

PRESCRIPTION FOR CHANGE

The Guiding Principles and Strategic Objectives
Underlying the Transformation of the
Veterans Healthcare System

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Preface

In October 1995, the Veterans Health Administration (VHA) restructured both its field and headquarters operations. This reorganization was a major step in operationalizing a new vision of the nation's largest integrated healthcare system.

The VA's new vision and the strategic principles upon which it is based have been articulated in a variety of publications, presentations and other forums since VHA began to reinvent itself in late 1994; however, they have not been collated in one single source. This document attempts to do this, as well as to provide a status report on many action items being pursued to accomplish this prescription for change.

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

***“Our business is healthcare, not
hospital care.”***

*Kenneth W. Kizer, M.D., M.P.H.
Speech to VHA Headquarters Staff
March 22, 1995*

The Mission of the “New VA”

The Environment

In the coming years, the veterans healthcare system will be buffeted by powerful societal and industrywide dynamics. These “environmental” factors will influence the manner in which VHA accomplishes its mission, and they provide the context in which it must operate.

Assumptions made when envisioning the future of the veterans healthcare system include the following:

- The role of the federal government in American society will continue to be re-evaluated, and competition for federal government funding will become even more intense than it is now.
- Most healthcare in the U.S. will continue to be provided by the private sector.
- There will continue to be marked turmoil among and consolidation of medical groups, hospitals, health maintenance organizations and other elements of the private sector.
- Managed care within integrated delivery systems will become the most common mode of healthcare delivery in the United States.
- Medical and scientific information will continue to grow at an astonishing rate, and the next decade will likely see major biomedical breakthroughs for many disorders not now having effective therapy.
- Technological innovations will continue to revolutionize clinical practice. In addition, the trend of providing care in non-hospital settings will continue, and even accelerate, as concern about healthcare costs continues and as new medical devices and

pharmaceutical products allow even more medical care to be safely and effectively provided at home or in ambulatory settings.

- Advances in information and communications technology, and imaging systems in particular, will open many new opportunities for improving the delivery of healthcare.

- Integrated information systems will be the key to success for future healthcare systems.

- Non-physician caregivers will be increasingly used in healthcare systems of the future.

- Delivery of care will become more “cafeteria style” as the continuum of services is provided in ever more settings.

- Healthcare systems will be increasingly expected to prevent disease and promote community wellness, in addition to treating individual cases of illness.

- There will be increased demand for accountability in healthcare and increased emphasis on healthcare outcomes and measurements.

- While the rate of increase of healthcare costs has diminished in recent years, healthcare costs will continue to be the major driving force in the industry. Nonetheless, quality of care and customer service will become more important issues.

- The veteran population eligible for care at VA facilities will continue to age and decrease at about the same rate as in recent years. However, the need for both acute and long term care services for this aging population will rise disproportionately to the decrease in users for several years due to the greater healthcare needs associated with aging.

- In addition to the “macro” issues, there will be myriad local and regional dynamics impacting individual facilities and networks.

Finally, in envisioning the veterans healthcare system of the 21st century, it is assumed that the future is unpredictable and that VA must be flexible enough to rapidly respond to unforeseen circumstances.

Mission and Vision of the “New VA”

In brief, the mission of the veterans healthcare system is to serve the needs of America’s veterans. It does this by providing specialized care for service-connected veterans, primary care, and related medical and social support services.

To accomplish its mission, VHA needs to be a comprehensive, integrated healthcare system that provides excellence in healthcare value, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability and by being an employer of choice (figure 1).

Figure 1. The Mission of the New VA

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

To guide this mission, a new VHA vision statement has been adopted (figure 2) and key guiding principles and strategic objectives have been identified. These principles and objectives underlie many policy and program changes or enabling actions that either have been initiated, are planned or are being sought with authorizing legislation or budget action.

Figure 2. VHA Vision Statement

Healthcare Value begins with VA . . .

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

In considering these guiding principles and strategic objectives, it is important to remember their overarching nature. The principles are interrelated, and in most cases the actions needed to accomplish the objectives have multiple interconnections and feedback effects on each other. Indeed, conceptually, they constitute a policy and performance “web” instead of the more linear relationship typically found between program objectives and performance measures in manufacturing industries.

Notwithstanding their connectivity, for purposes of presentation here, the principles and objectives have been grouped under one of the five mission goals according to their proximate relationship to the goals. Key action items have been allocated to the objectives, although they may impact several objectives.

In reviewing these principles and objectives it will also be useful to keep in mind that for purposes of this document, and in practice, “customers” refers to patients and their families, while other key entities (e.g., Congress, veteran service organizations and academic affiliates) are considered “stakeholders.” In some selected situations, VA caregivers and other elements of the system are considered to be customers because they are reliant upon elements of the organization to provide them with data or services that are, in turn, used in providing patient care.

Further, it should be kept in mind that while the environment in which VA now operates requires that greater attention be given to the financial management of the system, this should not be misinterpreted as a change in focus or a commercialization of VA’s mission. VA will continue to uphold its long tradition of advocating for the sick and vulnerable, and of putting the patient’s welfare first. However, VA has an obligation to ensure that taxpayer monies are well spent and that it is getting the best possible healthcare return on its resources.

To date, perhaps the most tangible sign of the changes underway in the veterans healthcare system is the implementation of the Veterans Integrated Service Network (VISN) management structure with its emphasis on decentralizing day-to-day operations, pooling and aligning resources with local needs, and improving customer service. However, a review of the many awards for innovation and process redesign that VHA has received in the past two years provides solid evidence of the dramatic changes underway throughout the system (see Appendices I and II for a partial compilation of these awards).

The organizational culture changes that are envisioned will take time to fully manifest themselves; however, over the next several years, the “new VA” that emerges will represent one of the most profound transformations of any organization — public or private — in American history.

MISSION GOAL 1

Provide Excellence in Healthcare Value

Guiding Principles

Principle 1. The genesis of the current revolution in American healthcare is a quest for value.

Principle 2. Technological advances, economic concerns and other factors have fundamentally changed the role and nature of the hospital as an institution. While it will continue to provide essential services, the hospital is no longer the center of the healthcare universe. Healthcare has become an ambulatory care-based activity.

Principle 3. Healthcare systems should be both comprehensive and integrated (across inpatient and outpatient settings) in promoting health and treating illness.

Principle 4. Healthcare delivery systems should be structured so that therapeutic interventions are provided when they will have their greatest effectiveness and in a way that promotes efficiency.

Principle 5. While VHA's various statutory missions and its core service population are very different from those of most private managed healthcare companies, as an organized healthcare system VHA could improve its effectiveness and efficiency by selectively adopting or adapting many managed care principles and practices.

Principle 6. The quality of care in VHA must be demonstratively equal to, or better than, what is available in the local community. Comparisons should be made using similar measures or performance indicators and after appropriate risk adjustment for differences in service populations.

Principle 7. Every person and every process in the system should be able to demonstrate how he/she/it adds value to the system and, ultimately, to patient care. This added value should be measurable in clear and understandable terms.

Principle 8. Information systems and strategic alliances are the “bricks and mortar” that will hold healthcare systems together in the future.

Principle 9. The delivery of quality healthcare and its continuous improvement requires a team effort. No single healthcare provider has all the required skills and knowledge to provide for all the healthcare needs of a single patient, nor can any single healthcare organization provide every service needed by all of its users.

Principle 10. The delivery of quality healthcare is critically dependent on organizational systems and structures which minimize the chances for mistakes to occur, improve efficiency, promote accountability and encourage continuous improvement.

Principle 11. All component elements must be in total alignment with the organization’s goals and strategic objectives if it is to be optimally functional.

Principle 12. The effectiveness and efficiency of healthcare can be measured and defined by data.

Strategic Objectives

Objective 1. Re-engineer the operational and management structure of the veterans healthcare system so that it facilitates accomplishment of the vision of the “new VA.”

Action 1. Implement the Veterans Integrated Service Network (VISN) management structure described in Vision for Change.

On March 17, 1995, a proposal, Vision for Change, to restructure VHA’s field operations into VISNs was submitted to Congress. Congress authorized VA to implement the plan on September 5, 1995. The 22 network directors were named on September 21, 1995. Most assumed their new assignments in October and November 1995, and all were on board by January 29, 1996. The transition of operations from the regional offices to the networks commenced in October 1995.

Organizational charts have been approved for all networks. Recruitment for key positions in the network offices (e.g. network clinical manager and network finance officer) is almost completed. As of March 31, 1996, 18 network offices were fully operational. The rest are expected to be operational by May 1996. Executive Leadership Councils and Management Assistance Councils are either operational or being established in all networks. One of the benefits of this restructuring was a \$9.3 million annual recurring savings resulting from the elimination of the regional offices.

Action 2. Restructure VHA headquarters as described in Vision for Change.

Restructuring VHA headquarters also began in October 1995. Restructuring included eliminating certain positions and offices, reorganizing other offices and functions, and establishing new offices of Policy, Planning and Performance; Chief Information Officer; and Employee Education. In addition, the Chief Network Officer became part of the integrated Office of the Under Secretary for Health.

Consequent to budgetary constraints, a 25 percent reduction-in-force (RIF) was undertaken, eliminating 202 positions in headquarters (802 to 600 FTE) and achieving an \$8.7 million savings.

Action 3. Recruit management personnel with skills or expertise needed to operationalize the vision of the “new VA.”

A mix of internal and external expertise is represented in VHA’s new appointments. For example, seven of the 22 network directors were recruited from outside VA. Likewise, a number of the network clinical managers and financial officers have come from outside VA. Several of these individuals have extensive backgrounds in managed care.

The new Chief Information Officer, Chief Policy, Planning and Performance Officer, Chief Patient Care Services Officer, and Medical Inspector were also recruited from outside VA and bring private sector and other experience to their new jobs.

Overall, with this restructuring of VHA comes the largest ever infusion of “outside talent” into VHA’s senior management.

Action 4. Develop staff education and training programs to teach skills needed to operationalize or facilitate accomplishment of the vision of the “new VA.”

Six teams have been formed to implement the education and training recommendations associated with the Vision for Change. These are: customer service, primary care, new employee orientation, network orientation, strategic planning, and marketing research and business planning.

Another set of six teams will focus on how the network of Regional Medical Education Centers and other such resources can help implement the education and training concepts in Vision for Change.

Additional opportunities for specialized training are being explored with management consultant companies, professional organizations, universities and other entities.

These plans are in addition to numerous TQI-related courses that have been taught during the past year, and which will continue to be offered as part of VHA’s quality improvement programs. (See also Objective 4, Action 12, and Objective 18, Action 2.)

Objective 2. Reduce operating costs.

Action 1. Transition the veterans healthcare system from a hospital, bed-based system to an ambulatory care-based system.

VHA, like the private sector, is expanding outpatient care, while inpatient care is declining. In FY 95, VA closed 2,409 hospital beds and in the first two quarters of FY 96, closed another 2,255 beds, leaving the system with a total of 48,521 hospital beds, along with 15,415 nursing home and 6,830 domiciliary beds. Since 1980, VA has closed 34,934 (42 percent) of its hospital beds.

In FY 95, VA increased its outpatient visits by 2.44 million (from 26,496,000 to 28,939,000) or 9.2 percent. This was the largest such annual increase in history. Overall, since 1980, VA has increased its outpatient visits by 10,735,000 (18,204,000 to 28,939,000) per year — a 60 percent increase.

Action 2. Seek legislative relief from statutes that hinder efforts to provide care in the most cost-efficient setting.

The current laws governing eligibility for care in the veterans healthcare system are out of date. They are markedly biased towards inpatient care and are the root cause of many of the inefficiencies in the system.

On September 12, 1995, VA forwarded its eligibility reform proposal to Congress. The House subsequently passed an eligibility reform measure (H.R. 2517, Title 11). The Senate deferred action until 1996. The Senate Veterans Affairs Committee held hearings on eligibility reform in March 1996, and more are scheduled for May.

The major obstacle to enactment of eligibility reform legislation is uncertainty about the costs associated with reforming the present anachronistic statutes. VA believes that the reform it is proposing will not impose any new costs on taxpayers and, in fact, should save money.

Action 3. Increase VA's outpatient capacity to accommodate the workload shifted from inpatient to outpatient settings and to obviate the need for as much inpatient care as possible.

In the past 10 years, VHA has increased the number of outpatient clinics by 66 percent, i.e., from 226 in 1985 to 376 in 1995. In February 1995, VHA issued an "Access Points Policy" trying to make further progress in this area. Congress concurred with establishing 15 new community-based access points in 1995; 58 more have been identified and are now awaiting Congressional concurrence.

Since January 1994, VHA has completed 26 renovation projects, costing \$232.1 million, to facilitate the transfer of inpatient workload to ambulatory care settings.

Action 4. Develop a policy and program infrastructure that fosters high quality, effective and economical care.

Action 4.1. Each network shall develop hospital admission, utilization and length of stay criteria.

VHA implemented a systemwide Utilization Review (UR) Program on October 1, 1993, using standard criteria. The program collects and analyzes national data to assess how patients utilize resources in terms of admissions and days of care in acute medical and surgical beds. Roll-up of national data for April 1994 through September 1995 is underway. In addition, the Office of Quality Management is working with the Ann Arbor Center for Research on Managing Clinical Practice and Outcomes to compile and distribute risk adjusted length of stay information. Ann Arbor will be using additional utilization review data on selected diagnoses to identify improvement opportunities. Alternatives to this system are also being considered.

Action 4.2. Each network and all facilities shall implement pre-admission screening and discharge planning programs.

Action 4.3. Based on network experience, develop a systemwide hospital utilization policy and program.

Action 4.4. Promulgate policies encouraging use of the most cost-effective, therapeutically appropriate care setting.

To date, VHA has published several policies encouraging use of the most cost-effective, therapeutically appropriate care setting. These include “Utilization Review Program” (June 1993); “Implementation of Utilization Management Roll-up IBQ 1.0 software” (November 1995); and “Reduction of Excessive Waiting Time” (July 1995).

Action 4.5. Expand VA’s Hospital Based Home Care Program to include home IV therapy, total parenteral nutrition and other services.

Action 5. Establish primary care as the central focus of patient treatment in both outpatient and inpatient settings.

In non-VA settings, primary care has been shown to have considerable potential to improve both the quality and efficiency of care by improving the coordination of services and continuity of care. In October 1994, VHA issued Directive 10-94-100, “Guidance for the Implementation of Primary Care in VHA,” which requires all VA facilities to implement primary care programs by October 1, 1996.

In October 1995, VHA conducted a survey to determine progress toward implementing primary care in its facilities. The survey showed that 40 percent of patients systemwide had been enrolled in primary care. Future surveys will be used to track VA’s progress in implementing primary care.

Action 6. Expand VHA’s continuum of clinical service settings (i.e., treatment site alternatives) so that patient care can be provided in the most cost-effective setting that is clinically appropriate.

Action 6.1. Expand utilization of noninstitutional long term care when clinically appropriate and financially sound.

In recent years, VHA has spent between 5 and 7 percent of its long term care budget on noninstitutional care. Use of home care, assisted-living facilities, adult day healthcare and other alternatives to nursing home care should be expanded in the future.

Action 6.2. Increase ambulatory surgery and diagnostic procedure capacity and utilization.

In FY 92, the proportion of VA surgical and invasive diagnostic procedures performed on an ambulatory basis was less than 5 percent. A survey in September 1995 indicated that use of ambulatory surgery settings for these procedures had increased to 39 percent. Efforts are underway to further increase the percentage of surgical and diagnostic procedures performed on an ambulatory basis to over 50 percent.

Training sessions have been completed for all Chiefs of Surgery on the National Surgical Quality Improvement Program; these sessions emphasized the need to increase ambulatory surgery.

Of 134 hospitals with surgical capabilities, 107 have implemented the Decentralized Hospital Computer Program (DHCP) surgical package, which will permit tracking of ambulatory surgery. The remainder are in the process of implementing the package. A directive is being developed specifying that all facilities conducting surgery must utilize this surgical informatics package.

A modification of the package is being developed that will allow surgical cases and invasive diagnostic procedures to be tracked separately.

Action 6.3. Support expansion of the state veteran home program.

The state home program provides grants to site state domiciliaries and nursing homes for veterans at very favorable rates because of the state-federal sharing provision. At present, there are 83 state homes in 41 states.

Action 6.4. Increase VA's temporary lodging and residential care capacities to accommodate patients needing housing but not acute hospital care while undergoing diagnostic evaluation or treatment.

A VHA Directive is being developed to provide guidelines for the development of temporary housing capability at every VA hospital. This should be issued in April 1996, although many medical centers are already pursuing this.

Action 7. Implement multi-disciplinary "service line" (aka "product line") clinical care services in recognition of the transdimensional nature of healthcare today.

VHA headquarters has reorganized its Office of Patient Care Services along service lines and has established 10 “Strategic Healthcare Groups” (see Appendix III). Since changing VHA’s policy requiring uniform hospital management structures in March 1995, an increasing number of facilities are submitting clinical reorganization plans to headquarters showing dissolution of discipline-specific services and institution of multidisciplinary service lines.

Action 8. Standardize clinical processes (e.g., with nationally developed clinical guidelines) and delegate clinical care responsibility to non-physician caregivers, when appropriate, through locally developed clinical pathways consistent with achievement of quality outcomes.

Clinical practice guidelines can be used to both measure and improve care. A collaborative effort between the Office of Policy, Planning and Performance and the Office of Patient Care Services has undertaken dissemination of existing clinical practice guidelines. The offices have also initiated an effort to develop a uniform process for development and implementation of clinical practice guidelines in VHA.

Action 9. Implement a “disease management” approach for targeted chronic conditions.

Action 9.1. Identify conditions and clinical cohorts most likely to benefit from a disease management approach.

Disease management has been defined as “a comprehensive, integrated approach to care and reimbursement based on the natural course of a disease, with treatment designed to address the illness by maximizing the effectiveness and efficiency of care delivery. The emphasis is on preventing disease and/or managing it aggressively where intervention will have the greatest impact.”

A multidisciplinary integrated approach is being taken in treating an increasing number of chronic conditions. The Spinal Cord Injury Service has incorporated this approach for years. A national diabetes disease management program has been under development at VAMC East Orange for the past three years. AIDS patients are routinely managed by this method, as are a number of subsets of homeless and addicted populations. A computer

software program for the diagnosis and management of ischemic heart disease is under development at VAMC Denver. The experience and lessons learned from such programs are being collated for application to additional clinical cohorts.

Action 9.2. Develop and provide disease management training, as needed.

National and regional programs in primary care are addressing the disease management approach. Training will follow as the identification and management of specific disease cohorts are developed.

Action 10. Explore ways of improving the accessibility, quality and cost-effectiveness of VA's special emphasis programs.

VA has developed special expertise in a number of conditions that are unique to or especially prevalent among veterans (e.g., spinal cord injury, PTSD and prosthetics). As part of headquarters restructuring, these conditions were specifically designated as "special emphasis programs" for the first time. Specific policy statements and performance measures are being developed for each of the special emphasis programs.

In addition, the productivity, accessibility and quality of these special emphasis programs are the focus of a number of initiatives. Examples of initiatives underway include: publication of "A Mental Health Program Performance Monitoring System," which compares costs and effectiveness of VA mental health programs; a cost-benefit comparison of various PTSD programs; movement of spinal cord injury in headquarters to the primary care strategic health group; issuance of performance standards for access to care for Persian Gulf veterans; and emphasis on clinically appropriate group treatment and expanded hours of operation by Vet Centers. Five of the National Performance Review Hammer Awards received by VHA recognize innovations in the special emphasis programs (Appendix I).

Action 11. Expand use of case management, especially for patients with multisystem disease and for the special emphasis programs.

Case management is being developed and supported throughout the veterans healthcare system. Some specific examples of achievements in this regard include: publication of practice guidelines for case management for social workers in October 1994; funding 49

intensive community care programs for psychiatry; emphasis on case management for VA homeless programs; use of case managers for amputees and patients at risk for limb loss, and traumatic brain injuries; and assignment of Persian Gulf veterans to primary care teams.

Action 12. Increase the proportion of VA's caregiver workforce providing primary care.

VHA has established a working group and is developing a budget-neutral action plan to increase the number of VA non-physician primary care providers by 200 percent over the next two years.

Action 13. Develop tailored training/re-training programs in primary care.

The VAMC Northport Education Center has developed a primary care education and consultative program. Teams have been developed to assist facilities and networks meet the challenges of providing primary care.

The Northport Education Center also has developed primary care educational initiatives in organizational transformation, strategic planning, faculty development, team development, information management, performance measures, patient and family education, and customer service.

At the Birmingham Education Center, regular satellite broadcast programs are produced on selected aspects of primary care.

In addition, the Long Beach Education Center is exploring ways to re-train specialists to provide primary care.

Action 14. Implement user friendly telephone triage and advice programs (i.e., "call in" or "call center" programs) systemwide.

In non-VA settings, telephone advice programs have been found to reduce unscheduled clinic and emergency department use and to improve the timeliness and coordination of care.

A VA Telephone Liaison Care Program was initiated in March 1994. A survey completed in October 1995, showed that 144 facilities had implemented the program as of that date.

Action 15. Revise VA's ambulatory care database to meet national data requirements and to make it comparable to the private sector.

A new Ambulatory Care Data Collection Project has been implemented to switch VHA from using clinic stop codes to Current Procedural Terminology (CPT) codes. The use of industrywide CPT codes for outpatients will allow the direct comparison of VA costs with private sector cost and billing data. Systemwide implementation of the new Ambulatory Care Data Collection Program is planned for October 1996.

Action 16. Reduce the variation in both professional and administrative staffing that exists among facilities and services having similar missions and workloads.

Action 16.1. Develop and implement performance indicators and operating criteria for the allocation of personnel.

Action 16.2. Develop facility, network and systemwide databases on personnel workload and productivity.

Objective 3. Provide improved services through better integration of VHA inpatient and outpatient resources and through increased functioning as a "virtual" organization.

Action 1. Take advantage of the excess hospital inpatient capacity that exists in the private sector and negotiate for bed capacity where needed and cost effective.

Expanded contractual authority is needed to pursue this in many situations.

Action 2. Pursue legislation authorizing contracting flexibility so as to be able to tailor healthcare solutions to local circumstances.

The House Veterans Affairs Committee expanded contracting flexibility as part of its eligibility reform bill (H.R. 2517) in 1995. This bill was not enacted.

Senator Simpson introduced S.1359 in October 1995. This bill would have markedly expanded VA's sharing and contracting authority. VHA supported this bill in a hearing on October 25, 1995. Subsequently, a nearly identical measure, H.R. 2798, was introduced in the House of Representatives. Neither bill was enacted in 1995.

Action 3. Develop strategic partnerships with other government healthcare providers and the private sector.

Action 3.1. Increase VA-DoD sharing activities.

At the beginning of FY 95, 147 VA medical facilities were involved in 605 sharing agreements with 167 DoD facilities; the agreements represented 4,133 shared services.

By January 1996, the number of operating agreements had risen to 665 and the number of shared services to 4,453, a 10 percent increase in agreements and an 8 percent increase in shared services.

Action 3.2. Increase sharing activities with academic affiliates.

A total of 293 scarce medical specialty contracts were in effect in FY 95; most of these were with academic affiliates. In FY 95, 140 new sharing agreements were established for services in diagnostic radiology (e.g., CT and MRI), radiation therapy, anesthesiology, clinical laboratory and organ transplantation; these contracts were valued at \$34.3 million. (See Appendix IV and V for a listing of VA-medical school affiliations and sharing agreements.)

Action 3.3. Seek opportunities for sharing activities with private sector entities when doing so would be cost effective and improve service to VA patients.

In FY 95, 125 VA medical centers reported 449 active sharing agreements with private healthcare providers. (See Appendix VI for a list of sharing agreements with the private sector.) Total sharing of medical resources in FY 95 was valued at \$74.6 million; resources purchased totaled \$56.2 million and resources provided totaled \$18.4 million.

Legislation has been proposed (S.1359/H.R. 2798) to expand the sharing authority to allow VA to buy or sell any healthcare resource from or to any other public or private entity.

Action 4. Develop a VA telemedicine strategic plan.

Telemedicine is expected to play a larger role in VA's future. VHA has initiated recruitment for a Chief of Telemedicine.

At present, VHA is actively working on several collaborative telemedicine efforts, including participation with DoD in an Information Integration and Interoperability Laboratory, the Pacific Medical Network Project and several on-site joint ventures in care delivery. VA has also developed software for DoD's Composite Health Care System radiology picture archiving and communication systems. VHA is working with the Office of Rural Health Policy, Department of Health and Human Services; the National Science Foundation; and the National Telecommunications and Information Administration on using telemedicine to optimize resource utilization.

A task force has surveyed telemedicine activities throughout VHA and conducted a literature search. A report with recommendations was prepared for the Chief Network Officer. Examples of promising initiatives include a telemedicine project at the Seattle Geriatric Research, Education and Clinical Center to evaluate frail elderly patients at remote locations, and three telemedicine networks for nuclear medicine at VAMCs in St. Louis, Ann Arbor, and Cincinnati.

Another noteworthy telemedicine project is a telepathology initiative between VAMCs Milwaukee and Iron Mountain. This represents one of the first uses in this country of a robotic microscope. This innovative project allows pathologists in Milwaukee to interactively read frozen sections and slides at Iron Mountain. The images can be digitized, stored and retrieved as electronic records at Iron Mountain.

Action 5. Restructure institutions or their management, and groupings of facilities to reduce administrative costs and increase the proportion of resources devoted to direct patient care.

Action 5.1. Assist network management to complete implementation of the 18 facility integrations commenced in March 1995.

Formal integration of the management of 18 VA medical centers into eight was initiated in March 1995. Since then, each of the new organizations has been evaluating services and programs across the integration. It may take up to two years to achieve full integration at all these sites. One two-facility integration, VAMCs Palo Alto and Livermore, has been completed.

Action 5.2. Support additional facility management mergers and clinical or support service consolidations, as recommended by network management, where such would produce administrative efficiencies or improve patient care.

Integration of six more VA medical centers was initiated in March 1996. Additional integrations are anticipated to be undertaken in FY 96.

Action 5.3. Promulgate screening criteria for potential further realignment of facilities and programs.

A list of "Criteria for Potential Realignment of VHA Facilities and Programs" was promulgated in September 1995 (see Appendix VII). The "CPR List" provides screening guidelines to evaluate both facility and program realignment possibilities.

Action 5.4. Implement the Dialysis Technical Advisory Group's (TAG) recommendations for cost saving interventions.

Based upon the Dialysis TAG's earlier work, in February 1996, a work group of headquarters, network and field clinicians met to finalize criteria to be used to achieve cost savings in renal dialysis (see Appendix VIII).

Action 5.5. Aggressively seek opportunities to restructure processes so that resources are optimally aligned to provide convenient and responsive patient service.

Work groups are being convened at the network and facility level to identify process improvement opportunities.

Many re-engineered processes have been recognized for their cost savings and innovation by receipt of the National Performance Review's Hammer Award (Appendix I) and the Scissors Award from the Department of Veterans Affairs (Appendix II). In FY 95, VA won more Hammer Awards than any other federal agency.

A number of other re-engineered processes have been recognized by other entities. For example, VAMC Northport's re-engineered ambulatory care program was a semi-finalist in the 1995 Innovations in Government Program sponsored by the Ford Foundation and Harvard University.

Action 5.6. Effect personnel policy changes needed to tailor VA's workforce consequent to facility management integrations, program consolidations, reduced funding, etc.

Authority to conduct reductions-in-force (RIF) actions for Title 5 personnel was delegated to field management on February 2, 1996. Authority to conduct Title 38 staffing adjustments was delegated to field management on March 22, 1996, changing policy that had been in effect since 1947.

Action 6. Each network will develop a strategic plan that will include a one-year tactical plan, a two- to three-year strategic plan, and five-year strategic targets.

Action 7. VHA headquarters will develop a business plan based on input from the networks.

VA's draft strategic and business planning policy includes provisions for a systemwide business plan. To this end, VHA plans to utilize the 22 network business plans as a basis for a systemwide plan.

Objective 4. Promote a VHA culture of ongoing quality improvement that is predicated on providing excellent healthcare value.

Action 1. Continue developing and implementing the existing quality improvement program, utilizing the Baldrige Management System framework, Total Quality Improvement (TQI), Value Engineering and other such constructs to expand and improve the program where needed.

Twenty facility-based quality improvement teams were trained in FY 95. All TQI coordinators and quality managers received Baldrige system orientation in FY 95. In early FY 96, Baldrige educational tapes were distributed to all VA medical centers. Training in use of the Baldrige system as a deployment tool has been offered to all VA medical center directors. Currently, two networks and 10 medical centers are scheduled for training in FY 96. Since 1993, the Quality Management Institute at VAMC Durham, has delivered these cost-efficient courses using distance learning modalities. Additionally, such resources as the SurVAtool and the Data Management Directory have been distributed to all facilities. Other quality improvement instruments and methods (e.g. External Peer Review Program, Quality Improvement Checklist, etc.) will continue to be refined.

In FY 95, both VAMC Albany and the VA Domiciliary in White City won the national Robert W. Carey Award. Carey categorical awards were also received by VAMCs Dayton, Indianapolis, Tuscaloosa and Kansas City. VAMC Dayton was also given the 1995 Dayton Area Quality Excellence Award. Likewise, in 1994, VAMC Iowa City received the Governor's Quality Award, and VAMC Temple received the Central Texas Quality Quorum Quality Recognition Award.

Action 2. Develop and implement performance indicators or operating criteria that measure both effectiveness and efficiency for all VHA programs. The measures should: (1) be tied to the four domains of value, (2) be linked to the vision and strategic principles of the "new VA," (3) use existing databases whenever possible, and (4) be used in management's negotiated performance agreements. (See Figure 3.)

Figure 3. The Four Domains of Value

1. Cost/price

2. *Technical quality*
3. *Customer satisfaction*
4. *Access*

A draft of measurement categories and performance indicators within the domains of value and related to strategic priorities has been developed for use in performance agreements between headquarters and network directors.

Work is progressing in development of performance measures in ambulatory care, mental health and the special emphasis programs.

Action 2.1. Establish provider, service line, facility, network and systemwide benchmarks and performances measures for the four domains of value. Use measures that facilitate VA/non-VA comparisons of performance where possible.

Performance measures for rehabilitation medicine and ischemic heart disease were developed in FY 95. Measures for major depression and ambulatory care are under development this year.

Action 2.2. Develop an easily understood and valid risk adjustment methodology that facilitates comparison of VA, private sector and other service populations.

Risk-adjusted measurement systems have been developed for re-admissions, length of stay, pressure sore development in long term care, surgical morbidity and mortality, psychiatric and substance abuse re-admissions and cardiac surgery.

Appropriate risk-adjustment methodologies for other conditions or clinical cohorts are being developed or sought through private vendors.

Action 2.3. Design a process for national clinical guideline development and revision. Derive performance measures for clinical cohorts from the guidelines.

Using Agency for Health Care Policy and Research (AHCPR) and other guidelines as a core, a process was applied to the implementation of the “rehabilitation of the stroke

patient” and “amputee” guidelines in FY 94 and “ischemic heart disease” guidelines in FY 95. In FY 96, the same process is being used to implement guidelines for major depression with substance abuse and Post Traumatic Stress Disorder co-morbidities. (See also Objective 2, Action 8.)

Action 2.4. Establish minimum criteria for local development of clinical pathways and a mechanism for inter-network sharing of developed pathways.

A clinical pathways networking group has been established at the Quality Management Institute in Durham. They are developing various approaches to clinical criteria use at the local level.

Action 2.5. Establish a VHA Center for Dissemination of Innovations and Best Practices.

Plans are being developed by the Office of Policy, Planning and Performance to establish this center.

Action 2.6. Develop a benchmarking program to share best practices systemwide so as to improve overall performance and comparison to non-VA benchmarks.

Programs are in place to benchmark performance in length of stay for cardiac bypass surgery, pressure sore development in long term care and follow-up outpatient appointments. A comprehensive program using non-VHA comparisons will be developed.

Action 3. Implement a performance monitoring system that routinely tracks performance and provides timely feedback to relevant providers.

Action 3.1. Evaluate the utility of current quality management databases and programs to provide data for the performance measures within the four domains of value.

VHA has completed an initial review of the adequacy of current databases. More complex analysis is planned as the use and utility of quality management data bases is assessed.

Action 3.2. Develop analysis and report protocols for facilities, networks and headquarters that provide facility-specific, network-specific and national performance information for clinical cohorts, service lines and special emphasis programs, along with VA and non-VA comparative information.

National protocols will be developed by the Office of Policy, Planning and Performance. Experience from protocols developed by VHA's National Customer Feedback Center, VAMC Bedford, MA, will be utilized.

Action 3.3. Establish a VA clinical "Centers of Excellence" program to celebrate and disseminate best practices and to foster studies that identify organizational characteristics that lead to performance excellence.

A task force has been formed to establish defining criteria for Centers of Excellence and to develop the process for facilities to apply and be selected as a center of excellence (for a procedure, program, or service). Criteria should be available in May 1996. Current facilities that identify themselves as a Center of Excellence will need to apply for continued designation after the criteria are promulgated.

Action 4. Maintain JCAHO accreditation of all hospitals and review the usefulness of JCAHO network accreditation.

All VA medical centers are currently JCAHO accredited. In 1995, JCAHO conducted 65 surveys of VHA facilities; six facilities received near perfect scores of 99 and received accreditation with commendation. Another 20 received scores of 95 or better, and an additional 24 rated scores between 90 and 94.

Action 5. Pursue a relationship with the National Committee on Quality Assurance (NCQA).

Meetings with NCQA are being held to discuss the potential development of VA-HEDIS (Health Employer Data Information Set) measures and other interactions.

Action 5.1. Explore potential use of a subset of HEDIS measures for use in VA, especially for chronic diseases.

Action 5.2. Consider the applicability of NCQA's accreditation standards for the networks.

Action 6. Obtain Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation for all VA rehabilitation programs.

On February 1, 1996, VHA and CARF signed a Memorandum of Understanding (MOU) that will serve as a vehicle to promote continuous quality improvement in VHA rehabilitation programs. This MOU sets a goal for VHA to gain CARF accreditation for all 400 (approximate) VA rehabilitation programs by the year 2000.

Action 7. Implement "management by outcomes" through use of performance contracts, non-monetary and monetary rewards (e.g., bonuses), and other available means.

FY 96 performance contracts have been negotiated with all network directors, and work is underway for VA headquarters personnel. Further work is required in a number of areas, including defining the extent of coverage for Title 38 executives, standardizing executive performance measures for headquarters personnel, and using award pools and strategies to enhance incentives.

VHA is adopting a new executive performance and compensation strategy. Under this strategy, fewer SES management bonuses will be given each year, but they will be larger and linked to specified performance measures.

Action 8. Develop and implement a mental health service performance monitoring system.

A draft performance monitoring system for the Mental Health and Behavioral Sciences Strategic Healthcare Group has been developed by the Northeast Program Evaluation Center and is undergoing final review. The evaluation systems developed for the homeless, PTSD and substance abuse treatment programs are being incorporated into a

performance monitoring system. Through ongoing monitoring, measures will be refined. The goal of the performance monitoring system is to identify problems and to test corrective solutions.

Action 9. Establish linkages of VA data systems with other federal healthcare programs (e.g., Medicare and Medicaid).

VHA is implementing standard data sets and coding schemes to align its data systems with other federal healthcare programs. This will facilitate comparisons among the programs.

In 1995, VHA participated in the National Committee on Vital and Health Statistics' Core Data Elements Project sponsored by the National Center for Health Statistics. In 1996, VHA will finish revising its decentralized and national databases to match the requirements of the Uniform Ambulatory Medical Care Minimum Data Set.

VHA is also developing standards-based software to facilitate communicating data with other healthcare providers. Various DHCP applications will begin testing the exchange of data using these interfaces during the summer of 1996.

Action 10. Issue systemwide policy directives and performance measures for VA's special emphasis programs. Ensure that these policies support a continuum of quality care.

Each of the special emphasis program offices has developed proposed performance measures and policy statements. The proposed policies and performance measures were sent to the field, veteran service organizations, interested Congressional staffs, and others for review and comment in December 1995. Hundreds of pages of comments have been reviewed by the program offices and revised measures are expected in April 1996.

Action 11. Educate employees, patients and others about the VA's new "value-based culture" and the four domains of value.

The four domains of value will be part of the culture change education for employees that is being developed by the Office of Employee Education. It will also be incorporated into other education (e.g., primary care and customer service), as appropriate.

An educational videotape about VA “value” has been developed and distributed to all field facilities.

Action 12. Implement a systemwide technology assessment process.

A VHA national technology assessment program was established in December 1994. Four of five main components of the program are underway.

Action 13. Link the quality improvement program to ongoing VA Health Services Research efforts.

A number of quality improvement initiatives are underway. For example, in collaboration with AHCPR, a project is being implemented to assess educational models for pressure sore treatment guidelines. This research project intends to use both traditional dissemination techniques as well as newer approaches to adapting research findings to clinical care of pressure sores. In addition, health services research assistance was obtained for developing risk adjustment for re-admission rates, lengths of stay and pressure sore rates.

Objective 5. Aggressively implement cost-effective health promotion and disease prevention activities.

Action 1. Develop a systemwide health promotion and disease prevention strategic plan that addresses the needs of both patients and employees (where relevant).

The VHA National Center for Health Promotion and Disease Prevention at VAMC Durham has the lead on this.

Objective 6. Develop a means for allocating resources in an equitable manner that encourages use of the most appropriate setting for each episode of care and that supports VHA’s special emphasis programs.

Action 1. Develop resource allocation goals and targets.

Resource allocation goals for FY 96 were approved and shared with VHA top management at a national conference on September 6, 1995. Budget targets for FY 96 were developed at anticipated budget levels. This includes specification of expected clinical workloads, risk pool size, blended rates, inflation, activations and non-clinical program targets. Preliminary simulation of FY 97 resource goals and targets was prepared and is under review by a new Capitation Advisory Panel named by the Under Secretary for Health in January 1996. Network targets should be developed by May 1996.

Action 2. Develop and implement the “blended rates” for FY 96 and FY 97 as a bridge to a capitation-based resource allocation system.

Over the years, the allocation of resources among VA facilities has become inequitable. Blended rates are a step toward restoring equity in resource allocation.

Blended rates are being phased in beginning in FY 96. These allocations will require all networks to meet or exceed efficiency standards, i.e., risk-adjusted cost per person. The network budgets have been developed based upon a blended rate of 5 percent network; 5 percent medical center peer-group; 20 percent national; and 70 percent facility. This use of blended rates will shift nearly \$150 million from high cost facilities to low cost facilities in FY 96. (A more detailed explanation of the blended rates methodology and a listing of the changes per network is included as Appendix IX.)

Action 3. Develop a capitation-based resource allocation system that takes into consideration VA’s special emphasis programs and other unique patient populations.

The major features of a potential capitation-based resource allocation methodology are under review by the new Capitation Advisory Panel. The methodology under review gives particular consideration to the special emphasis programs and VA’s other unique patient populations.

Action 4. Review and realign VHA surgical programs according to resource allocation, workload and outcomes.

Action 4.1. Develop surgical program efficiency and effectiveness benchmarks.

Action 4.2. Ensure surgical program workload is sufficient to maintain provider skills and high quality outcomes.

Objective 7. Decrease the unit cost of purchased goods and services.

Action 1. Arrange for more routine supplies to be purchased under master agreements that lower unit cost but maintain quality.

VHA field and headquarters staff are working to identify and award master or single-award contracts for commonly used supplies. Action is underway on 27 products/product groups.

Action 2. Develop and implement a major medical equipment acquisition methodology.

A proposed new methodology for purchasing expensive medical equipment is under review by field and headquarters staff. The proposed methodology takes into consideration the need for facilities and networks to make local decisions on equipment procurement, and the need for headquarters to ensure that federal procurement law and regulations are observed.

Action 3. Consolidate contract nursing home care under fewer individual contracts when beneficial to do so (e.g., when cost savings or improved quality can be achieved).

On any given day, VHA has about 9,000 patients in contract community nursing homes. Historically, contracts for this care have been initiated and managed by each facility. At present, VHA has approximately 3,200 contracts in effect for community contract

nursing home care. The number of such contracts is being targeted for reduction, and better rates are being sought through solicitation of regional and national contracts. In August 1995, VHA issued a solicitation package. An industry forum was held on August 31, 1995, and the Requests for Proposal was released to bidders in September 1995. Proposals were received in January 1996, followed by technical and price evaluations. These proposals are under review.

Action 4. Consolidate fee-basis care when beneficial to do so.

An initiative is underway to centralize fee-basis claims processing. As currently envisioned, implementation will result in standardizing claims payments while effecting substantial reduction in current, decentralized expenditures. VHA plans to begin centralized fee-basis claims processing by October 1, 1996.

Through centralized processing of fee-basis programs, data systems will be developed to identify consolidation opportunities and development of service agreements, as well as bulk purchasing potential.

Action 5. Adopt the Medicare fee schedules for reimbursement of fee-basis care.

Use of the Medicare fee schedule as the basis for reimbursing fee-basis outpatient care is expected to be implemented in late 1996.

Action 6. Arrange for more routine maintenance services to be provided under master agreements that lower cost but maintain quality.

A number of master agreements for routine maintenance services are in effect at the local and network levels. VHA is working to identify additional opportunities for master agreements.

Objective 8. Improve the efficiency and effectiveness of pharmacy service while maintaining VHA's preferential pharmaceutical products pricing.

Action 1. Develop a pharmacy benefits management plan, including VISN formularies and, later, a national formulary. The plan should ensure systemwide coordination and sharing of drug reviews and drug treatment guidelines.

A plan has been developed to implement a Pharmacy Benefits Management Program. In January 1996, data was released on medication utilization by network. The target date for the establishment of network formularies is April 30, 1996.

Action 2. Develop a plan for further development of Consolidated Mail Out Pharmacies (CMOPs).

Four CMOPs are now in operation at VAMCs Leavenworth, West Los Angeles, Dallas and Bedford. The fifth and sixth CMOP sites will be activated in FY 96 at VAMCs Murfreesboro and Hines. Equipment installation is ahead of schedule. Equipment for the seventh site (VAMC Charleston) will be procured in FY 96.

The four existing CMOP sites dispense one-third of all VA mailed prescriptions. VA's CMOPs — which are being used as a model by a major private sector managed care company in California — have increased VA pharmacist productivity from less than 20,000 to over 50,000 filled prescriptions per FTE per year. They have also lowered the personnel processing cost per outpatient prescription by \$1.25 each. At an expected fill volume of 11 million prescriptions in 1996, this should save \$13.75 million.

Opportunities for VA's pharmacies to service other federal healthcare providers are being sought.

Action 3. Pursue additional savings through volume-committed purchasing and better managed drug utilization.

At present, VA pays less than 50 percent of what would be paid in the private sector for outpatient prescriptions. Further savings will be sought through better drug utilization.

VHA has identified a number of therapeutic classes for national volume-based competitive contracting. The initial listing includes: H-2 blockers; oral beta blockers; ophthalmic beta blockers; oral alpha blockers; oral quinalones; oral cephalosporins; and inhaled corticosteroids. VHA has requested tiered pricing quotes for all Federal Supply

Schedule contracts so that networks may realize volume discounts by committed purchase agreements.

Action 4. Implement the Pharmacist Training Program sponsored by the University of Tennessee through a grant from CibaGeneva Corporation.

This Pharmacist Training Program has been implemented. Program participants have rated it very highly. Three training sessions were completed by February 1996. A follow-up session is planned for January 1997.

Action 5. Re-engineer outpatient pharmacy software to improve efficiency and effectiveness of service.

VHA will develop a plan for this re-engineering by July 1, 1996.

Action 6. Finalize the prime vendor program.

The prime vendor program will be fully in place in FY 96, resulting in a projected \$18-\$20 million savings per year.

Objective 9. Implement a management information system.

Action 1. Develop and implement a clinical information system that integrates clinical information (including outcomes), as well as cost information, across inpatient and outpatient settings, within and across facilities, and which allows easy and timely retrieval of individual patient information, provider-specific information, and trends of care.

In February 1995, VHA initiated a clinical system that integrates across inpatient and outpatient settings and creates a longitudinal clinical record for care received anywhere within the VA system. Specification and design work are almost complete. A pilot test of the Clinical Information Resources Network is scheduled to begin later in FY 96.

Action 2. Implement the (Transition System, Inc. (TSI) Decision Support System systemwide.

As of March 1996, 68 medical centers were in various stages of implementing the TSI Decision Support System software, providing VA with a state-of-the-art cost accounting system. Starting in August 1996, 30 additional sites will be added every six months until the implementation is complete. These medical centers are routinely auditing their data and tailoring this system to produce information about patterns of care for specific patient populations; utilization of inpatient and outpatient care, ancillary services and other products and procedures for individual patients; and facility-specific costs of labor, supplies and materials that support these activities.

In addition, VISN 13 is serving as a pilot network to begin roll-up utilizing a common department methodology.

(See also Objective 4, Actions 9 and 10, and Objective 30, Action 3.)

Action 3. Develop the capability for PC/laptop links to the core information system to facilitate electronic communication with community access sites.

Action 4. Adopt a graphic user interface development environment.

In March 1995, VHA selected the Delphi graphical user interface development tool. This will allow users to run applications in a Windows environment. Four applications are nearing the end stages of development and being readied for field test: Primary Care Management Module, Computerized Patient Record System, Agent Cashier Module, and Automated Information Collection System. The Primary Care Management Module is the first application scheduled for release, targeted for June 1996.

Action 5. Develop and implement a strategy to standardize how private sector hardware and software will interface with VA's DHCP.

VHA is implementing its strategy for providing users with a seamless interface between DHCP and commercial off-the-shelf systems. DHCP software to further this goal was made available to VA medical centers in October 1995.

The VA Hybrid Open Systems Technology Laboratory was established in August 1995 to participate in testing standards for open systems integration of commercial software with DHCP. It will also provide ongoing conformance testing of commercially available software against this standard; facilitate implementation in the clinical environment; and monitor emerging technologies.

Objective 10. Diversify VHA's medical care funding base.

Action 1. Obtain authorization for gainsharing via the Medical Care Cost Recovery (MCCR) program.

The National Performance Review includes a gainsharing proposal that would permit VA to retain a portion of the MCCR third party insurance recoveries. The proposal outlines a policy where the VA would retain 25 percent of MCCR recoveries for Category A veterans, and 100 percent for Category C veterans, above a baseline level specified in the President's Budget. VHA is currently developing legislation to implement this proposal.

Action 2. Explore the possibility of selling MCCR services to DoD and other government agencies.

MCCR is sharing its technology and experience with Ellsworth Air Force Base, where a PC-based version of MCCR's Integrated Billing and Accounts Receivable software is being used to bill, record and recover medical care costs. Approval is also pending for a joint venture between the VAMC Omaha and Offut Air Force Base. Under this venture, the Omaha Centralized Collection Unit would electronically submit bills prepared for Offut. These two projects are important feasibility tests.

Action 3. Increase revenue obtained from CHAMPUS.

Action 3.1. Implement contracts with regional TRICARE contractors and providers as TRICARE is implemented by DoD.

A standard provider agreement has been negotiated with Foundation Health Corporation for medical and surgical care, and a mental health agreement is nearing completion. A

provider agreement with Humana is under review. Agreements for VA medical centers in Dallas and Central Texas to promote CHAMPUS services were signed with Foundation in December 1995. A third agreement with Foundation, proposed by VAMC Palo Alto, has recently been finalized.

Action 3.2. Explore opportunities to contract directly with DoD for CHAMPUS care and to become preferred providers under CHAMPUS.

New contracts at the Indianapolis and Syracuse VAMCs are in place, and CHAMPUS patients are being treated. Billing issues are being resolved with DoD and the fiscal intermediary.

These two contracts with DoD are in addition to the previous one with VAMC Asheville. Additional opportunities for providing CHAMPUS services are being explored at VAMC Richmond. While DoD has indicated it prefers to postpone new agreements until TRICARE comes on line in this and other regions, discussions are continuing.

Action 4. Increase utilization of the CHAMPVA Inhouse Treatment Initiative.

VHA will continue to explore opportunities to expand participation in this program.

Action 5. Seek authorization to retain Medicare revenues.

Action 5.1. Initiate Medicare pilot projects.

Under the National Performance Review, the Health Care Financing Administration (HCFA), Office of Management and Budget (OMB), and VA are jointly working to establish pilot projects to authorize Medicare reimbursement to VA. Work groups have been established to lay the framework for three pilot reimbursement models: capitation, fee for service and participating centers. A final report with recommendations will be submitted to the three organizations in spring 1996.

Action 5.2. Based on outcome of pilots programs, pursue legislation authorizing VA to bill and retain Medicare revenues.

This legislation will be developed as part of the Medicare pilot effort.

Action 5.3. Implement VHA’s “Medicare Readiness Initiative.”

Based on an analysis of the requirements for VA to be a Medicare provider, a Medicare readiness action plan is being developed by a field-based work group.

Action 6. Develop acceptable strategies to market specialized VA clinical services to other government healthcare providers and the private sector when such would be advantageous to VA and veterans patient care.

Current law authorizes VA to offer available medical resources and services to government and selected private sector healthcare facilities. VHA program guidance has been updated to aid medical center officials in establishing resource-sharing agreements.

Pending legislation

(H.R. 2798/S.1359) would expand the resource sharing authority to allow VA to offer any healthcare resource to any public or private entity. Responsibility for “Economy Act” agreements may be consolidated in the Medical Sharing Office.

Action 7. Seek opportunities to offer administrative and other support services to other government healthcare providers.

Action 8. Increase the number of enhanced-use lease arrangements that generate revenues or in-kind services.

Numerous initiatives are at various stages of development, including 15 child development centers, three assisted living/senior housing communities, and eight energy production developments (see Appendix X). Based on preliminary analyses, savings could total \$70 to \$100 million.

Action 9. Ensure that employees obtaining care at VA facilities are appropriately billed for services received.

Locally, Medical Administration Services identify billable cases based on individual eligibility or health insurance coverage. Information concerning these cases is furnished to local MCCR. Appropriate billings are developed and forwarded to individuals or their insurers.

Action 10. Explore opportunities for VA facilities to gain provider status and reimbursement under Medicaid managed care initiatives.

Objective 11. Focus management attention on VHA's key business of providing healthcare.

Action 1. Dispose of, or contract out, management of VA's golf courses so that appropriated funds are not being used to support them.

A total of 22 nine-hole or smaller golf courses are under VHA purview. The Under Secretary for Health has directed that VA medical centers eliminate the use of appropriated funds to support these. To date, 10 VA medical centers have achieved this goal by various means. For example, VAMCs Murfreesboro and St. Cloud have entered into leases with their local communities. VAMC Palo Alto has developed and submitted a business plan to lease its golf course site for development of a community nursing home. Seven VA medical centers are developing operating plans which eliminate the need for VHA funding through collection of fees. Four sites are precluded from disposal by existing real property encumbrances or by Congressional mandate.

Action 2. Explore opportunities for contracting out fire protection services.

In the late 1960s, VHA operated 67 fire departments. That number has been reduced as the communities where VA medical centers are located have grown and fire protection services could be provided by the community. VA now operates 32 fire departments. Efforts to contract for fire protection services at these facilities continue.

Action 3. Explore opportunities for contracting out law enforcement services.

VA's Office of Security and Law Enforcement (OSLE) maintains that contracting for law enforcement services and replacing police officers is not an option because Title 38 and current policy require that VA police enforce federal laws and VA rules on Department property. Further, law enforcement is generally considered to be a function of government that may not be contracted for. The OSLE has acknowledged, however, that

if a support function to police operations can be clearly separated from the legislated requirements for law enforcement presence, consideration may be given to contracting that support function. Possible support functions include dispatcher, SSTV monitoring and parking lot attendants.

Action 4. Increase use of design-build construction projects.

Seven design-build projects were completed over the past five years. Eight such projects are currently underway. This mode will be used in the future whenever possible.

Objective 12. Increase utilization of electronic commerce.

Action 1. Increase use of government-wide commercial purchase cards for micropurchase transactions.

Training on the use of the cards was given to all purchasing agents in the fall of 1995, and approving officials and cardholders in all services within each medical center were identified.

VHA has set a goal of making 95 percent of all micropurchases by purchase cards by the end of June 1996. (Micropurchases are defined as purchases of less than \$2,500. It is estimated that 95 percent of VHA purchases fall into this category).

Action 2. Implement VHA's directives and forms automation initiative.

Equipment and software necessary to provide up to four workstations for each facility have been obtained. Equipment installation at test sites will be accomplished in March 1996. Installation nationally will be accomplished by the end of the fiscal year.

Action 3. Increase VA information available via the Internet.

VHA established the VA World Wide Web Home Page in July 1994 (www.va.gov). The page provides detailed information on a wide scope of VA programs. By December 1995, VA's home page was among the top 5 percent most used, with more than 180,000 users per month. It is the busiest home page of any healthcare provider in the U.S.

In addition, VHA activated and maintains VAONLINE, a toll-free electronic bulletin board service with Internet accessibility that provides user-driven, interactive services and assistance.

VHA is also coordinating VA beta test projects for Internet Grateful Med, a user-friendly interface to Medline, and DxPlain, a diagnostic support system, via the World Wide Web.

Action 4. Explore potential opportunities for use of patient "smart" cards.

A Veteran's Universal Access and Identification Card (VIC) is now being developed and will be piloted at six locations. It includes embossed and imprinted information about the veteran, a bar code, and a magnetic strip. Future development will be vigorously pursued to include kiosk interaction, medical information, patient registration, photo image and waiting time analysis.

Action 5. Replace paper processes with electronic communication where possible.

VHA's medical imaging system, which is fully integrated with DHCP, replaces traditional methods of storing medical images with electronic storage and communication. Text can also be stored and displayed, and the newest version, being implemented at several sites, has the capability to scan and transmit documents. In addition, paperless systems for clinical records (e.g., health summaries, progress notes and discharge summaries), financial management forms and directives (e.g., purchase orders, receiving reports and certified invoices), and electronic mail and data exchange within the networks have been developed.

Action 6. Finalize the Office of Facilities Management (OFM) electronic communications initiative.

VA's design and construction standards have been dramatically streamlined and benchmarked against the private sector for appropriate quality and cost effectiveness. Documents that formerly could be stacked seven feet high are now contained on 10 floppy disks. Access to these guides and standards is provided electronically through the Bulletin Board System (BBS), 24 hours a day, seven days a week (5,778 electronic downloads by VA medical centers in FY 95); OFM's Standards Services floppy disk distribution system and Design Guides distribution; and CD-ROM through the National Institute of Building Sciences.

OFM also has established a national electronic database of performance guides and standards that give local VA personnel the technical information necessary to make cost-effective design and construction decisions. VA medical center requests for electronic information in the first six months of FY 96 increased more than 17 times compared to FY 95 (approximately 6,800 versus 400).

Users of OFM's electronic library have a direct voice in the development and updating of this national database through OFM's Electronic Field Networks, which permits VA construction sites to share information electronically.

Objective 13. Actively pursue development of a systemwide electronic medical record.

Action 1. Continue work on establishing a standardized medical nomenclature.

In 1995, VHA released the first version of a standardized dictionary of medical terms, with linkages to common coding systems such as ICD-9-CM and SNOMED.

VHA and the National Library of Medicine are collaborating to determine the applicability of the Unified Medical Language System to VHA vocabulary requirements.

A VHA Medical Informatics Fellowship program has been established and is supporting research into long term approaches to providing standardized vocabulary services to all clinical information systems.

Action 2. Increase interaction, with the National Library of Medicine and High Performance Computing Center.

VHA is an active member of the High Performance Computing and Communications Program. Specific projects include integrating technologies to enhance the existing computer-based record and to improve methods of data capture, presentation and exchange.

VHA also participates in the National Library of Medicine's electronic medical record system cooperative project to conduct large scale testing of vocabularies for computer-based patient records.

Objective 14. Pursue new facility construction only where alternative options to providing services are not cost effective or otherwise practical.

Action 1. Develop specific criteria to evaluate the cost-benefits of new construction versus alternative service delivery options.

VHA's requirements in planning a major construction project call for considering several alternatives. Justification is required in a number of areas, including: sharing with DoD, community hospitals and state or university facilities; buying services; leasing facilities; gaining support of other VA facilities in the network to perform the functions; renovating existing space in lieu of new construction; and utilizing the Enhanced-Use Lease Program. VHA will add a cost-benefit element to the construction prioritization system.

Action 1.1. Explore opportunities to acquire private sector/community or DoD facilities that have been vacated due to downsizing.

Action 2. Integrate the Facility Development Planning (FDP) process into the business planning/strategic planning process.

Modifications to the FDP process are under development.

Action 3. Expand use of leased space.

In these fiscally constrained times, leasing offers an affordable, expedient and flexible solution to VA's short-term needs for outpatient and nursing home capacity. In FY 95, new leasing guidelines were developed by the Office of Facilities Management, and the Under Secretary for Health delegated expanded leasing authority to facility directors.

Objective 15. Ensure readiness to fulfill VA's emergency preparedness role as backup for DoD during national security contingencies, for VA internal emergencies and as a federal support organization for major catastrophic disasters.

Action 1. Develop and implement a network-level emergency preparedness structure to ensure rapid and effective response.

In 1995, the Office of Emergency Medical Preparedness (OEMP) eliminated two levels of field management and developed transition guidance for networks to establish Emergency Medical Preparedness Assistance Councils to advise and assist readiness requirements at the network level.

Action 2. Review, modify and implement VA/DoD Contingency Plans to reflect network level changes affecting readiness.

A review is underway to modify former regional provisions for contingency bed reports, exercises, patient transportation, etc., to maintain system readiness.

Action 3. Develop guidance for rapid VA response to internal emergencies that assures continuity of care for veterans.

Networks have been tasked to conduct a risk analysis, determine backup arrangements, etc., for initial response and require OEMP national headquarters to facilitate support and coordination beyond network boundaries.

Action 4. Improve plans to coordinate and facilitate VA's participation under the Federal Response Plan to provide medical assistance to supplement state and local governments affected by major disasters.

OEMP is leading a review of the National Disaster Medical System Federal Coordinating Center roles in rapidly accessing and better utilizing public and private healthcare resources for natural disasters and as the civilian backup component to the VA/DoD Contingency Hospital System.

MISSION GOAL II

Provide Excellence in Service as Defined by Customers

Guiding Principles

Principle 13. Healthcare is fundamentally a local activity.

Principle 14. Both continuity of care and patient satisfaction will improve by reducing the number of transactions required to get care.

Principle 15. Relieving employees of unnecessary paperwork and administrative functions will facilitate their ability to focus on patient care.

Principle 16. Patients should know what type of service they can expect.

Principle 17. Patients define excellence according to the degree to which services received match their expectations.

Principle 18. Effective communication is the cornerstone of the physician-patient relationship and is the single most important factor determining patient satisfaction.

Strategic Objectives

Objective 16. Determine the needs of VHA's customers and stakeholders.

Action 1. Identify VHA's customer needs by using focus groups and customer surveys to evaluate services and results desired and to evaluate satisfaction with existing services.

In 1994 and 1995, VHA conducted focus groups and telephone market surveys in over 75 VA medical centers constituting patient referral networks in Minnesota, Washington, Ohio, Kentucky, Florida, California, Vermont, Oregon, Maryland and Pennsylvania. An average of six focus groups and 3,000 telephone interviews were conducted in each of these areas. The veteran population targeted by these studies included three categories: current users, former users and non-users of VA healthcare. Study findings have helped VA better understand its customers, their perceptions about VA healthcare and their individual needs.

Objective 17. Eliminate unnecessary paperwork and administrative functions.

Action 1. Eliminate redundant forms.

On September 30, 1994, 3,874 forms were in use by VHA. Six new forms were added during FY 95 and 887 were eliminated, producing a 23 percent reduction in the number of forms used by VHA.

Action 2. Simplify necessary forms whenever possible.

VA's Application for Medical Benefits (Form 10-10) was simplified from 64 questions to 19, and the admission process was streamlined.

VHA is also developing a CD-ROM containing 800 low-use forms for distribution to the field to facilitate on-demand printing and minimize the need for forms storage.

In 1995, VHA revised the forms used to conduct annual joint reviews with member organizations of local VA Voluntary Service committees, improving communications and yielding useful new information.

The Income Verification Match Center is testing a new data collection program to allow VHA to be more responsive to patients by further streamlining the eligibility process. The program consolidates three forms into a single, abbreviated instrument which veterans complete in the privacy of their home once a year. Eligibility for medical care, prescription co-payment exemption and travel benefits is determined concurrently.

Action 3. Eliminate unnecessary reports.

VA proposed to eliminate eight reports, and was successful in eliminating one, as part of the 1995 Congressional Reports Elimination Act. Another Reports Elimination Act is being developed by OMB. VHA will submit its list of reports considered unnecessary for inclusion in that effort.

VHA is also reviewing intra-Departmental reports with an eye toward eliminating any that do not address a demonstrated need.

Objective 18. Promulgate customer service standards and ensure that they are known by both staff and patients.

Action 1. Promulgate VHA customer service standards.

VHA published Customer Service Standards for all medical facilities in October 1994. These standards address staff behavior, care processes, patient knowledge and timeliness. Local facilities are required to post the standards prominently and to make copies available to patients. VHA has also developed a brochure that describes the standards in simple terms. Compliance with the standards are measured regularly through surveys, and the results are provided to facilities. Additional, specific customer service standards are being considered.

Action 2. Develop employee training programs regarding the customer service standards and other areas key to the vision of the “new VA.”

VHA employees have started to receive a variety of customer service training. The TQI program emphasizes that the driving force for VHA is service to the patient. New provider-patient communication training is aimed at improving the effectiveness of physician/caregiver-patient communication. This effort was initiated in September 1995, when 16 VA clinicians were trained by the Bayer Institute for Health Care Communications (West Haven, CT) to be faculty for three Bayer workshops.

These workshops (“Physician-Patient Communication,” “Difficult Physician-Patient Relationships” and “Communication: A Tool for Risk Management”) have been extensively field tested and are widely acclaimed for their effectiveness. As of March 1996, 33 workshops at VA medical centers had been completed, providing training to approximately 600 physicians, nurses and other caregivers. Sixteen additional VHA clinicians are scheduled to take the Bayer faculty training certification course in July 1996. Each network will then have at least one certified trainer. Each trainer is expected to complete 11 workshops at VA medical centers each year.

The new Office of Employee Education has also charged a team to develop additional education activities in support of customer service.

Action 3. Revise employee performance measures and job/position descriptions so they contain a heightened emphasis on customer service and other behaviors supportive of the vision of the “new VA.”

Efforts to revise employee performance measures and position descriptions are being initiated.

Action 4. Develop methodology whereby VA patients contribute to the appraisal of managers and service providers; clinical staff rate the support they get from administration; and field staff grade the support provided by headquarters.

VHA is exploring development of a revised performance appraisal system to incorporate a “360-degree” appraisal process.

Action 5. Conduct regular surveys of patients that inquire about their treatment or other service experience.

VHA will, at least annually, assess compliance with customer service standards through patient surveys.

To date, VHA has conducted two surveys of inpatients and one survey of outpatients. A survey of long term care patients will be piloted this summer and conducted in the fall of 1996. In addition, VHA will conduct surveys of employees using focus groups and questionnaires.

Action 6. Develop and implement corrective plans for those areas where customer feedback or other data indicate there is a need for service improvement.

Meeting customer service standard goals are incorporated into the network director performance contracts. Relevant performance measures are also being incorporated into employee periodic assessments.

Objective 19. Increase accessibility to VA services.

Action 1. Bring clinical and other care sites and services closer to the patient.

In February 1995, VHA promulgated a policy encouraging VA facilities to establish more points of access for veterans. VHA facilities opened 15 new access points in FY 95. An additional 58 access points have been submitted to Congress for concurrence, and approximately 200 more are being considered. (See also Objective 2, Action 5.)

Action 2. Clarify the criteria for siting additional community care access points.

A policy directive on the establishment of community care access points was distributed in February 1995. Additional guidance is being developed, although siting these primary care access points is a local decision determined by needs and resources. Sites are primarily determined by the location of underserved eligible veteran populations, availability of transportation and the ability to fund the site within existing resources.

Establishing more of these ambulatory care sites is critical to meeting clinical care needs with the constrained funding anticipated in the future, since care can be provided cheaper at these ambulatory sites.

Action 3. Decrease waiting times for appointments.

VHA has issued policy directives on both excessive waiting times and customer service standards (“Reduction of Excessive Waiting Times,” 10-95-067, July 12, 1995; and “Customer Service Standards,” 10-94-102, October 14, 1994). These require the achievement of specific timeliness goals by 1998. Two national surveys have been conducted to determine waiting times in the VA healthcare system. Early results indicate that waiting times in some specialty clinics have been reduced, but much more work is needed.

Action 4. Improve continuity of care.

Preliminary data from a number of locations is showing much improved continuity of care as a result of implementing primary care.

Action 5. Establish criteria for use of VHA’s mobile clinics.

Criteria for mobile clinics were established in Public Law 100-322, Section 113. The statutory criteria were also reviewed in VHA’s March 1995 report to Congress, “Evaluation of the Department of Veterans Affairs’ Mobile Clinics.” The report recommends that mobile clinic use be determined by the network and medical center directors using locally developed criteria.

Objective 20. Improve access for targeted groups, including combat veterans with PTSD or service-connected conditions, women, ethnic minority veterans, Persian Gulf veterans, spinal cord injured veterans, blind veterans, amputees, homeless veterans, frail elderly and other “at risk” veteran groups.

Action 1. Seek additional opportunities to tailor the care environment to the particular needs of related groups of patients.

Special populations of patients are receiving targeted attention by program managers at headquarters and caregivers in the field. For example, VISN 1 is developing a special compensated work therapy program targeted for women veterans with PTSD. The Readjustment Counseling Service is working on the special needs of newly discharged service personnel.

Evaluations of the homeless chronically mentally ill, PTSD, substance abuse, and seriously mentally ill programs are emphasizing increased use of residential care, tailoring programs to meet specific patient needs, and enhanced use of compensated work therapy. A new blind rehabilitation outpatient program will employ specially trained staff to work with blinded veterans in the local community.

Full- or part-time women's veteran coordinators provide special emphasis and support at all VA facilities. During FY 94 and FY 95, more than 125 facilities designated women's clinics, and over 80 established women's primary healthcare teams.

Objective 21. Empower staff to plan and execute their work in ways that are most responsive to patient needs.

Action 1. Clarify employee rights and responsibilities in making decisions in response to patient needs.

Efforts are being initiated to review relevant policies so as to empower employees to take "real time" action to address patient needs.

Action 2. Develop an employee empowerment strategic plan.

Action 3. Establish new positions of "multi-skilled caregivers."

Action 4. Survey front-line employees on ways to match "best in business" practices.

VHA's customer service directive (Customer Service Standards, 10-94-102; October 14, 1995) requires that medical centers adopt a mechanism to solicit from employees perceived barriers to improved customer service. Planned employee focus groups will assess a range of employee needs and expectations. Focus group findings will lead to a national employee survey. These are essential building blocks pointing the way to matching a best-practices environment in veterans healthcare.

Objective 22. Establish a system of incentives and rewards that encourages and empowers staff at all levels of the organization to provide quality service that meets the customer's needs "first time, every time."

Action 1. Build consensus and commitment throughout the organization around specific "people practices" that reinforce customer service and satisfaction.

Action 2. Develop and implement incentives and rewards that reinforce behavior and results supportive of the vision of the "new VA."

A headquarters work group is reviewing VA's incentives and rewards program.

Objective 23. Ensure that VHA's culture and routine practices do, in fact, involve the patients at the beginning of the decision-making process and actively solicit their input throughout the process.

Action 1. Establish feedback loops and survey instruments to validate patient involvement.

MISSION GOAL III

Provide Excellence in Education and Research

Guiding Principles

Principle 19. The organization and structure of medical education activities should be driven by the clinical delivery system.

Principle 20. Education and research activities should be held accountable to, and managed with, performance expectations and outcome measures in the same manner as clinical care.

Principle 21. Today, the science of applying new information is just as important as the science of discovering new information.

Principle 22. VA's educational offerings should emphasize areas of greatest societal need as well as greatest need to veterans. In particular, the number and types of healthcare professionals trained by VA should be determined by the needs of the system and the needs of the nation.

Principle 23. Academic affiliation agreements should be fair and equitable, and VA personnel should have recognition and influence in affiliated universities commensurate with the contributions of their educational services.

Principle 24. There should be a clear linkage between the VA's research strategy and project funding, and the conditions most commonly treated by the system, or that are otherwise of significance to the system.

Principle 25. Health professional training and research can be beneficial to patient care when they are integrated with patient care and properly managed.

Principle 26. Senior VA personnel should not be put in a position of having potential financial conflicts which might affect, or appear to affect, negotiations with affiliated universities.

Strategic Objectives

Objective 24. Ensure that VHA's educational offerings emphasize areas of greatest societal need and are responsive to the needs of veterans, today and in the future.

Action 1. Convene the Residency Realignment Advisory Committee to provide guidance in ensuring VA's postgraduate physician training programs are responsive to the needs of VA and the nation.

The Residency Realignment Advisory Committee held its inaugural meeting on December 5 and 6, 1995. Additional meetings have been held, and its report is due by June 1996.

Action 2. Increase the proportion of trainees in general medicine and other primary care specialties.

In October 1993, VHA's Office of Academic Affiliations initiated a program to increase VA physician training in primary care. Since then, the number of residents in primary care training has grown from 2,892 to 3,519, an increase of 627. This is planned to increase by another 40 residents in FY 97. The percentage of VA residents training in primary care specialties has increased in recent years from 33 percent to 40 percent. Despite this increase, a further increase is needed.

Action 3. Academically affiliated VA facilities should re-evaluate their affiliation(s) in light of VHA's restructuring, and vision of the "new VA," and the present educational role of VA. Affiliation agreements should defend the prerogatives of VA, control the use of VA resources and protect the interests of VA patients. (See Appendix IV for a list of VA-medical school affiliations.)

Action 3.1. Initiate review and re-negotiation of all academic affiliation agreements.

Action 3.2. Identify and resolve all situations where senior VA facility or network managers have potential conflicts which might affect or appear to affect, their negotiations with universities.

Action 4. Reassess the role and function of Deans Committees in light of today's changed health educational environment and effect changes where needed.

Action 5. Develop formal structures for facilitating and affirming VA/university relationships commensurate with VA's present educational responsibilities.

Action 6. Develop a database on VA's costs of providing healthcare professional education (for physicians, nurses and allied health professionals).

Objective 25. Ensure that VHA's research program is responsive to the needs of VA and that its infrastructure is sound.

Action 1. Convene the Research Realignment Advisory Committee.

The Research Realignment Advisory Committee held its inaugural meeting on September 20, 1995. It met again in December 1995, and March 1996. A final report is expected by June 1996. It will make recommendations about VHA's research program according to criteria specified by the Under Secretary for Health. (See Figure 4.)

Figure 4. Criteria for Evaluating VHA's Research Program

Is/Does VHA's Research Program:

- 1. Appropriately target the needs of veterans;***
- 2. Capitalize on the unique resources and opportunities provided by the veterans healthcare system;***
- 3. Have sufficient managerial flexibility to accommodate a rapid response to changing healthcare needs while maintaining the stability of the research infrastructure;***
- 4. Have an appropriate balance of basic, applied and outcomes research;***
- 5. Targeted to projects that cover a spectrum of healthcare issues or disease conditions so as to increase the likelihood of multiplicative benefits;***

- 6. Have an appropriate infrastructure in place to accept grants from and/or enter into investigative partnerships with private industry, non-profit foundations and other “alternative” sources of funding; and*
- 7. Have adequate and appropriate informed consent policies and procedures, especially with regard to psychiatric and substance abuse patients.*

Action 2. Develop and promulgate a research strategic plan.

A committee of field and headquarters research and development staff have met three times to develop a research strategic plan. Further action is being deferred until the Research Realignment Advisory Committee makes its recommendations and a new Chief of the Office of Research and Development is on board.

Action 3. Examine each of VHA’s research program elements to ensure that appropriate fiscal and grant award practices are being utilized.

Field and headquarters staff have formulated internal control objectives and have conducted vulnerability assessments. Current practices are being reviewed by the Research Realignment Advisory Committee.

Objective 26. Expand collaborative investigative efforts with government and non-government entities.

Action 1. Ensure close coordination of Persian Gulf War-related illnesses research, and augment these efforts as needed.

VHA provides leadership to the Persian Gulf War Veterans Coordinating Board Research Working Group. The group has published “Federal Activities Related to the Health of Persian Gulf War Veterans” and an annual report on VA, DoD, and Health and Human Service’s Persian Gulf War research. The group also sponsored a Persian Gulf War Research Investigators Meeting in June 1995, and has issued “A Working Plan For Research on Persian Gulf War Veterans Illnesses.” The working plan provides a framework for identifying gaps in knowledge, guidance on research priorities and for

preventing duplications in Persian Gulf War-related illness research. In addition, the group reviewed and prioritized responses to a DoD request for proposals on clinical, toxicological and epidemiological research related to Persian Gulf War veterans' health.

Action 2. Implement a Diabetes Research Initiative with the Juvenile Diabetes Foundation (JDF).

A memorandum of agreement between VA and JDF was signed on August 15, 1995, setting the terms for an innovative collaboration in diabetes research. Each organization is expected to contribute up to \$1.5 million annually over a five-year period (\$15 million total). A solicitation for proposals to create VA diabetes research centers of excellence was issued in September 1995. These proposals are now being reviewed. Successful proposals will be funded beginning October 1996.

Action 3. Expand joint efforts with the Agency for Health Care Policy and Research (AHCPR) pursuant to the memorandum of understanding.

A Memorandum of Understanding agreeing to plan future collaborative research was signed by VHA and the AHCPR on September 23, 1995. The scope of collaboration of such research initiatives will depend on the two agencies' FY 96 appropriations.

Action 4. Expand co-ventures with the University Health Systems Consortia (UHC).

On May 8, 1995, VA signed a Memorandum of Understanding with UHC agreeing to share information on drug monographs and technology assessments. As a result, all VA medical facilities receive new UHC monographs and their Technology Alert newsletters as they are published. VA shares all internally developed drug monographs and drug class evaluations with UHC.

VA and UHC have further agreed to collaborate on the collection of drug-related treatment guidelines and on a clinical practice bulletin on the treatment of dementia. A working group is now considering additional areas for VA and UHC to collaborate.

Action 5. Expand collaborative research efforts with manufacturers of high cost/high technology equipment.

VA has the patient base, clinical expertise and research infrastructure to serve as a proving ground for leading edge technology. Opportunities for collaborative research efforts with industry will be actively sought.

Objective 27. Capitalize on the special research opportunities available in VA.

Action 1. Finalize implementation of a Spinal Cord Dysfunction Registry.

The infrastructure and software for establishing a spinal cord dysfunction registry at each VA medical facility and linking these hospital registries into a centralized national registry have been developed. Early in 1996, the registry will be populated with information from a national survey.

Action 2. Develop a Request for Proposals (RFP) and establish Mental Illness Research and Education Centers (MIRECs).

VHA is developing an RFP for up to five MIRECs. The RFP is being reviewed by the Mental Health Field Advisory Board and the Committee for New Knowledge in Mental Health.

Action 3. Implement a Nursing Research Initiative.

The Under Secretary for Health's Nursing Research Initiative was operationalized in August 1995, with a request for applications. Of the 248 Letters of Intent received, 46 were approved and accepted for full proposal development. Final proposals were due by March 1996. Selections will be made in mid-FY 96, with funding set for the end of the FY 96.

Action 4. Initiate an Emerging Pathogens Registry.

VA provides a unique opportunity to assist public health surveillance activities for new antibiotic-resistant or otherwise problematic pathogens. Partnerships with other federal

agencies have been initiated and staffing for the Emerging Pathogen Initiative is in progress. The development of the needed DHCP interface is in the planning stages.

Action 5. Initiate a Health Outcomes Research Initiative.

In FY 96, VHA funded 11 new outcomes-related projects. Three additional projects have been approved for funding in FY 96. New outcomes research projects address the following: analyzing medical outcomes in patients treated in VA hospitals compared to private sector hospitals; analyzing coronary angioplasty outcomes in veterans compared to patients receiving care in the private sector; developing instruments for assessing the impact of oral conditions on quality of life in the elderly; and measuring the quality of medication treatment for patients with psychotic disorders. A large multi-site study has also been initiated to determine if telephone contact with veterans in lieu of clinic visits would lower the cost of providing care without adversely affecting quality. (See also Objective 4, Action 13.)

Action 6. Expand environmental hazards research activities.

In FY 95, VHA established three environmental hazards research centers. The objective for these centers is to serve as foci for research on the health effects of environmental toxicants unique to military service. Initially, these research centers are focusing on Persian Gulf War veterans' illnesses. Planning for a fourth environmental hazards research center to focus on other environmental health issues will begin in FY 96. Additional sites and topics will be considered depending on funding and needs.

Action 7. Expand collaborative activities with the National Institute on Drug Abuse (NIDA).

On September 28, 1995, an Inter-Agency Agreement between NIDA and VA was signed to establish Collaborative Substance Abuse Medication Development Research Centers. These research units will serve as centers for evaluating pharmacotherapeutic compounds for the treatment of drug abuse and addiction. Five VA medical centers have been funded for five years for a total of \$41.4 million. These centers are now responding to a new project solicitation recently issued by NIDA.

Objective 28. Increase awareness and understanding of VHA's role in healthcare education and research.

Action 1. Solicit agreement from the Journal of the American Medical Association to feature a "From the Veterans Health Administration" section.

The Journal of the American Medical Association has agreed to feature a "From the VHA" section.

Action 2. Continue the National VA Research Week that was started in 1995.

National VA Research Week was held for the first time during July 1995. The week of April 7 - 14 has been designated National VA Research Week for 1996.

Action 3. Hold the 1996 Under Secretary's Substance Abuse Research Conference.

The previously planned Under Secretary for Health's Substance Abuse Research Conference has been postponed until late FY 97 due to funding issues.

Action 4. Commemorate 1996 as the 50th anniversary of VA-academic affiliations.

On January 31, 1996, in Chicago, VA and the Association of American Medical Colleges (AAMC) inaugurated a series of events to commemorate the 50th anniversary of VA-medical school affiliations. Commemorations are tentatively scheduled at other locations around the country. The House of Delegates of the American Medical Association passed a commemorative resolution at its December 1995 meeting, and planning is underway for an event at the June meeting of the House of Delegates.

MISSION GOAL IV

Be an Organization that is Characterized by Exceptional Accountability

Guiding Principles

Principle 27. High performing organizations are characterized by their individual member and collective organizational accountability.

Principle 28. As a public, taxpayer-supported institution, VA has to meet a higher standard of accountability than similar private sector institutions.

Principle 29. Being accountable is a fundamental tenet underlying the physician/caregiver-patient relationship.

Strategic Objectives

Objective 30. Promote a culture that places a high value on individual and collective accountability.

Action 1. Implement a performance-based pay system for senior VHA executives.

Efforts are being made to more closely link pay with performance within existing statutory allowances.

Action 2. Develop a medical caregiver performance-based pay system.

VHA appointed a task group to review pay plans for physicians and dentists, which would focus on individual productivity and de-emphasize tenure. This group has written its first report, and will meet to focus on the mechanisms required to proceed.

Action 3. Design the management information system so that it tracks and links care to individual caregivers throughout VHA's continuum of service delivery.

VHA initiated the Clinical Information Resource Network in February 1995. It will include a National Provider Index which will identify caregivers and link patient care to these providers. This information will be incorporated into the Decision Support System and National Patient Care Database, as well as local databases such as the medical record.

Action 4. Implement the Government Performance and Results Act of 1993 (GPRA).

GPRA requires a new, performance-based approach to planning, budgeting and measuring performance of government programs. Because of the complexity and level of change envisioned, GPRA permits agencies to develop pilot efforts to test effectiveness of these new approaches. VHA is pilot testing GPRA in six VAMCs: Albuquerque, Bedford, Cleveland, Milwaukee, Salt Lake City and Tomah. Reports from these pilot efforts are expected over the next several months. The results are expected to be

consistent with what VHA is pursuing regarding performance-based management contracts and other outcomes-oriented measures.

Action 5. Develop and inaugurate new incentives and rewards that promote teamwork and innovation.

A work group has been convened to review current VHA awards and to develop additional awards to promote teamwork, innovation and excellence.

Objective 31. Promote a culture where individually and collectively VHA provides a model of ethical behavior and integrity.

This objective is being pursued through a combination of new educational programs, performance contracts, new awards and incentives, and customer service standards.

MISSION GOAL V

Be an Employer of Choice

Guiding Principles

Principle 30. The more desirable an institution is to work for, the more likely it is to have a highly motivated staff that is focused on accomplishing the organization's mission.

Principle 31. Well-trained and empowered employees are more likely to provide high quality service, innovate and be maximally productive.

Principle 32. Organized labor unions should be viewed as partners in a long-term effort to improve patient care, enhance the quality of work life and build sustainable jobs for the future.

Strategic Objectives

Objective 32. Maintain high-level job satisfaction.

Action 1. Identify the major aspects of employment that affect employee satisfaction (e.g., working conditions, compensation, benefits, recognition, organizational leadership, relationships with peers, advancement opportunities, training opportunities) and establish baseline data for VHA.

Develop an instrument and survey employees on the key components of job satisfaction.

Action 2. From the employee satisfaction survey results, identify areas that produce high satisfaction and develop strategies for ensuring that these practices are widely disseminated and utilized to promote VHA as an employer of choice.

Action 3. Identify areas of dissatisfaction and develop strategies to address them.

Action 4. Ensure that various human resource systems, (e.g., performance management, awards, compensation) are linked to VHA's vision, business plan, strategic goals, and promote a sense of fairness and satisfaction among employees.

Proposed legislation would permit VHA to develop an alternative personnel system to the Title 5 civil service system that would be based on the needs of a healthcare system and its workers.

Objective 33. Promote a VA culture that facilitates being a “learning organization” and that encourages individual and interdisciplinary innovation.

Action 1. Educate employees about the expectations of a “learning organization.”

Several education centers and field facilities have been working with the private sector to develop interventions to create a learning organization. For example, three education centers and seven VA medical centers have worked with 11 private sector community hospitals in a learning consortium, which has recently produced a computerized management simulation, "Creating a Community-based Integrated Health Care System." Such efforts will continue and will be encouraged.

Action 2. Increase employee training and career development opportunities.

Action 2.1. Establish an Office of Employee Education.

The Office of Employee Education was established in headquarters in November 1995. Recruitment is underway for a permanent Employee Education Officer.

The Office of Employee Education will offer national training programs, special programs, tuition support, executive development, career field intern programs and mid-level manager training.

Action 2.2. Convene a work group to examine job cross-training, employee development and other workforce issues emerging as a result of VHA's restructuring and the changing nature of healthcare.

Action 2.3. Convene a work group to examine the facility director and other senior executive career tracks in light of VHA's restructuring and new vision.

A work group chaired by the VISN 7 director has been appointed to review the selection, advancement and training needs of the VHA career executive.

Action 2.4. Revise VHA directives on the role and use of nurse practitioners, physician assistants and clinical pharmacists in order to better utilize these professionals.

Revised policy directives on the scope of practice for physician assistants, nurse practitioners and clinical pharmacy specialists were developed and issued in March 1995. Prescribing guidelines for these professions were also promulgated in March 1995.

Objective 34. Visibly communicate to current and prospective employees VA's commitment to the principles of equal opportunity and the provision of a workplace free of discrimination and harassment.

Action 1. Develop a workforce that reflects diversity at all levels.

Action 2. Combat discrimination and harassment through continuing workforce education and "no tolerance" policies toward offenders.

Action 3. Hold managers accountable for taking appropriate action to promote workplace respect and equal opportunity, including leadership by example.

Objective 35. Ensure that VHA employees have the tools and equipment necessary to provide quality services to patients and have a work environment supportive of the vision of the "new VA."

Objective 36. Reduce work-related injuries, illnesses and workers compensation claims and costs.

Action 1. Expand use of the Compensation/Occupational Safety and Health Management Information System (this is a database containing information from the Department of Labor on the status of each compensation claim).

Seventy-two VA medical centers are currently on line using this database, which facilitates case management and savings.

Action 2. At each facility, designate a qualified individual to manage and be accountable for the facility's OWCP responsibilities.

Objective 37. Minimize the untoward effects of reductions-in-force (RIFs) through careful planning, open communication and by providing career transition assistance.

Action 1. All facilities anticipating a RIF will initiate a Career Transition Center to provide assistance in career counseling, job hunting and related services.

Action 2. All facilities anticipating a RIF will take steps to recognize and mitigate the emotional ramifications inherent in such actions.

Objective 38. Provide a secure work environment.

Action 1. Devote sufficient resources to security and law enforcement functions to ensure that facility programs meet current standards.

Action 2. Educate employees on safety/law enforcement programs (e.g., crime prevention, employee responsibilities).