Veterans Health Administration

Mission

The mission of the Veterans Health Administration (VHA) is to develop, maintain, and operate a national healthcare delivery system that:

- Ensures timely, quality medical care for eligible veterans;
- Increases the quality and delivery of healthcare through the education and training of medical, dental, and allied health professionals;
- Encourages and supports medical research that benefits healthcare delivery and quality of life improvements; and
- Serves as the primary healthcare backup system to the Department of Defense in the event of war or national emergency.

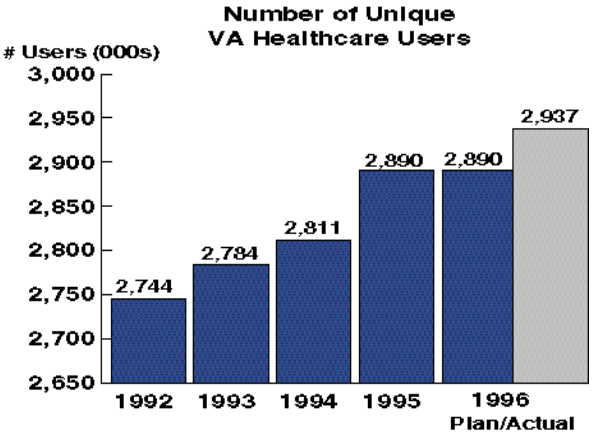
Vision

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

> *"Healthcare value begins with VA..."*
>
> Kenneth W. Kizer, MD, MPH
> *"Prescription for Change"*
> *March 1996*

Scope of VHA Activity

VHA operates the largest healthcare delivery system in the United States. It employs over 190,000 people with a budget that exceeds $17 billion. In FY 1996, VHA provided healthcare services to over 2.9 million unique users, a number that has been slowly but steadily rising for the past several years.



During FY 1996, there were 621,495 acute hospital, 18,625 rehabilitative, 177,287 psychiatric, and 32,691 subacute care patients treated in VA and non-VA facilities. Also in FY 1996, 110,426 veterans were admitted for long-term care in VA and non-VA nursing homes and residential domiciliaries. VA provided approximately 30 million outpatient visits, over 2 million prostheses and sensory aids, and 5.8 million radiology studies.

Historically, VA patients have been primarily men. As a group, VHA is treating patients that are older, sicker, poorer, and more likely to have social problems and mental illness than persons using private healthcare facilities. VA is continuing to strive to improve and expand the services provided to women veterans. During FY 1996, nearly 108,000 women sought outpatient care and almost 16,000 sought inpatient care at VA facilities.

VHA operates 173 hospitals, 398 ambulatory

care facilities, 133 nursing homes, 40 domiciliaries, and 205 readjustment counseling centers, commonly called "Vet Centers." In addition to providing medical care, VA is the nation's largest trainer of healthcare professionals. Through its affiliations with 105 medical schools and academic hospitals as well as other research institutions, VHA continues to be a major national research asset conducting basic, clinical, epidemiological, and behavioral studies across the entire spectrum of scientific disciplines. VHA further serves as emergency backup to the Department of Defense medical services and, during national emergencies, supports the National Disaster Medical System.

Performance Management System

Major organizational and functional restructuring of VA's entire healthcare system occurred during FY 1996. The organization has been flattened and decision making moved from the headquarters to the field. A major realignment from four highly centralized regions to 22 decentralized VISNs (Veterans Integrated Service Networks) has been completed. Key personnel have been hired, and work on local strategic plans is well underway. Organizational goals have been developed based on the Under Secretary's vision, and an initial set of performance measures linked to these goals has been established. Additionally, for the first time, performance agreements were made between the Under Secretary for Health and his senior managers linking individual success to organizational success. Results of those measures contained in the performance agreements as well as other organizational measures are provided below.

Organizational Goals

When the Under Secretary for Health published his vision for the VA healthcare system, he listed five organizational goals that reflect that vision:

- Provide excellence in healthcare value;
- Provide excellence in service as defined by veterans;
- Provide excellence in education and research;
- Be an organization that is characterized by exceptional accountability; and
- Be an employer of choice.

A comprehensive performance measurement and monitoring system is being developed that tracks the organization's success in achieving these goals.

Medical Care

Performance Agreement

In FY 1996, the Under Secretary for Health signed formal performance agreements with senior field (Network directors) and headquarters' managers. These agreements contained various qualifying and incentive measures that were used to gauge individual performance and, when viewed collectively, the performance of the organization as a whole. Nine qualifying measures were developed to emphasize the implementation of structural activities and processes necessary for organizational development of the 22 Networks for FY 1996. Six incentive measures were developed to gauge Network and overall organizational progress toward achieving the objective of moving toward an outpatient and primary care focus.

Corporate priorities dictated that the qualifying and incentive performance measures address the first organizational goal—provide excellence in healthcare value. Healthcare value is defined as balanced performance in the following five domains of value:

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

Cost/Price represents VHA's determination to get at the real costs of providing healthcare to veterans. *Customer satisfaction* represents the views of customers about their care. *Functional status* represents the ability of patients to perform usual and accustomed activities after medical interventions. *Technical quality* represents the exactness and appropriateness of the entire spectrum of medical interventions used to treat veterans. *Access* represents the time, distance, and level of difficulty in obtaining medical care. The ideal situation is one where a highly satisfied patient has an excellent quality outcome with a high functional status at an easy to get to location at the lowest possible cost. One does not always achieve the ideal; nonetheless, the program goal of providing excellence in healthcare value calls for VHA to aim for the ideal where the domains of value exist in a complementary state of equilibrium.

Qualifying Performance Measures

A summary of the qualifying measures established early in FY 1996 for each Network and the domain of value to which they most closely pertain is provided below:

Hiring

By June 30, 1996, all Network key personnel will be hired and management support and stakeholder involvement structures such as the Management Assistance Council and Executive Leadership Council will be operational. (Customer Satisfaction)

Strategic Planning

By September 30, 1996, all Networks will develop strategic and tactical plans. (Although all 22 Networks began the detailed planning effort during FY 1996, as the preliminary results of the measure were monitored and reviewed, it became evident that it was necessary to modify the completion date of the measure to December 31, 1996, in order to achieve a meaningful result.)

Telephone Liaison Program

All Network facilities will have implemented a telephone liaison or call center program by September 30, 1996. (Access)

Temporary Lodging

All Network acute care facilities will have temporary lodging capacity to accommodate ten patients by September 30, 1996. (Cost/Price)

Admission and Discharge Planning Program

All Network inpatient facilities will have admission and discharge planning programs in place by September 30, 1996. (Technical Quality)

Utilization Review

Each Network will have a Network-wide utilization review policy and program in place by September 30, 1996. (Cost/Price)

Clinical Guidelines

By September 30, 1996, each Network will implement five nationally developed guidelines. (Technical Quality)

Functional Assessment of Spinal Cord Injury Patients

100 percent of spinal cord injury patients undergoing initial rehabilitation will be monitored with an appropriate functional outcome measure. (Functional Status)

Prosthetic Orders

By September 30, 1996, the number of prosthetic orders taking greater than five days to be placed will be less than two percent at all facilities in each Network. (Customer Satisfaction)

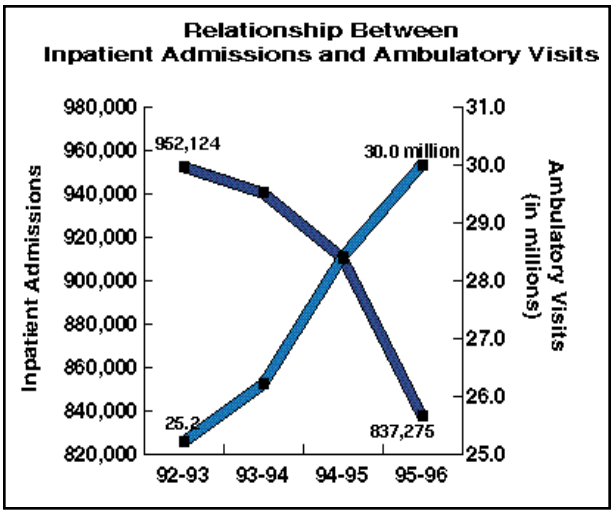
Performance Summary

All but one Network fully achieved the objectives outlined in these qualifying measures.

Incentive Performance Measures

There were several incentive measures designed to achieve the objective of shifting

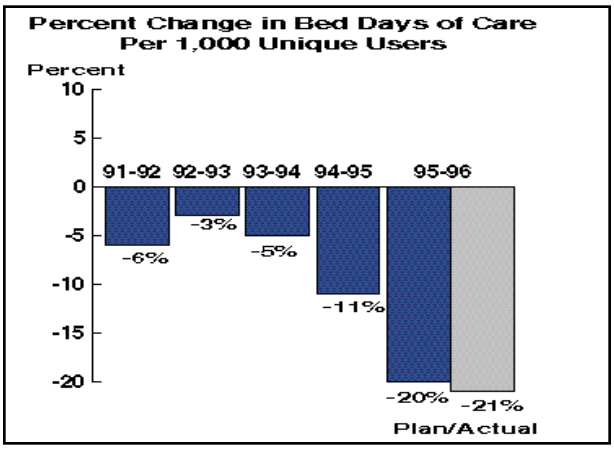
VHA from an inpatient-driven healthcare delivery system to one that is outpatient and primary care focused. This shift is illustrated in the following graph.



In summary, VHA achieved the following during FY 1996: significant declines in the number of bed days of care per 1,000 unique users of the healthcare system; greater use of the ambulatory care setting for appropriate surgical and invasive diagnostic procedures; improved patient satisfaction with inpatient care and outpatient services; increased primary care enrollment; and reductions in clinic waiting times.

The General Accounting Office (GAO) has reviewed various aspects of VHA's ambulatory care program and has recommended use of existing and improved databases to monitor access. Existing databases were used to compile performance data included in this report, and VHA is exploring additional enhancements which will be incorporated in FY 1997. GAO also recommended use of time and distance standards in determining the need for additional access points, and appropriate guidelines have been developed and published.

Decrease the Bed Days of Care per 1,000 Unique Users by 20 Percent.



Nationally, the number of bed days of care per 1,000 unique users of acute care facilities came to 2,525 in FY 1996, a figure some 21 percent below the value of 3,183 for the previous fiscal year. This proportionate change bettered the performance objective of a 20 percent decrease in this measure. Until more refined unit cost measures are identified and developed, VHA is using this measure as one of its proxies for the efficiency of its healthcare delivery system.

A total of 13 of the 22 Networks achieved proportionate reductions in the number of bed days of care per 1,000 unique users of 20 percent or more. Three of the Networks registered 29 percent decreases in this measure from FY 1995 to FY 1996. Even those that did not achieve at least a 20 percent reduction still recorded statistically significant improvements.

Increase the Percent of Appropriate Surgical and Invasive Diagnostic Procedures Performed on an Ambulatory Basis to 50 Percent by September 1996.

Another proxy measure of the cost/efficiency of VA healthcare operations is the percent of all appropriate surgical and invasive diagnostic procedures that are performed in an ambulatory care setting. VHA's performance objective was for this measure to reach 50 percent

or more by the end of FY 1996. Not only was this objective bettered at the national level, but 14 of the 22 Networks also recorded values of at least 50 percent. One of the Networks performed 65 percent of its appropriate surgical and invasive diagnostics procedures on an ambulatory basis.

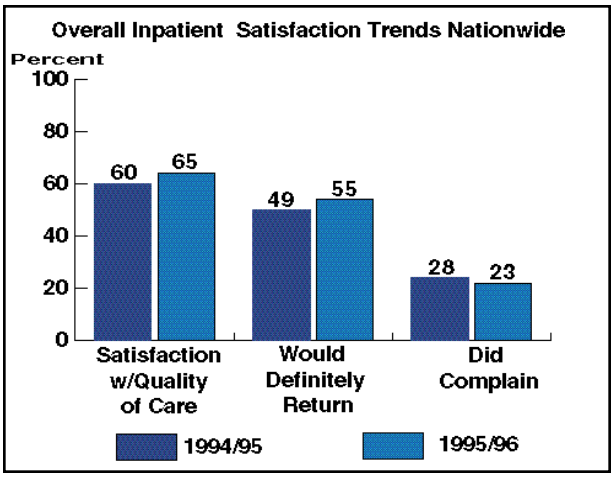
Ambulatory Surgical/Invasive Diagnostic Procedures as Percent of Total

	Ambulatory Procedures % of Total	Total Procedures	Ambulatory Procedures
1994	35	52,100	18,300
1995	39	49,700	19,200
1996 Plan	50	N/A	N/A
1996 Actual	52	50,200	26,200

Improve at Least One Customer Satisfaction Standard Score by 15 Percent.

VA measures customer satisfaction with the healthcare services it provides through three different vehicles—inpatient, outpatient, and long-term care survey questionnaires. While the long-term care survey is still under development, information has been gathered on both inpatient and outpatient satisfaction.

During FY 1995 and FY 1996, VA conducted the second in a series of surveys to gather information on the level of satisfaction expressed by users of inpatient healthcare services. There were a number of questions dealing with patients' overall impressions of the care they received. Among these were patients' satisfaction with the quality of care they received at the hospital, information on whether or not patients would choose to be hospitalized at a VA hospital again even if they could receive free care elsewhere, and whether or not inpatients ever complained to anyone about the care they received. The results from the most recent survey of inpatients revealed that satisfaction increased on all three of these measures relative to the satisfaction scores derived from the first inpatient survey.



Feedback was also obtained from patients on a variety of different customer service areas—preferences for care; emotional support; patient education; coordination of care; physical comfort; family participation; continuity of care; transition; access; and staff courtesy. When compared to the results of the initial inpatient survey, the second survey showed that significant improvements were made in all of the inpatient customer service standards. The lowest problem rates were found in the area of physical comfort which, for example, indicates how long it took for a patient's call button to be answered or pain medicine to be given after requested, and in staff courtesy, which indicates whether the patient felt the staff treated him/her with courtesy and dignity. The highest problem rates were reported in emotional support which indicates how the doctor/nurse handled concerns, anxieties, and/or fears the patient had about his/her condition or treatment, and patient education which deals with, for example, how a patient felt test results were explained or important questions answered by doctors/nurses.

VHA has also conducted two outpatient customer satisfaction surveys which, like the inpatient surveys, yield information on a variety of different customer service areas. VHA's performance objective for FY 1996 was that each Network would improve their performance by 15 percent or more on at least one

of the customer service standards. VHA bettered this objective, as all of the Networks improved their performance by 15 percent or more in at least two of the customer service standards. The most significant improvements at the national level were obtained in the areas of coordination of care, continuity of care, and staff courtesy.

Increase Primary Care Enrollment to 65 Percent of All Patients.

Primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. As one measure of the quality of VA healthcare services, a performance objective was set that at least 65 percent of all patients would be enrolled in primary care by the end of FY 1996. Information on this measure was derived from the outpatient survey in which patients were asked "Is there one person or team in charge of your care?" Nationally, 72 percent of all VA patients were enrolled in primary care by the end of FY 1996, a figure well above the target level of performance and noticeably above the FY 1995 figure of 66 percent. Only one of the 22 Networks failed to meet the 65 percent performance objective.

Increase Sufficiency of Compensation and Pension Exams to 97 Percent.

Another measure of the quality of healthcare services provided 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 by the Veterans Benefits Administration. This measure is also an important indicator of the extent to which the two major operational elements of the Department are working in concert to provide high quality service to its veteran customers.

VHA set an FY 1996 objective of ensuring that at least 97 percent of all C&P exams were carried out in a manner that was sufficient for claims rating purposes. Nationwide, this performance objective was reached, although nearly half of the 22 Networks fell somewhat short of the 97 percent threshold.

Decrease Wait in Days for Clinic Appointments to Within 30 Days.

One of the critical measures of the extent to which VHA provides sufficient access to its healthcare services is the number of days patients have to wait for primary care and specialty care appointments. Primary care includes visits to general medicine, primary care, or women's clinics, while specialty care includes mental health, prosthetics, physical medicine and rehabilitation, spinal cord injury, general surgery, and a wide range of other clinic specialties. The FY 1996 performance objective was to ensure that waiting times did not exceed 30 days. This was the first year in which this type of information was systematically collected throughout the healthcare system.

VHA far exceeded its performance objective on waiting times during FY 1996. At the national level, the average median waiting time was just 5 days for specialty clinics and only 10 days for primary care clinics. At the Network level, the longest waiting time for a specialty care appointment was 7 days while for primary care the longest wait was 21 days.

Oversight Reviews

Material Weaknesses

Two material weaknesses have been identified by the IG concerning pharmaceuticals. Corrective action has not been completed; therefore, they will be carried over into FY 1997. Corrective action for one of these involving controls over prescriptions for patients treated at more than one VA facility had actually been completed when the Under

Secretary added a requirement. There are legitimate cases where a veteran who has a prescription written at one facility needs to have it filled at a different facility, and the Under Secretary wanted to have that capability built into the system. Such a capability requires computer software enhancements that will provide VA facilities with real time prescription information from multiple facilities. VHA expects that the installation of new software scheduled for FY 1997 will remove this material weakness.

A second weakness involves controls over addictive drugs. Recommended changes to VA manuals regarding the narcotics inspection program were completed. Radio frequency equipment used to track administration of narcotics on inpatient wards has been distributed to facilities in the first of four annual phases with subsequent installations scheduled for FY 1997-FY 1999.

General Accounting Office (GAO)

GAO recommended that malpractice claims data be made available to VA medical facilities as a source for improvement activity, and VHA has advised facilities through its quality management activities. In addition, a Risk Management Task Force is evaluating the issue of tort claims with a view toward further refinements. Another GAO review addressed the issue of equitable funding for VA medical facilities, and VHA has been addressing recommended actions through a system of capitated funding, decentralized operational management, and performance-based oversight. A review of the Readjustment Counseling Program has resulted in actions taken to improve documentation of care and demonstrating cost effectiveness. Software enhancements are underway to upgrade reporting mechanisms. A review of the efficiency of service delivery resulted in implementation of 100 percent pre-admission review using data provided by external reviewers. VHA welcomes external reviewers of its operations and will continue to be responsive to their recommendations.

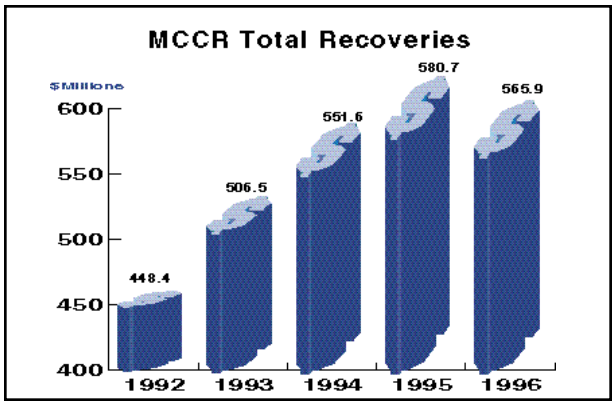
Medical Care Cost Recovery

Mission

To maximize the recovery of funds due VA for the provision of healthcare services to veterans, dependents and others using the VA system.

MCCR fulfills its mission by: (1) submitting claims to veterans' third party insurance carriers for treatment of nonservice-connected conditions; (2) collecting copayments from certain veterans for the treatment of nonservice-connected conditions; and (3) collecting copayments for medications. Improvements continue to be made in identifying patients with medical insurance through the preregistration process developed in the MCCR process reengineering pilot.

MCCR's overall collections for FY 1996 were $565.9 million, ending five years of increasing recoveries. During FY 1996, MCCR's third party recoveries fell while the other categories grew slightly, but not enough to offset the decrease in third party collections. MCCR is facing new challenges in the insurance industry and is seeking ways to regain its leadership position. In areas that hold potential for increasing collections, MCCR is currently working on a number of projects designed to make MCCR processes more efficient: Consolidation Copayment Processing; Electronic Funds Transfer; Electronic Data Interchange; Decentralized Hospital Computer Program Enhancements; as well as utilizing contract opportunities in certain circumstances and improving claims submitted to Medicare Supplemental insurers.



The data below demonstrate the types of performance measures the MCCR program uses to monitor its progress. These measures are maintained to provide a historical perspective; however, additional measures are being developed that are less sensitive to uncontrollable changes in the insurance industry. MCCR was affected by VHA's continued shift from delivering care in an inpatient setting to an ambulatory care setting because potential bills are for smaller amounts. Also, changes in payment practices by third party insurance companies affected the amount of money that was recovered. To measure overall program efficiency, MCCR uses as its baseline a ratio of recovery to cost not to exceed an average of 20 percent. In FY 1996, Cost to Operate was 21 percent, which is due to a lower amount collected from third party insurers as well as the additional costs of implementing the Automated Information Collection System (AICS). Through the AICS initiative, VHA will be able to capture more complete data on ambulatory care encounters and services for billing purposes.

Summary of MCCR Performance Measures

	Cost to Operate	Performance to Recovery Goal	%Recovery Increase Prior Year	Collections per FTE	Average Personal Services Cost per FTE
1992	16.9%	83%	68%	$274,083	$32,984
1993	18.2%	77%	13%	$245,153	$34,835
1994	17.4%	95%	8%	$256,668	$35,891
1995	17.6%	99%	5%	$257,633	$36,859
1996 Plan	17.1%	100%	12%	$287,315	$38,420
1996 Actual*	21.0%	87%	-3%	$249,414	$38,532

* Includes cost for Automated Information Collection System

The MCCR program is initiating several efforts to improve its third party outpatient collections. Several factors currently impact outpatient collections levels, including the labor-intensive aspects of the outpatient billing process, the lower collection potential for outpatient visits when compared to inpatient workload, and the natural inclination of medical center MCCR managers to concentrate resources on the inpatient side of the billing and collecting process. Therefore, MCCR is developing systems that will allow MCCR to generate higher quality bills that foster a greater reimbursement response from third party insurers.

During FY 1996, GAO reviewed copayments for medication and recommended that facilities apply the statutory income limitations. Administrative procedures and software are being developed and will be implemented in FY 1997.

Education

VA's mandate to assist in the training of health professionals is twofold. Educating and training of medical, dental, nursing, and associated health professions students, residents, and fellows support both VA and national workforce needs. Recent efforts have been directed toward increasing primary care training.

Each year, over 106,000 medical and other students receive some or all of their clinical training in VA facilities through affiliations with over 1,000 educational institutions. Only about 23,000 of these individuals receive funding from VA. The education mission of VA, *"...to train for VA and the nation,"* is realized through the participation of VA in training for these and the other 83,000 learners who rotate through our hospitals each year without remuneration. More than 32,000 medical residents and 20,000 medical students receive some of their training in VHA facilities every year. VHA is also affiliated with

many of the nation's schools of dentistry, optometry, and podiatry and supports residencies in these professions. Together these activities directly support the patient care mission of VA and assist in training health manpower for the nation and in recruitment and retention of VHA medical staff. Current efforts are being directed toward increasing primary care training.

VHA also contributes significantly to education and training in more than 40 different associated health professions. Each year, an average of 54,000 students at the graduate and undergraduate level receive all or part of their clinical experience at VHA facilities. The great majority of associated health students (95 percent) participate on a without compensation (WOC) basis. VHA provides funding support to over 2,500 advanced trainees who contributed to patient care during their training in 29 program areas such as Audiology/Speech Pathology, Blind Rehabilitation, Dietetics, Nursing, Occupational Therapy, Pharmacy, Psychology, and Social Work. Affiliated education programs also include areas of specific importance to VHA such as primary care, substance abuse, post-traumatic stress disorder, geriatrics, interdisciplinary team training, and research.

Increase Primary Care Training

Health Professions Education (Physicians, Residents and Associated Health Trainees)

	Individuals Rotating through VA	Individuals Receiving VA Funding	Total Primary Care Funded Positions
1993	104,964	23,492	2,943
1994	108,515	24,864	2,926
1995	108,703	25,710	3,355
1996 Plan	108,703	N/A	3,577
1996 Actual	106,913	23,250	4,188

One factor influencing the larger proportion of primary care residents is the increased investment by VHA in the provision of primary care training. This has been accomplished through a reallocation of existing funds from specialty training and reflects changes in healthcare delivery patterns in VHA and across the nation. Traditionally, the VHA healthcare system provided mainly episodic, illness-based, inpatient hospital care. The future of VHA healthcare lies in the provision of preventive and outpatient, team-based care.

The Primary Care Education Program (PRIME) was created in FY 1994 by the Office of Academic Affairs (now Office of Academic Affiliations) to fund trainee awards to those facilities demonstrating provision of primary and managed care to a population of veterans using a multidisciplinary team approach. As a result of PRIME, the share of medical residents trained in primary care has increased from 34 percent in FY 1993 to 39 percent in FY 1996.

Percent of All Medical Residents Who are Trained in Primary Care

	Total Medical Residents	% of Medical Residents Trained in Primary Care
1992	8,690	33.6
1993	8,632	33.7
1994	8,511	34.0
1995	8,826	37.5
1996	8,910	38.5

In FY 1996, the Under Secretary for Health appointed a Residency Realignment Review Committee to advise on realignment of VHA's medical residency programs to ensure that VHA graduate medical education meets present and future healthcare needs of VA and the nation. By the year 2001, VHA will make a shift of 1,000 specialty resident positions, 250 positions will be eliminated, and 750 will be filled as primary care positions. The first phase of implementation will be Academic

Year 1997-1998 which begins July 1997. This realignment of VHA's graduate medical education portfolio will continue the progress that VHA has made towards training a greater proportion of generalist physicians while protecting specialties that are particularly germane to special VHA programs.

Research

Mission

Discover knowledge and create innovations to improve the health and care of veterans and the nation.

Program Goals

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

Summary of Performance Measures

	Total Ongoing Projects Funded	Total New Projects Funded	% Projects Receiving Extramural Funding	% Funds from Extramural Sources
1992	2,142	245	52%	54%
1993	2,003	172	56%	55%
1994	1,870	261	58%	54%
1995	1,771	334	58%	54%
1996 Plan	1,743	131	61%	59%
1996 Actual	1,666	192	57%	59%

The above table presents information on current trends within the research area; these numbers are driven by the annual budget. In FY 1996, the Research budget was $257 million. Because the size of the projects varies from small investigator-initiated projects ($100,000 maximum) to large multi-site projects (several millions of dollars), the number of projects funded does not fully describe the performance of the research program. As ongoing projects were scheduled for competitive renewal, funds were diverted to new projects in areas of higher priority, ie., "designated research areas." This resulted in a larger number of new projects actually funded than were planned in FY 1996.

During FY 1996, the Research Realignment Advisory Committee, a federally chartered advisory committee established by the Under Secretary for Health, published its final report. This report provides useful information in formulating strategic plans required by GPRA.

Based on VHA's "Prescription for Change" and the advisory committee's recommendations, the Research program has developed new performance measures that, when taken together with the historical trend data, provide a better understanding of the program's overall performance. While these measures were identified in FY 1996, no data will be available until FY 1997.

The percentage of proposals in Designated Research Areas (DRA), which were identified by the Research Realignment Committee, and the number of investigators receiving funding from VA or non-VA sources have been added to help show how the VHA's research program is responsive to the needs of VA and that its infrastructure is sound. DRAs are selected according to their importance to the mission of VA and the prevalence of the disease to be studied among veterans seeking assistance from VHA. Research will also monitor the number of collaborative agreements with other government or private sector organizations which will identify whether or not VHA

is meeting its objective of expanding its collaborative investigative efforts with government and non-government entities.

Future measures will also focus on addressing other program objectives, including capitalizing on the special research opportunities available to VA, increasing the awareness and understanding of VHA's role in healthcare education and research, and demonstrating the quick operationalizing of VA-sponsored and VA-conducted research into VA policies and procedures.