive Disorder Guidelines at a number of medical centers.

Homelessness

In FY 1997, the Homeless Providers Grant and Per Diem Program, administered by the Mental Health Strategic Healthcare Group, awarded grants to 17 non-profit organizations, and state or local government agencies to develop new programs to assist homeless veterans. These awards will create supportive housing or service centers in 17 cities and 14 states. During FY 1997, the Mental Health Strategic Healthcare Group also continued implementing the per diem component of the program. Twenty programs, with a total of 600 supportive housing beds, were approved for per diem payments. By the end of FY 1997, more than 750 veterans had either completed per diem supportive housing programs or were currently enrolled.

Spina Bifida

A program was established in FY 1997 to benefit Vietnam veterans' birth children diagnosed with spina bifida. Health care benefits available under this program are limited to those necessary for the treatment of spina bifida (except spina bifida occulta) and related medical conditions.

Other Special Populations

Among other areas of emphasis, VA researchers conduct studies to evaluate treatments and to improve the quality of life of disabled veterans who need prosthetic devices, sensory aids, and mobility assistance. VA achievements in FY 1997 included the establishment of six rehabilitation research centers of excellence to focus on areas of great importance to veterans with disabilities; the development of the SMART wheel, a movement-sensing device, now in use in assessments of wheelchair propulsion mechanics; and the application by VA investigators of computer tomography (CAT scans) to monitor bone loss in patients with spinal cord injury and patients treated for ankle fractures.

Management Strategies

When veterans request services, benefits, or information, they make no distinction among the Veterans Health Administration, the Veterans Benefits Administration, the National Cemetery System, or the Board of Veterans' Appeals; rather, they think of us as "One VA." Achievement of the following goals

and objectives demonstrates how well the Department operates as “One VA”—providing world-class customer service, ensuring a high-performing work force to serve veterans, and providing the taxpayer maximum return on investment.

General Goal 1: Ease of access

A veteran, beneficiary, or representative will be able, and encouraged, to access VA in the fastest possible time, by the easiest possible means, and where possible, receive one-stop assistance.

Technology is changing all aspects of our lives including the way we work, the way we do our banking, the way we do our shopping, the way we are taught and learn, and the way we receive medical care. Technology is allowing VA to significantly improve the way we administer and deliver benefits and services. In FY 1997, a veteran-focused information technology (IT) architecture project was initiated. The purpose of this initiative is to ensure that VA uses technology to provide better service to veterans and other customers and program management support services, to include development of an IT vision and identification of critical issues and major decision points and time frames. This project will provide VA's management with a Department-wide vision and architecture to ensure that VA uses technologies wisely and in a cost effective and efficient manner to meet the needs of veterans in the 21st Century.

Objective 1.1: Increase interactive, electronic access for veterans and their families

The Department was successful in meeting its FY 1997 performance goal to install two kiosks in national cemeteries. The first kiosk was installed in New Mexico at the Santa Fe National Cemetery. Use of the kiosk allows visitors to find gravesite locations of decedents in the cemetery, and provides quick information access to burial eligibility requirements, historical cemetery data, upcoming events, and hours of operation. An automated kiosk is also in place at the Tahoma National Cemetery in Washington State.

Objective 1.2: Improve telephone access to information

Toll-free telephone service provides the most important communications link to insurance customers. During FY1997, nearly one million telephone calls were answered. In order to improve telephone service, the Department continued to shift personnel from other positions into telephone agent positions. By expanding the number of telephone agents, VA was able to better accommodate high telephone traffic periods when most blockage occurs. For example, the blockage rate for Mondays during FY 1997 was 63 percent while the average blockage for Tuesdays through Fridays was only 32 percent.

In FY 1997, VA added a new feature called Smart Answer to the toll-free telephone service. When customers are on hold waiting to speak to telephone agents, Smart Answer tells them how long their wait will probably be. If the wait exceeds a set parameter, i.e., three minutes, they are offered the opportunity to be called back. Smart Answer will ask the caller to enter their telephone number using a touch-tone phone and when an agent is available, Smart Answer automatically dials the caller's number.

A pilot program has been successfully serving education benefit customers in Missouri and Illinois since January 1997. About 2,000 customers a week have been calling the toll-free number to receive information from an interactive Automated Response System (ARS) that answers many frequently asked questions or to speak to an Education Case Manager in the Education Customer Service Section (ECSS). The pilot has three goals: eliminate blocked calls; increase the number of veterans' assistance inquiries (VAI) that are resolved at first contact with the veteran; and increase customer satisfaction. It is meeting these goals: 95 percent of education VAIs for customers from Missouri and Illinois have been resolved in two days, and almost 92 percent of all telephone inquiries to the ECSS were answered on the first call. The lost call rate has averaged about 8 percent and there have been no blocked calls. Finally, customer surveys have been very positive. Plans call for setting up limited toll-free service in Atlanta, Buffalo, and Muskogee, as well as expanding service in St. Louis, followed by gradual expansion as resources permit.

General Goal 2: Customer satisfaction

Service will meet or exceed customer expectations.

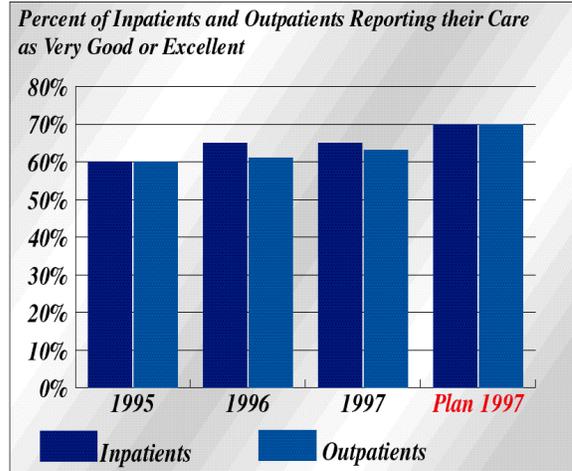
The Nation's veterans and their families must be satisfied with the services provided by VA. To ascertain how well our customers and stakeholders perceive us, each of the programs has been seeking feedback through customer surveys. VHA has ongoing surveys of inpatients, outpatients, and those in home-based primary care. Additionally, VHA has results from its patient satisfaction survey of spinal cord injury and dysfunctional patients. Future customer satisfaction surveys are planned for some of the special emphasis programs. VBA has active customer satisfaction surveys in place for the compensation and pension program, the loan guaranty program, and the insurance program. During FY 1998, VBA will implement an education assistance customer satisfaction survey to measure satisfaction with education claims processing, as well as develop a survey instrument for vocational rehabilitation and counseling program participants. In FY 1997, NCS launched its second effort to collect customer satisfaction data on the appearance and maintenance of national cemeteries using Visitor Comment Cards. The Department uses the information from the surveys to determine specific improvement opportunities and training needs.

Objective 2.1: Increase, to the highest level possible, customer satisfaction of veterans, their dependents and beneficiaries, and stakeholders who interact with VA employees

In FY 1997, VA successfully tested a Data Collection Pilot program in the northeastern states and North Carolina that simplifies the application process for veterans whose eligibility for VA medical care (including prescription co-payment exemption and travel reimbursement) is based on income. The program improves customer service because it enables these veterans to complete a single application in a calendar year instead of one for each benefit at the medical facility providing care.

As part of VA's efforts to measure patients' level of satisfaction with the health care services we provide, outpatients are asked if they had any problems in the areas of access to care, emotional support, courtesy of VA staff, and other important standards of customer service.

For inpatients, VA did not achieve the goal of 70 percent for FY 1997 and, instead, maintained the FY 1996 customer satisfaction level at 65 percent. A favorable reply to this measure calls for a response of "Very Good" or "Excellent." When the measure includes the response of "Good," the favorable rate rises to 90 percent. For outpatients, VA did not achieve the goal of 70 percent for FY 1997, but did improve its performance by 2 percentage points from 61 to 63 percent. Overall improvement in customer satisfaction scores has not been progressing as quickly as desired. Early emphasis on courtesy and timeliness has resulted in a 50 percent improvement in these particular scores, but less improvement in preferences, coordination of care, and emotional support. These three categories involve deeply ingrained clinician behaviors, which require more concerted improvement efforts. To that end, specific initiatives have been planned for FY 1998 that focus on clinician-patient communication, including training in handling difficult clinician-patient situations and shared decision-making.

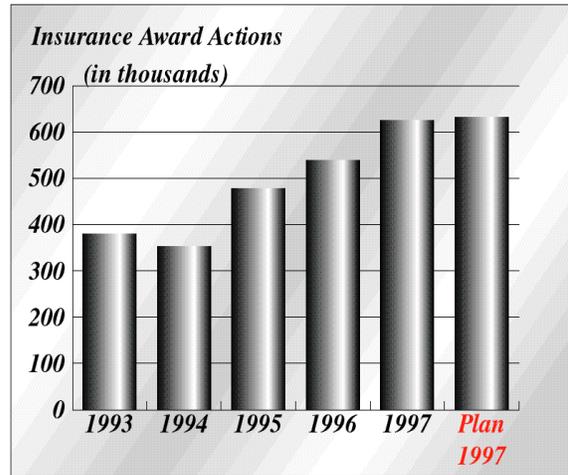


During FY 1997, VA completed a survey of recent applicants for compensation and pension benefits to provide accurate and timely customer feedback nationwide, for area and regional offices. Nationally, 59 percent of all surveyed veterans were satisfied with the way VA handled their claims. Claimants were most satisfied with the helpfulness of VA employees and they thought the claims process reflected the courtesy, compassion, and respect due a veteran.

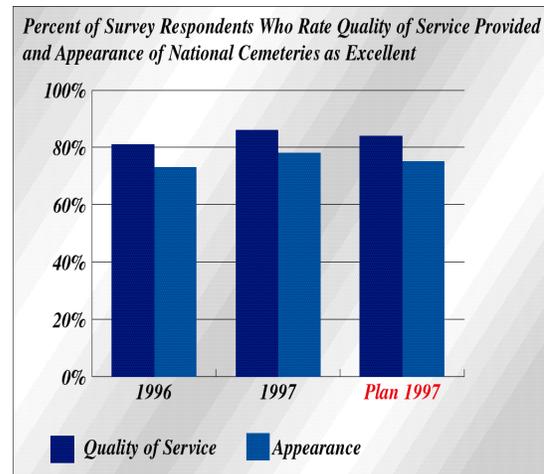
VA surveys veterans and lenders who participate in the loan guaranty program. For FY 1997, the veterans survey was modified to add a "neither satisfied nor dissatisfied" response category. As a result, a lower share (90 percent) of respondents was "satisfied" or "very satisfied" with VA than expected. VA would like to improve lender satisfaction by increasing lender training and improving lender access to VA regional offices. However, an increasing technology gap between VA and the mortgage industry makes it difficult to improve lender satisfaction.



In order to measure and continually improve customer satisfaction of the insurance program, VA formulated nine different customer surveys for all the primary insurance services being provided such as death claims, policy loans, and disability claims. Customers are asked to evaluate different aspects of service delivery on a five-point scale. During FY 1997, 90 percent of insurance program participants gave VA a high rating and 5 percent gave VA a low rating. In addition to being a barometer of the customers' assessment of services rendered, each survey instrument also asks the open-ended question, "What could VA do better?" Based on this feedback, adjustments are then made to work processes and training needs in order to improve in the delivery of services.



VA collects customer satisfaction data regarding the quality of service provided by national cemeteries, as well as the appearance and maintenance of national cemeteries, using visitor comment cards. In FY 1997, satisfaction rates improved in each of these categories. National cemeteries are national shrines, a tribute to our gallant dead, and all are important locations for visitation, including patriotic and commemorative events. Maintenance of the national cemeteries as national shrines meeting the highest standards of public expectation has long been an indicator of the honor, recognition, and commemoration afforded those who have served in the military and are now interred in national cemeteries.



When a veteran or family member dies on a weekend, the family may experience a stressful delay if interment arrangements cannot be made until the following Monday. To better serve its customers, three hub cemeteries have been designated to provide weekend scheduling of the interment in a national cemetery for a specific time in the ensuing week.

	1993	1994	1995	1996	1997	Plan 1997
Burial Program Data						
Number of Weekend Requests	5,558	5,528	5,755	5,239	5,456	5,650
Percent Scheduled for Ensuing Week	91%	90%	90%	92.5%	94.2%	90%
Number of Developed Acres	5,038	5,355	5,410	5,630	5,843	5,819

General Goal 3: Do it right the first time

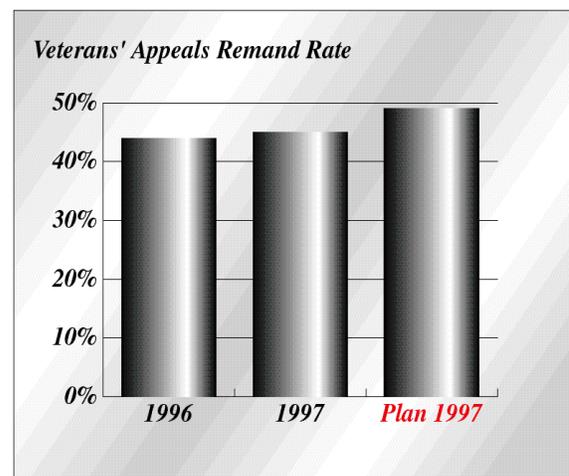
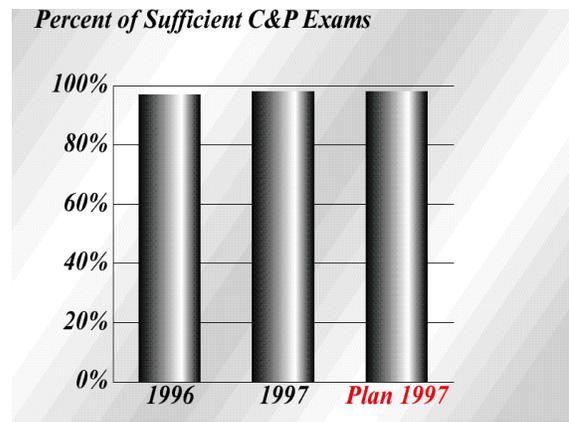
Accurate and complete benefits and services will be delivered with zero defects. If it is not done right the first time, there will be candid acknowledgment of mistakes and priority assignment to correction of mistakes.

One of VA's key management strategies is to improve payment and service accuracy throughout the Department. VA recognizes that improving the accuracy of all actions is essential to improving timeliness, efficiency, and effectiveness.

Objective 3.1: Assess and improve the level of accuracy for all work

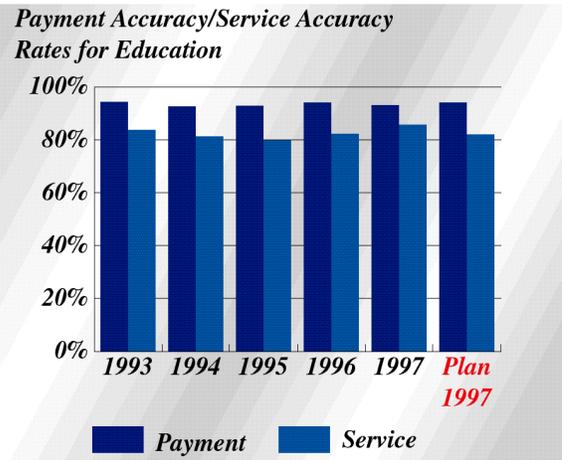
Another measure of the quality of health care services VA provides is the percentage of veterans applying for compensation and pension (C&P) benefits who receive a medical exam that is considered adequate for claims rating purposes. Specific strategies used by Networks to maintain their excellent performance included partnering and networking between VA medical facilities and VA regional offices, and establishment of pre-discharge C&P information and processing for active duty military personnel.

A key determinant of customer satisfaction is the accuracy of claims processing. Data indicate that a significant number of decisions on original and reopened claims contain flaws from the customer's perspective. In the past, information on accuracy was based on Quality Assurance reviews that measured a random sample of all cases but did not differentiate by specific benefit program. Separate accuracy rates for original and reopened compensation and pension claims were calculated and expressed by sorting the Quality Assurance results by benefit program and redefining some errors into different categories. In FY 1997, a methodology for a new Statistical Technical Accuracy Review (STAR) program was recommended to replace the current Quality Assurance program to determine national accuracy rates. The STAR program protocol is dramatically different from the current program and will provide accountability at various levels of the Department, i.e., the C&P Service Director level, Area Director level, Regional Office Director level, and Adjudication Officer/Service Center Manager level.

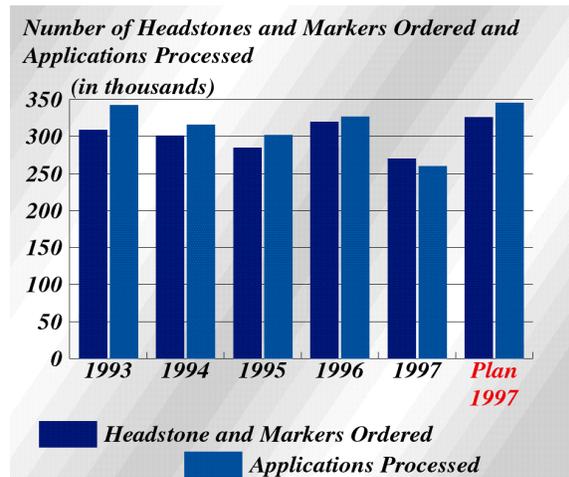
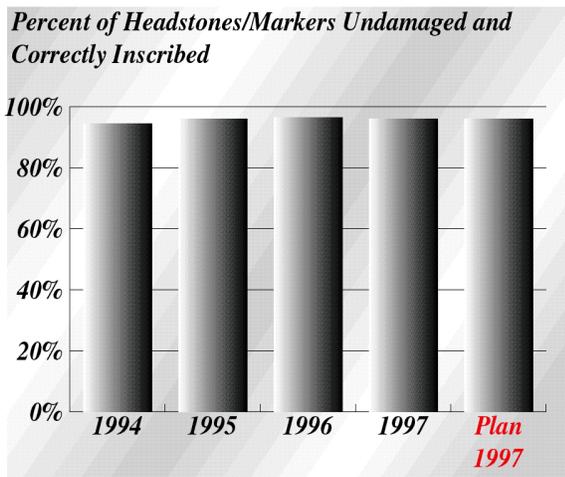


VA's early loan default index was 1.5 percent. These are loans that go into default within six months of origination and are likely to be related to the quality of underwriting of VA guaranteed loans.

The education payment and service accuracy rates measure how well claims examiners process claims. Payment accuracy refers to an error in claims processing which resulted in erroneous payment. Although this rate has varied only slightly over the last several years, the Department has set a long-term goal to achieve a 99 percent payment accuracy rate. Service accuracy represents the degree to which claims examiners accurately request or provide needed information in the adjudication of education claims. Before and during the consolidation of claims processing into the four offices responsible for handling education claims, service accuracy showed signs of deterioration. That downward trend was reversed in FY 1996 and continued to improve in FY 1997.



Several changes occurred during the fiscal year that had an impact on both the number of headstone and marker applications processed and the number ordered. A major reorganization was implemented to decentralize headstone and marker application processing from Washington, DC, to NCS-owned space at three of its cemeteries. In addition, a totally new computer system was implemented which required training of all employees. Further disruption of operations resulted from the physical relocation of the headquarters office. In spite of the disruptions, the Department achieved an accuracy rate of 95 percent in the share of headstones and markers provided that were undamaged and correctly inscribed. VA provides replacements regardless of the cause of error, i.e., government, contractor, or applicant.



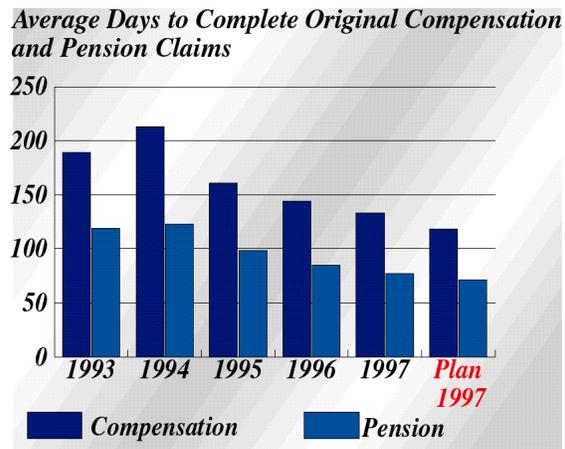
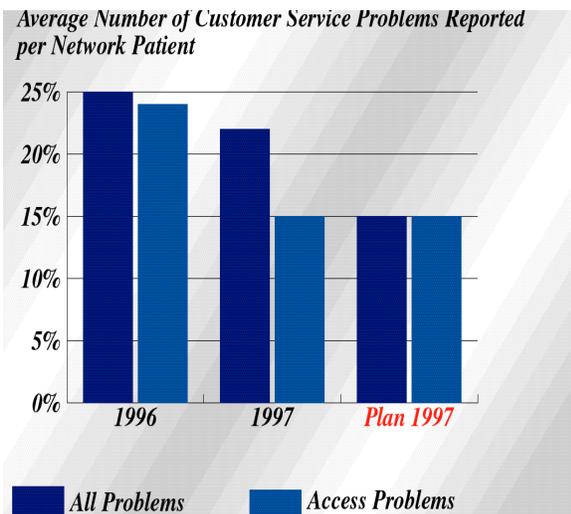
General Goal 4: Prompt delivery of services and benefits

Timeliness of service delivery will meet or exceed customer expectations and will be analyzed against the best-in-business.

One of the Department’s primary management strategies is the prompt delivery of services and benefits. There are many measures of the timeliness of VA’s operations. In health care, VA matched the Picker Institute benchmark performance for timeliness of access by cutting in half the number of problems reported by VA patients. Fully 75 percent of patients now report clinic waiting times of less than 30 minutes. VA improved its timeliness for original compensation claims, original pension claims, dependency and indemnity compensation claims, and death pension claims. However, the Department did not meet its FY 1997 timeliness goals for three of these four categories. Finally, claims appeals response time improved dramatically during FY 1997.

Objective 4.1: Improve customer satisfaction with timeliness of service

Outpatient Customer Service Standard scores on timeliness of access are based on questions that have to do with the timeliness of clinic appointments, scheduling, waiting time upon check-in, waiting time to see a provider, and whether a patient’s problem should have been handled sooner. VA’s FY 1997 goal was to match the non-VA benchmark performance of one problem reported per six questions answered (15 percent). Seventeen VISNs met or exceeded the FY 1997 national goal. A major part of VA’s success in this area is due to the implementation of primary care.



A broad consensus among customer survey participants indicated that the compensation and pension claims process is too long. Therefore, VA is reengineering its claims process to improve timeliness by eliminating unnecessary tasks and reducing the number of hand-offs involved in the process. In addition, information technology initiatives will dramatically reduce the time required to gather the documentation necessary to process and evaluate a claim and facilitate the decision and notification processes.

The FY 1997 timeliness goal was met for only dependency and indemnity compensation. Factors contributing to the slippage include: a labor intensive review conducted of Gulf War environmental hazards claims; a substantial number of hours invested in the training required to move toward the consolidation of Adjudication and Veterans Service divisions; and the number of original and reopened compensation claims received in FY 1997 exceeded the number of claims received in FY 1996 by approximately 14 percent.

Average Days to Complete Other Claims						
	1993	1994	1995	1996	1997	
					Actual	Plan
Original DIC	102	111	92	75	66	66
Reopened Compensation	N/A	N/A	143	107	101	97
Reopened Pension	N/A	N/A	111	77	67	62
Death Pension	67	65	50	45	41	24

Program Note: The FY 1997 Accountability Report goals differed from the timeliness benchmarks established by VBA's Strategic Management Committee. The Department met three of the five revised goals (original dependency and indemnity compensation, original pension claims, and death pension claims) and was within five days and four days of timeliness goals for original and reopened compensation claims.

Accomplished Workload					
	1993	1994	1995	1996	1997
Original Compensation	138,226	158,385	141,804	127,074	117,454
Original DIC	24,632	26,871	26,794	23,349	23,716
Reopened Compensation	N/A	253,067	349,085	346,831	368,971
Original Veterans Pension	41,238	42,370	39,933	35,293	35,368
Original Death Pension	39,611	38,944	38,269	35,551	35,728
Reopened Pension	N/A	171,322	117,990	100,727	94,497

Gulf War environmental hazard/undiagnosed illness claims were redistributed from four Area Processing Offices (APOs) to most regional offices during FY 1997. The decision to distribute these claims was based on the expectation of faster processing times for these and other pending claims. To ensure proper han-

ding of these complex claims, training on processing the environmental hazard/undiagnosed illness claims was provided. A Rapid Response Team was created in VA Central Office to provide ready answers to claims processing questions received from field stations.

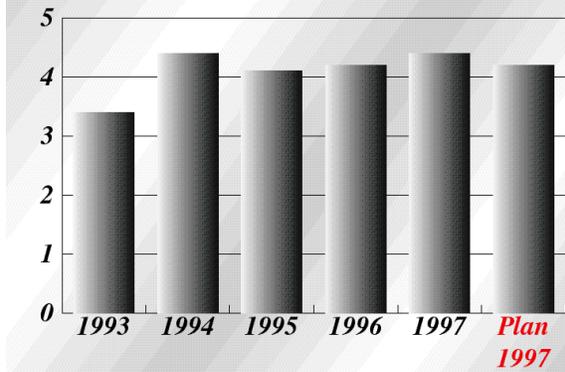
The timeliness for processing education claims was much better than expected because the Department had anticipated that the problems caused by the furlough in FY 1996 would have a residual, negative impact in FY 1997. This did not occur and, as a result, timeliness improved dramatically.

Disbursements are considered the most important services VA provides to insurance program customers. Disbursements include death claims, and applications for policy loans and cash surrenders. The indicator used to measure timeliness is the weighted composite average processing days for all disbursements. VA strives to increase productivity for disbursements of death claims while maintaining current levels of productivity for loan and cash surrender disbursements. For FY 1997, the average days to pay insurance disbursements exceeded the goal by half a day due to delays encountered in transferring death claim cases from St. Paul to Philadelphia during the initial phase of consolidation.

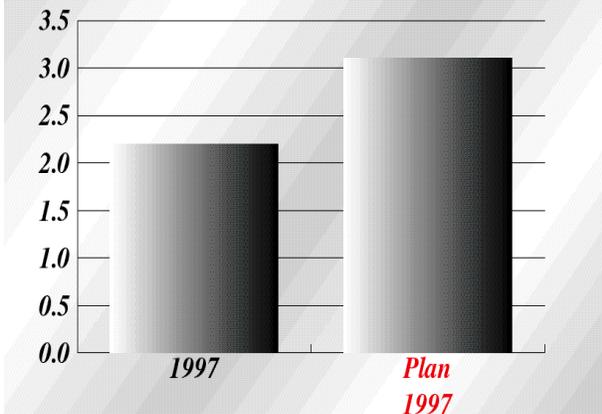
Number of Education Trainees and Average Days to Complete Education Claims

	Education Trainees	Average Days to Complete Claims
1993	432,777	N/A
1994	454,250	14.0
1995	447,804	15.3
1996	437,388	20.1
1997	426,346	12.3
Plan 1997	N/A	24.0

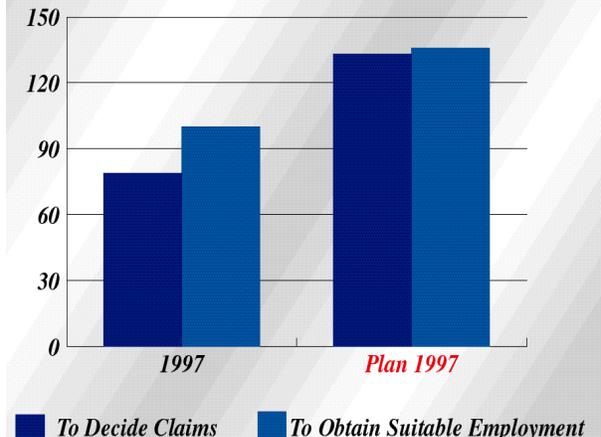
Average Days to Pay Insurance Disbursements



Average Processing Days for OSGLI Key Services

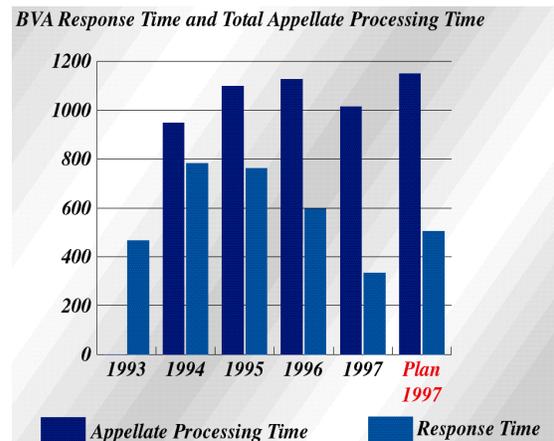


Average Days to Decide Claims for Vocational Rehabilitation Benefits; Average Days to Obtain Suitable Employment



In addition, VA supervises the Office of Servicemen's Group Life Insurance (OSGLI) program by ensuring that the administration of the program is efficient and effective. In FY 1997, VA introduced a new indicator to measure the average processing days for OSGLI key services. The actual performance level of 2.2 days proved to be significantly better than the target level of 3.1 days.

The Department's Board of Veterans' Appeals issued 43,347 decisions in FY 1997, the highest total since FY 1991. While doing this, the Board dropped the number of processing days by 44 percent. Four major factors led to this improved performance: (1) attaining additional resources; (2) attaining legislative outcomes needed to overcome process and organizational constraints; (3) organizational realignment and the attendant strategic and tactical objectives underlying the realignment; and (4) the use of overtime in FY 1997.



General Goal 5: Support VA's ability to create and maintain a high-performing workforce to serve veterans today and tomorrow

VA is a service organization, and the quality of that service depends on a workforce that understands, believes in, and fulfills the mission, as well as reflects the diversity of the veterans we serve. VA holds its employees accountable for their contributions and, to that end, owes them the opportunities to be successful in a work environment that encourages success.

Objective 5.1: Provide employees the opportunity to develop or enhance requisite skills and program knowledge

In FY 1997, 87 percent of VHA employees surveyed knew VA's medical care mission. This level of performance was 22 percent higher than the 65 percent target level for this first year baseline measure. This is due to widespread dissemination of the Under Secretary for Health's mission, vision, and values as articulated in his strategic organizational documents, *Vision for Change* and *Journey of Change*. The excellent result obtained on this performance measure is also explained by the fact that it was included in every Network director's individual performance agreement with the Under Secretary for Health.

General Goal 6: Reduce costs and improve the revenue stream for the health care system

One of the Department's primary management strategies is to provide taxpayers with maximum return on their investment in VA programs. During FY 1997, the Department made significant achievements in dramatically reducing the number of bed days of care per 1,000 unique patients, reducing the count of oper-

ating beds, and increasing the proportion of appropriate surgical and invasive diagnostic procedures performed on an ambulatory basis.

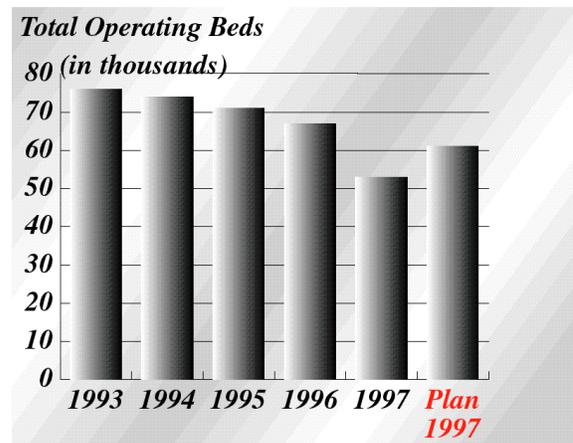
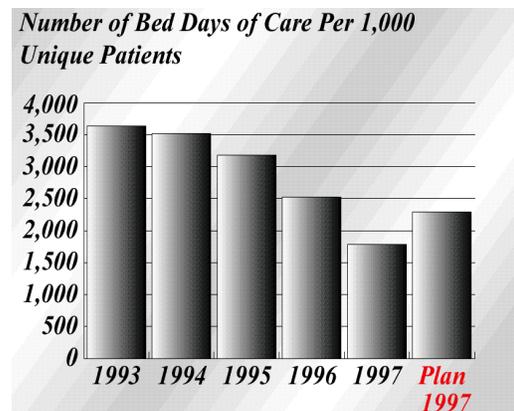
Objective 6.1: Decrease the average cost (expenditure) per patient

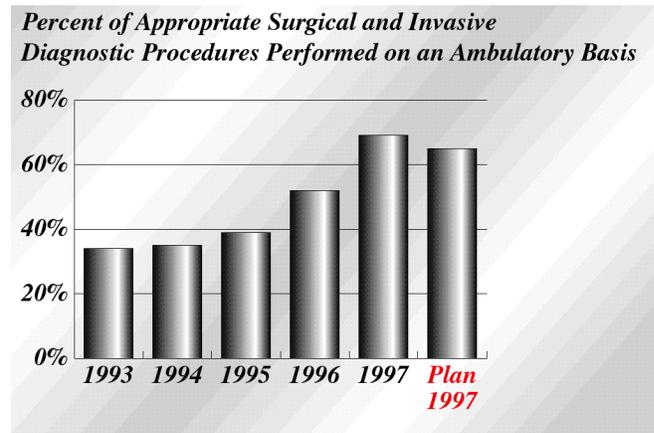
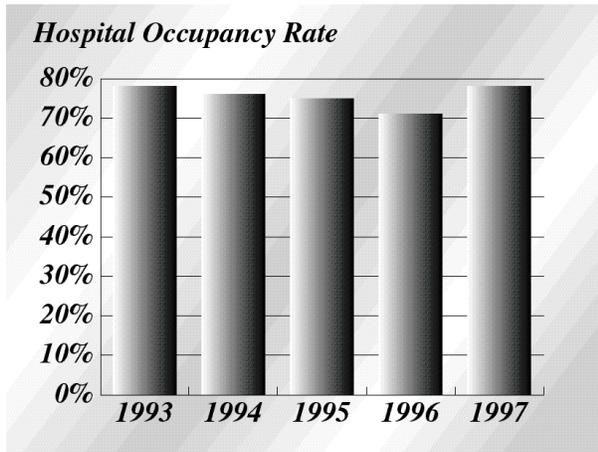
Until more refined unit cost measures are identified and developed, VA is using the number of bed days of care per 1,000 unique patients as one of its proxies for measuring the efficiency of the health care delivery system. This measure reflects VA's commitment to reduce the utilization of high cost care settings and to increase the utilization of alternative settings such as ambulatory care.

VA's FY 1997 national goal was to decrease the bed days of care per 1,000 unique patients by 10 percent from the FY 1996 level. VA exceeded the planned 10 percent reduction by an additional 19 percent. Each Network was to reduce its bed days of care per 1,000 unique patients to match the Health Care Financing Administration's (HCFA) 1997 projected bed days of care ratio for that particular geographic region; 21 VISNs were successful. The actual ratio of 1,782 bed days of care per 1,000 unique patients is down to almost half the VA's FY1994 level of 3,523, and is now lower than HCFA's published FY 1996 ratio of 2,102 for acute care hospitals. Performance on this measure can be attributed to the strategic vision called for by the Under Secretary for Health when he said, "Our business is health care, not hospital care." Specific goals that call for implementation of primary care and ambulatory surgery are directly linked to the excellent performance in reducing bed days of care.

In FY 1997, total operating beds declined 21 percent. The decline in total hospital beds is due to the increased emphasis on primary care, ambulatory care, and the decline in bed days of care.

Commensurate with the significant decline in operating beds, the hospital occupancy rate rose to a level 12 percent higher than the private sector.





The percent of appropriate surgical and invasive diagnostic procedures done in an ambulatory setting identifies the extent to which VA is shifting current inpatient surgical procedures to an outpatient setting.

The FY 1997 rate of ambulatory procedures exceeds VA’s national goal by 4 percent and is a proportion one and one-third times higher than it was in FY1996. The increase in ambulatory surgery procedures supports the Under Secretary for Health’s key strategy of decreasing costs and increasing users. One of the factors associated with VA’s excellent performance in increasing ambulatory care surgical procedures is the investment in capital improvements over the past several years that facilitate provision of ambulatory medical and surgical procedures. Construction and renovation that permit more efficient practice of ambulatory care has been underway for a number of years, and is a contributing factor in the improved performance.

Transforming the health care delivery system to treat patients in the most appropriate settings is a key means for achieving VA’s objective to decrease the average cost per patient. However, there are additional measures of the efficiency of VA’s health care system, examples of which are illustrated below.

	1993	1994	1995	1996	1997	Plan 1997
<i>Medical Care Cost Recoveries</i>						
<i>Average Days of Outstanding Receivables for Third Party</i>	NA	NA	NA	131	109	125
<i>Total Recoveries per Total FTE (in thousands)</i>	\$238	\$254	\$258	\$248	\$232	\$236
<i>Ratio of Cost to Collections</i>	18.2%	17.3%	17.6%	21.3%	21.8%	22.4%
<i>Total Recovery Increase/Decrease Over Prior Year</i>	13%	8%	5%	-3%	-7%	-4%

The reduction in the average days of outstanding receivables was made possible by the greater availability of electronic data interchange (EDI) in VA facilities and by additional training provided by VA's Medical Care Cost Recovery (MCCR) program office on how to clean up aging receivables.

In FY 1997, collections per FTE were very close to the planned figure. The maintenance of relatively steady employee productivity, in the face of fewer dollars per average case, shows that VA has managed to find the right balance among the workforce and the collection workload, now consisting of an increasingly higher proportion of outpatient billings. Additional training provided from headquarters, and designed to point to areas requiring special attention, also helped in maintaining high staff productivity.

The lower than expected ratio of costs to collections was achieved by a reduction in planned administrative expenses.

In FY 1997, the MCCR program collected 7 percent less in reimbursements than in FY 1996. The most apparent reason for the decline in recoveries can be ascribed to a reduction in inpatient collection workload and a simultaneous increase in outpatient collection workload. The lower average cost and hence the lower value of an outpatient billable case is the major reason for the smaller overall amount collected in FY 1997.

There are other reasons for the reported decline in collections. For example, in FY 1997, a greater percentage of the veterans treated by VA were insured by Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) than in previous years. HMOs and PPOs tend to reimburse out-of-group providers at a lower rate than fee-for-service health insurers. Consequently, the shift in insurance coverage among veterans in favor of managed care organizations has had a noticeable negative impact on the size of the collections per case and overall MCCR collections.

Lastly, supplemental insurance carriers are changing their payment practices that are also resulting in lower average inpatient payments per claim. This can be best illustrated when the care categories are examined separately. For example, MCCR third party recoveries per case for inpatients declined 17 percent while the usually lower valued outpatient recoveries increased 4 percent. Likewise, means test and pharmacy co-payments increased 20 and 11 percent, respectively. On the other hand, nursing home and hospital per diems, which tend to yield higher payments, declined 12 percent from FY 1996.

General Goal 7: Reduce benefit delivery costs and improve productivity

During FY 1997, VA launched several initiatives to ensure the best value for the available taxpayers dollars. For example, VA's insurance program, with the assistance of a contractor, performed an Activity Based Costing (ABC) study of insurance processes and the costs associated with those processes. The ABC project is providing meaningful data which is an invaluable aid in identifying opportunities for cost control and service improvement.

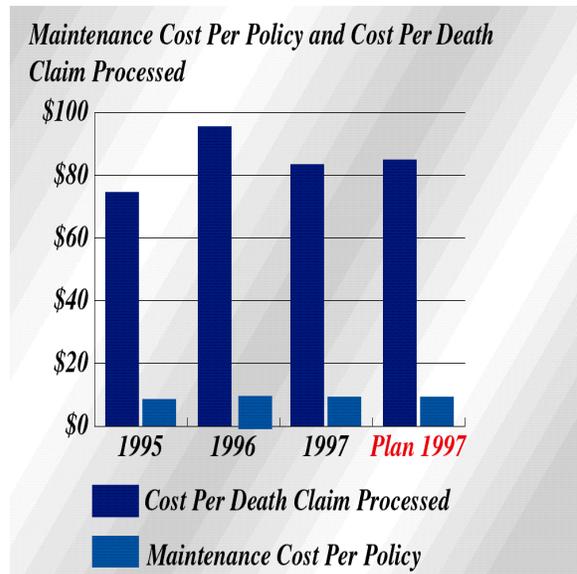
Objective 7.1: Reduce the administrative costs of benefits programs

For years, VA has directly serviced a portfolio that consists primarily of direct and refunded home loans to veterans and “vendee” loans made to finance the sale of acquired properties. In FY 1997, VA contracted with a private sector company to assume this function. The contract resulted in an estimated reduction of 170 FTE and will reduce the administrative unit cost of servicing those loans.

<i>VBA Loan Guaranty Productivity</i>	<i>Cost Per Loan Guaranty Issued</i>	<i>Property Inventory Level</i>	<i>Foreclosure Avoidance Ratio</i>
<i>1993</i>	<i>N/A</i>	<i>11,273</i>	<i>N/A</i>
<i>1994</i>	<i>N/A</i>	<i>10,973</i>	<i>33.1</i>
<i>1995</i>	<i>\$147</i>	<i>9,319</i>	<i>37.3</i>
<i>1996</i>	<i>\$106</i>	<i>8,624</i>	<i>42.8</i>
<i>Actual 1997</i>	<i>\$291</i>	<i>9,484</i>	<i>41.1</i>
<i>Plan 1997</i>	<i>\$248</i>	<i>10,480</i>	<i>39.0</i>

The cost per loan guaranty issued is tied closely to the number of guaranties issued. VA has certain fixed costs in operating the program that are incurred regardless of the workload. For example, VA must maintain relations with over 4,000 different lenders whether the volume is 600,000 loans or 150,000 loans. Since loan volume was lower than expected in FY 1997, administrative unit cost was slightly higher than expected.

Property inventory is the number of properties acquired by VA but not yet sold. The longer VA holds the property in inventory, the more it costs VA in taxes, property maintenance, and foregone interest. On average, it should take six months or less to sell VA-acquired properties, which includes time for eviction, analysis of the property, performing repairs, listing the property for sale, accepting an offer, and closing the sale. As a result of continued efforts by VA staff to sell acquired properties in a timely manner, VA’s end-of-year property inventory was nearly 1,000 units below the planned level.



VA measures its success in assisting veterans who are facing foreclosure with the Foreclosure Avoidance Through Servicing (FATS) ratio. This ratio identifies the extent to which foreclosures would have been greater had VA not pursued alternatives to foreclosure. The costs to the government are reduced when VA is able to pursue an alternative to foreclosure. Veterans are helped by either saving their home or avoiding

the expense and damage to their credit rating caused by a foreclosure. Despite downsizing and restructuring, the decrease in the FATS ratio from the FY 1996 level was not as great as was expected. Hard work by VA's loan service representatives and increased reliance on loan servicers to assist VA in finding alternatives to foreclosure helped the Department obtain a FATS ratio of 41.1 to surpass its FY 1997 target level.

During FY 1997, the Department expanded a program in which the second inscription is added in situ (i.e., at the gravesite) to the currently existing headstone following the death and interment of a subsequent family member. Thirty-eight national cemeteries now have this capability. The Second Inscription Program not only improved service to veterans and their families, but also yielded significant cost savings to VA in terms of acquisition and transportation costs associated with replacing the original headstone. A major milestone was achieved in August 1997 when the cost savings realized by the Second Inscription Program passed the \$1 million mark.



Objective 7.2: Achieve 2 percent annual improvements in productivity of appeals processing

One of VA's productivity measures is the number of claims appeals decided per FTE. The Board of Veterans' Appeals processed 88.1 appeals per FTE during FY 1997, an increase of 22 percent over the FY 1996 productivity rate.

Objective 7.3: Maintain a modest annual increase in cost per BVA appeals case

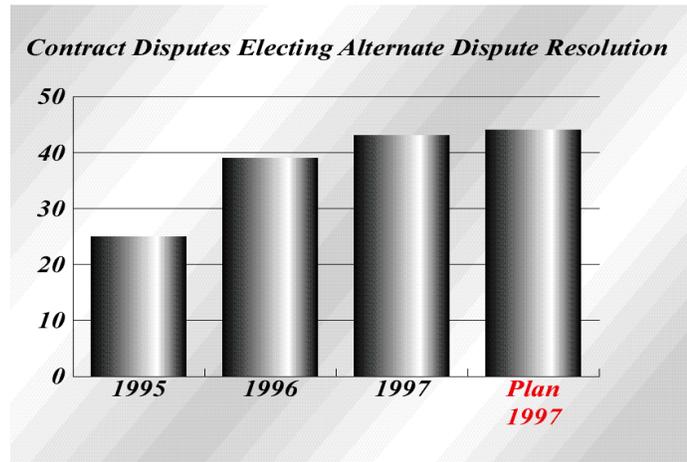
VA has decreased the cost per appeals case from \$950 in FY 1996 to \$839 in FY 1997. This 12 percent reduction was the direct result of the Board of Veterans' Appeals processing more cases than expected. The cost is determined by dividing the Board's total budget by the total number of cases processed.

General Goal 8: Conserve VA resources by increasing the use of Alternate Dispute Resolution (ADR) techniques

The Department's Board of Contract Appeals provides due process for the resolution of disputes between contractors and the Government by deciding appeals from decisions of contracting officers relating to construction, supply, and service contracts made with VA. Also, as VA's Dispute Resolution Specialist, the Board of Contract Appeals is responsible for promoting the appropriate use of ADR throughout the Department.

Objective 8.1: To resolve disputes, e.g., contracts with private sector providers, labor-management and discrimination, more quickly and at less cost, VA will promote and facilitate the use of ADR techniques

The Board of Contract Appeals' workload is volatile and dependent on such external factors as the number of disputes arising from contracting activity, the contractor's election of a forum, and the parties' willingness to use ADR techniques to resolve contract disputes.



The following crosswalk table summarizes all performance measures and associated data covered in the Accountability Report for each of the Department's lines of business. It includes a page reference showing where in the report each measure is presented or discussed. A definition of each performance measure is also provided.