Annual Performance Report FY 2000

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Letter of Transmittal

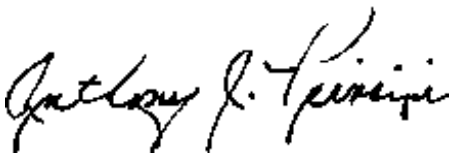
To the President of the United States, President of the Senate, President pro tempore of the Senate, and Speaker of the House of Representatives:

I am pleased to submit the Department of Veterans Affairs' (VA) Annual Performance Report FY 2000, as required by the Government Performance and Results Act of 1993. This report documents VA's progress in providing high-quality, timely benefits and services to America's veterans.

During FY 2000, the Department's efforts resulted in many notable accomplishments. VA provided health care to more patients than at any time during our history of service to veterans and their families. The quality of our health care delivery increased, while the cost of providing that care continued to decline. For the second year in a row, patients' satisfaction with VA outpatient care ranked above outpatient care offered by private sector hospitals. The average annual income of disabled veterans who completed the vocational rehabilitation and employment program was nearly six times greater than before they entered the program.

The Department took aggressive steps to improve access to benefits and services by expanding the number of facilities providing health care, reducing waiting times for health care, and opening three new national cemeteries. Veterans can now contact us more easily because of improvements in telephone service and the application of new technologies.

Our Nation is deeply indebted to the more than 25.5 million living men and women who have served our country in uniform. I am honored and privileged to have the opportunity to work with Congress, veterans service organizations, and over 200,000 dedicated VA employees to ensure that America fulfills the promise to our veterans and their families. As I begin my tenure as Secretary, I look forward to working together to improve the timeliness and accuracy of claims processing, to expand access to quality health care, and to meet the burial needs of veterans. Our veterans deserve the best our country can offer, and I intend to make sure they receive the care and service they have earned.



Anthony J. Principi
Secretary of Veterans Affairs

VA's PERFORMANCE SCORECARD FOR FY 2000

Strategic Goal	Performance Measure	Was the Goal Achieved: Yes	Was the Goal Achieved: No	Plan	Actual	Page(s)
Restore the capability of disabled veterans to the greatest extent possible, and improve the quality of their lives and that of their families	National accuracy rate for core rating work		✓	81%	59%	20, 126
	Percent of compensation and pension claimants who are satisfied with the handling of their claim		✓	65%	56%	23, 126
	Average days to process rating-related actions on compensation and pension claims		✓	160	173	24, 125
	Abandoned call rate for compensation and pension	✓		10%	6%	27, 125
	Blocked call rate for compensation and pension	✓		15%	3%	27, 126
	Appeals resolution time (in days)		✓↑	670	682	28, 130
	Vocational rehabilitation and employment rehabilitation rate	✓		60%	65%	30, 128
	Compensation and dependency and indemnity compensation (DIC) program outcomes			N / A	N / A	31
Ensure a smooth transition for veterans from active military service to civilian life	Montgomery GI Bill usage rate		✓	57%	55%	34, 127
	Average days to complete original education claims		✓	26	36	37, 127
	Average days to complete supplemental education claims		✓	17	22	37, 127
	Foreclosure avoidance through servicing (FATS) ratio		✓	39%	30%	39, 128
Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation	Percent of patients who rate VA health care service as very good or excellent: Inpatient Outpatient		 ✓↑ ✓	 67% 67%	 66% 64%	 44, 117 44, 117
	Percent of patients who are able to obtain a non-urgent appointment with a specialist within 30 days of referral			N / A	N / A	46
	Percent of patients who are able to obtain a primary care appointment within 30 days			N / A	N / A	46
	Percent of patients seen within 20 minutes of scheduled appointment at VA health care facilities		✓↑	75%	70%	46, 118
	Chronic disease care index	✓		89%	90%	49, 117
	Prevention index		✓	89%	81%	51, 119
	Percent reduction in average cost (obligations) per patient	✓		-16%	-18%	54, 117
	Percent increase in number of unique patients treated	✓		21%	21.5%	56, 120
	Percent of medical care operating budget derived from alternative revenue streams		✓	3.7%	3.4%	59, 118
	Pension program outcomes			N / A	N / A	60
	Insurance program outcomes			N / A	N / A	61
	Percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence	✓		75.1%	75.2%	63, 130
	Percent of respondents who rate the quality of service provided by national cemeteries as excellent	✓		88%	88%	65, 130
Contribute to the public health, socioeconomic well being and history of the Nation	Research projects relevant to VA's health care mission	✓		99%	99%	68, 125
	Percent of residents trained in primary care	✓		47%	48%	70, 125
	Percent of respondents who rate the appearance of national cemeteries as excellent	✓		82%	82%	71, 130

↑Indicates those measures for which there was an improvement in the FY 2000 performance over the FY 1999 performance.

EXECUTIVE SUMMARY

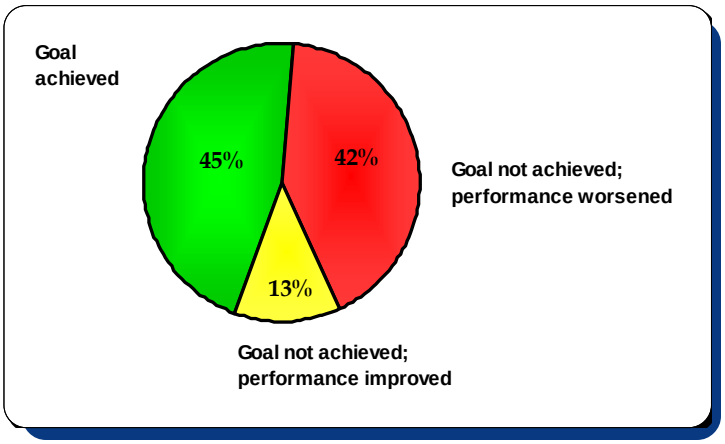
In FY 2000, with resources of $50.9 billion in obligations and nearly 203,000 full-time equivalent (FTE) employees, the Department of Veterans Affairs (VA) recorded significant accomplishments that brought us closer to attaining our long-term strategic goals. To help us gauge our progress, we established 116 performance goals at the beginning of the fiscal year, 29 of which were identified as critical to the success of the Department by VA's senior leadership.

VA's Performance Scorecard for FY 2000, shown on page IV, summarizes how well we did in meeting the key performance goals directly associated with each of the strategic goals. This approach allows us to examine performance from a Departmental, or *One VA*, perspective.

Some of the most important successes attained in FY 2000 include:

- VA provided health care to more patients than at any other time in our history of service to veterans and their families.
- The quality of health care provided by VA continued to improve, as the Department expanded its use of nationally recognized clinical guidelines for treating patients with chronic diseases.
- At the same time that more patients were provided high-quality health care, the cost (per patient) of that care continued to decline.
- Among both inpatients and outpatients, the percentage rating VA health care service as "very good" or "excellent" remained at a high level, particularly as compared to satisfaction levels among patients treated by the private sector.
- The Department made progress in improving access to health care, as a higher percentage of patients were seen within 20 minutes of their scheduled appointment at a VA health care facility.
- For the third consecutive year, the Department maintained at an extremely high level the proportion of medical research projects related to the health care of veterans or to fulfilling critical VA missions.
- VA continued to enhance the quality of care through an extensive education and training program involving health care students and residents.
- For the second year in a row, VA registered dramatic improvement in telephone service, as evidenced by the low abandoned call and blocked call rates.
- VA reduced the average length of time it takes to process veterans' appeals of the Department's decisions on compensation and pension claims.
- For the second year in a row, VA exceeded its annual target for rehabilitating disabled veterans by returning them to employment.
- The Department made significant progress in developing program outcomes for the compensation, pension, and insurance programs.
- The percentage of veterans served by a burial option in a national or state veterans cemetery within a reasonable distance of their residence continued to grow.

- An increasing share of respondents rated the quality of service provided by national cemeteries as "excellent."
- Satisfaction with the appearance of national cemeteries remained at a very high level.
- The Department received an unqualified opinion from the Office of Inspector General (OIG) on the FY 2000 consolidated financial statements.



Performance remained noticeably off track in the timeliness and accuracy of processing claims for compensation and pension benefits. Claims processing has become increasingly complex because of new legislation and regulatory changes. The Department remains committed to improving the timeliness and accuracy of claims processing and has developed strategies for accomplishing future performance goals.

Summary of Performance on Key Performance Goals

VA's senior leadership identified 29 performance goals considered critical to the success of the Department. Some of these deal with program outcomes; others pertain to the management of our programs. FY 2000 data are available for all but five of these key performance goals.

The Department achieved 11 of the 24 key performance goals for which we had FY 2000 data. For 3 of the 13 performance goals we did not meet, actual performance in FY 2000 was better than that reported in FY 1999.

We were not able to collect data in a format that provided information on the percent of patients able to obtain a primary care appointment or specialty appointment within 30 days. We are still refining the data collection vehicles to capture the information in an appropriate format. We expect to have data on these two performance measures during FY 2001.

We are still in the process of identifying the desired outcomes and supporting performance measures for three of our programs—compensation, pension, and insurance. We are working jointly with our key stakeholders in Congress, at the Office of Management and Budget (OMB), and among veterans service organizations in developing this information.

Key Performance Results by Strategic Goal

Strategic Goal 1: Restore the capability of disabled veterans to the greatest extent possible and improve the quality of their lives and that of their families.

We use eight key performance goals to gauge our progress toward achieving this strategic goal, which focuses on benefits and services for disabled veterans. FY 2000 data for one of these key performance goals—compensation program outcomes—are being developed. Of the remaining seven key performance goals, we achieved three.

For issues related to compensation and pension, telephone service to veterans continued to improve during FY 2000. We reduced the abandoned call rate (caller gets through but hangs up before speaking with a VA representative) from 9 percent to 6 percent. Also, we dramatically improved the blocked call rate (caller gets a busy signal) from 27 percent to 3 percent.

During FY 2000, the number of veterans who were rehabilitated was over 10,600; 65 percent of service-disabled veterans who exited a vocational rehabilitation program acquired and maintained suitable employment, a 12 percent increase over FY 1999. In FY 2000, the VA program responsible for helping veterans with service-connected disabilities to achieve suitable employment, or to enhance their ability to function independently in the home or community, was renamed the Vocational Rehabilitation and Employment program. This change more clearly states the program's focus on employment.

During FY 2000, the national accuracy rate in processing the Department's most important types of claims for compensation and pension benefits (i.e., rating-related actions) fell to 59 percent, a figure well below the target level of 81 percent. To reduce accuracy problems, the Department is working to improve how it shares best practices throughout VA's regional offices.

VA measures satisfaction with the way claims for compensation and pension are handled. FY 2000 customer satisfaction data show that only 56 percent of claimants were "very satisfied" or "somewhat satisfied," a figure below the performance target of 65 percent. There has been very little change in performance on this measure during the last 5 years, due at least in part to challenges associated with improving the timeliness with which these claims are processed.

Our current performance in the timeliness of claims processing, especially rating-related actions, is unacceptable *(see page 24)*. For FY 2000, the average for processing rating-related actions was 173 days, 13 days higher than the target level of performance. Rating-related actions, including claims for original compensation and original pension benefits, represent the most complicated and time-consuming work confronting regional office staffs. Due to new legislation and complex regulatory changes affecting the manner in which compensation and pension claims are processed, we expect performance to worsen during FY 2001.

We also fell short of meeting our FY 2000 performance target for appeals resolution time, which measures the overall length of time it takes VA to handle all types of claims, including cases that are appealed to the Board of Veterans' Appeals *(see page 28)*. Although we missed our target by 12 days, this performance reflects an improvement of 63 days, or 8.5 percent, from our FY 1999 performance.

Strategic Goal 2: Ensure a smooth transition for veterans from active military service to civilian life.

We did not meet the four key performance goals relating to achievement of this strategic goal in FY 2000. The Montgomery GI Bill (MGIB) usage rate remained about the same, at 55 percent *(see page 34)*.

Veterans use their VA education benefit as one important means of readjusting to civilian life. The MGIB allows them the opportunity to achieve educational or vocational objectives that might not have been attained had they not entered military service.

The timeliness of processing education claims deteriorated during FY 2000. While our plan was to process original education claims in no more than 26 days, it took an average of 36 days. The average number of days needed to process supplemental education claims was 22 days, or 5 days longer than the performance target.

Although we did not meet our goal to assist veterans who are in default on a VA-guaranteed home mortgage, as measured by the Foreclosure Avoidance Through Servicing (FATS) ratio, the variance from plan is not as great as it might appear. The actual level of achievement (30 percent) reflects a modification in the method of calculating the ratio, without changing the performance target (39 percent). Prior to FY 2000, the different means to avoid foreclosure were weighted to favor some means over others. Each of the means is now given equal weight.

Strategic Goal 3: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

VA uses several key performance goals to determine how well we are achieving this strategic goal. FY 2000 data are not available for 4 of these goals—the percentage of patients able to obtain a primary care appointment or specialty appointment within 30 days *(see page 46)*; and outcomes for VA's pension and insurance programs *(see pages 60 and 61)*.

We achieved 5 of the other 10 key performance goals; for 2 of the 5 key performance goals we did not meet, performance during FY 2000 was better than that reported in FY 1999.

During the last 4 years, the share of inpatients and outpatients rating VA health care service as "very good" or "excellent" has remained stable at about two-thirds. The inpatient and outpatient satisfaction levels recorded during FY 2000, although below the performance target of 67 percent, still indicate a very high level of satisfaction with VA health care. This is supported by results from a National Partnership for Reinventing Government (NPR) study using the American Customer Satisfaction Index (ACSI) as a national indicator of customer evaluations of

the quality of goods and services. The FY 2000 ACSI for VA outpatient care is 78 on a scale of 0 to 100. For the second consecutive year, VA outpatient care ranks above private sector hospitals, whose ACSI score is 71. In addition, the VA score is higher than the ACSI of 72 recorded by all Americans rating their health care services.

Although the Department did not meet its FY 2000 target—that 75 percent of patients would be seen within 20 minutes of their scheduled appointment at VA health care facilities—the actual performance level of 70 percent was an improvement over the 68 percent registered during FY 1999.

VA uses two key performance measures to assess the quality of health care delivery—the Chronic Disease Care Index (CDCI) and the Prevention Index (PI). These indices measure the degree to which the Department follows nationally recognized guidelines for the treatment and care of patients.

The CDCI focuses on the care of patients with ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and obesity. During FY 2000, VA improved its score by one point on the CDCI to 90 percent.

The PI focuses on primary-prevention and early-detection recommendations for eight diseases or health factors that significantly determine health outcomes: pneumococcal pneumonia, influenza, tobacco consumption, and alcohol consumption; screenings for colorectal cancer, breast cancer, cervical cancer, and prostate cancer. Although VA did not meet the performance target of 89 percent, the PI of 81 percent was the same as last year, and has more than doubled since 1996.

We achieved another of our key performance goals by improving our efficiency in providing health care services to patients (both veterans and non-veterans). Using constant dollars, the average cost (obligations) per patient was $4,470, which is 2.5 percent below the FY 1999 figure of $4,585. In addition, we succeeded in providing health care to more patients. VA treated 3,817,300 unique patients (including 3,505,000 veterans) in FY 2000—6.8 percent above the number for FY 1999 and an increase of 21.5 percent over the last 3 years.

VA did not meet its performance goal to increase the proportion of the medical care operating budget derived from medical cost recoveries and other sharing revenues. The rate of recovery in FY 2000, 3.4 percent, fell just short of the FY 2000 target of 3.7 percent and was slightly behind last year's rate of 3.8 percent.

The percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence increased to 75.2 percent in FY 2000. This increase reflects the opening of three new national cemeteries and four new state veterans cemeteries.

VA uses visitor comment cards to obtain feedback from customers on their satisfaction with the quality of service provided by national cemeteries. In FY 2000, VA increased to 88 percent the number of respondents who rated the quality of service provided by national cemeteries as "excellent."

Strategic Goal 4: Contribute to the public health, socioeconomic well being and history of the Nation.

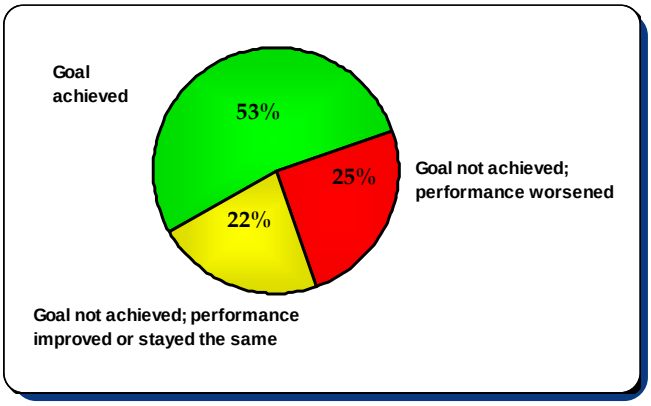
VA met all three key performance goals relating to this strategic goal in FY 2000. Since FY 1998, VA has maintained at 99 percent the proportion of medical research projects demonstrably related to the health care of veterans or to other Departmental missions. All research proposals are submitted through a peer review process. Those projects with VA health care relevance were consistently selected for funding before projects that lacked demonstrable relevance. In keeping with our tradition, VA's research program benefits not only veterans, but also the entire Nation and the international community.

VA conducts an extensive education and training program to enhance the quality of care provided to veterans within the VA health care system. FY 2000 marks the third consecutive year in which VA has exceeded its performance goal to increase the percent of residents trained in primary care.

In FY 2000, satisfaction with the appearance of national cemeteries remained at a very high level, as 82 percent of respondents completing visitor comment cards rated cemetery appearance as "excellent."

All Performance Goals

In addition to the key performance goals identified by VA's senior leadership as critical to the success of the Department, program managers established other performance goals at the beginning of FY 2000. Collectively, these performance goals demonstrate the full scope of the Department's programs and operations. A total of 116 performance goals were set at the start of the fiscal year. VA met 53 percent of the performance goals for which we had data. For another 22 percent, the Department's performance was equal to, or better than, that recorded last year. For more detailed information on the full range of performance goals, refer to the tables shown on pages 105 to 116.



ALTERNATIVE WAYS OF VIEWING PERFORMANCE

To meet the varied needs of Congress, OMB, veterans service organizations, the general public, and internal VA program managers, we have examined performance in several different ways. Most of our analysis focuses on the key performance goals and measures considered critical to the success of the Department.

The Performance Scorecard for FY 2000, shown on page IV, is structured around VA's strategic goals. The scorecard summarizes how well we did in meeting the limited number of key performance goals directly associated with each of the strategic goals. This approach allows us to examine performance from a Departmental, or *One VA*, perspective.

While the *One VA* point of view is important, this is not the only way in which we analyze performance. We want to know how well we did in meeting the goals established for each of our programs, and we are interested in information on how well each of our major organizations performed. The following chart demonstrates the interrelationship between these alternative ways of viewing performance related to our key performance goals.

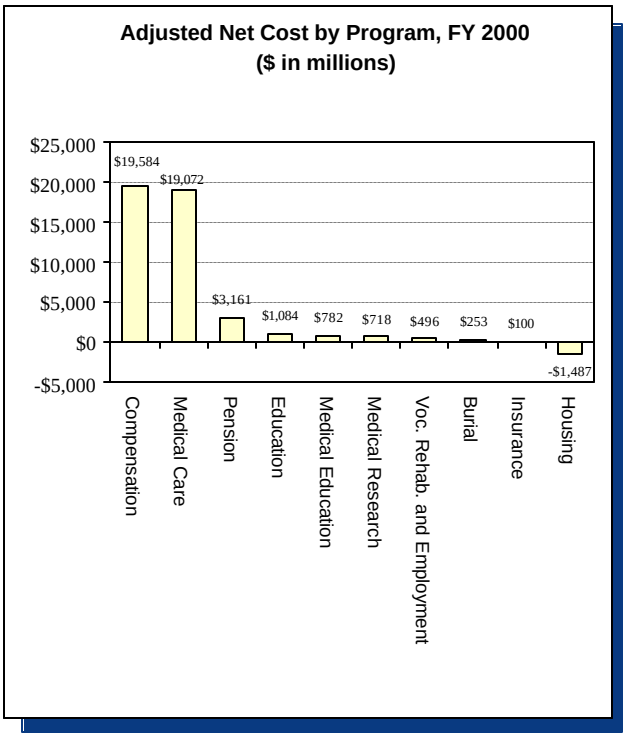
Key Performance Measures by Responsible Organization and Program

Responsible Organization and Measure	Program									
	Medical Care	Medical Research	Medical Education	Compensation	Pension	Education	Housing	Vocational Rehabilitation	Insurance	Burial
Veterans Health Administration										
Percent of patients who rate VA health care service as very good or excellent										
Inpatient	X									
Outpatient	X									
Percent of patients who are able to obtain a non-urgent appointment with a specialist within 30 days of referral	X									
Percent of patients who are able to obtain a primary care appointment within 30 days	X									
Percent of patients seen within 20 minutes of scheduled appointment at VA health care	X									
Chronic disease care index	X									
Prevention index	X									
Percent reduction in average cost (obligations) per patient	X									
Percent increase in number of unique patients treated	X									
Percent of medical care operating budget derived from alternative revenue streams	X									
Research projects relevant to VA's health care mission		X								
Percent of residents trained in primary care			X							
Veterans Benefits Administration										
National accuracy rate for core rating work				X	X					
Percent of compensation and pension claimants who are satisfied with the handling of their claims				X	X					
Average days to process ratng-related actions				X	X					
Abandoned call rate for compensation and pension				X	X					
Blocked call rate for compensation and pension				X	X					
Appeals resolution time				X	X					
Compensation and dependency and indemnity compensation (DIC) program outcomes				X	X					
Pension program outcomes					X					
Montgomery GI Bill usage rate						X				
Average days to complete original education claims						X				
Average days to complete supplemental education claims						X				
Foreclosure avoidance through servicing (FATS) ratio							X			
Vocational rehabilitation and employment rehabilitation rate								X		
Insurance program outcomes									X	
National Cemetery Administration										
Percent of veterans served by a burial option within a reasonable distance (75 miles) from their residence										X
Percent of respondents who rate the quality of service provided by national cemeteries as excellent										X
Percent of respondents who rate the appearance of national cemeteries as excellent										X

FINANCIAL HIGHLIGHTS

- Pursuant to the requirements of 31 U.S.C. 3515 (b), VA's financial statements have been prepared to report the financial position and results of operations of the Department. The audit of the statements was performed by Deloitte & Touche, LLP, under the direction of the Office of Inspector General (OIG). The financial statements received an unqualified opinion from the auditors in FY 2000, continuing the success first achieved in FY 1999. While the statements have been prepared from the books and records of the Department in accordance with the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources prepared from the same books and records. The statements are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so. For more information on VA's financial statements, refer to the FY 2000 Annual Accountability Report.

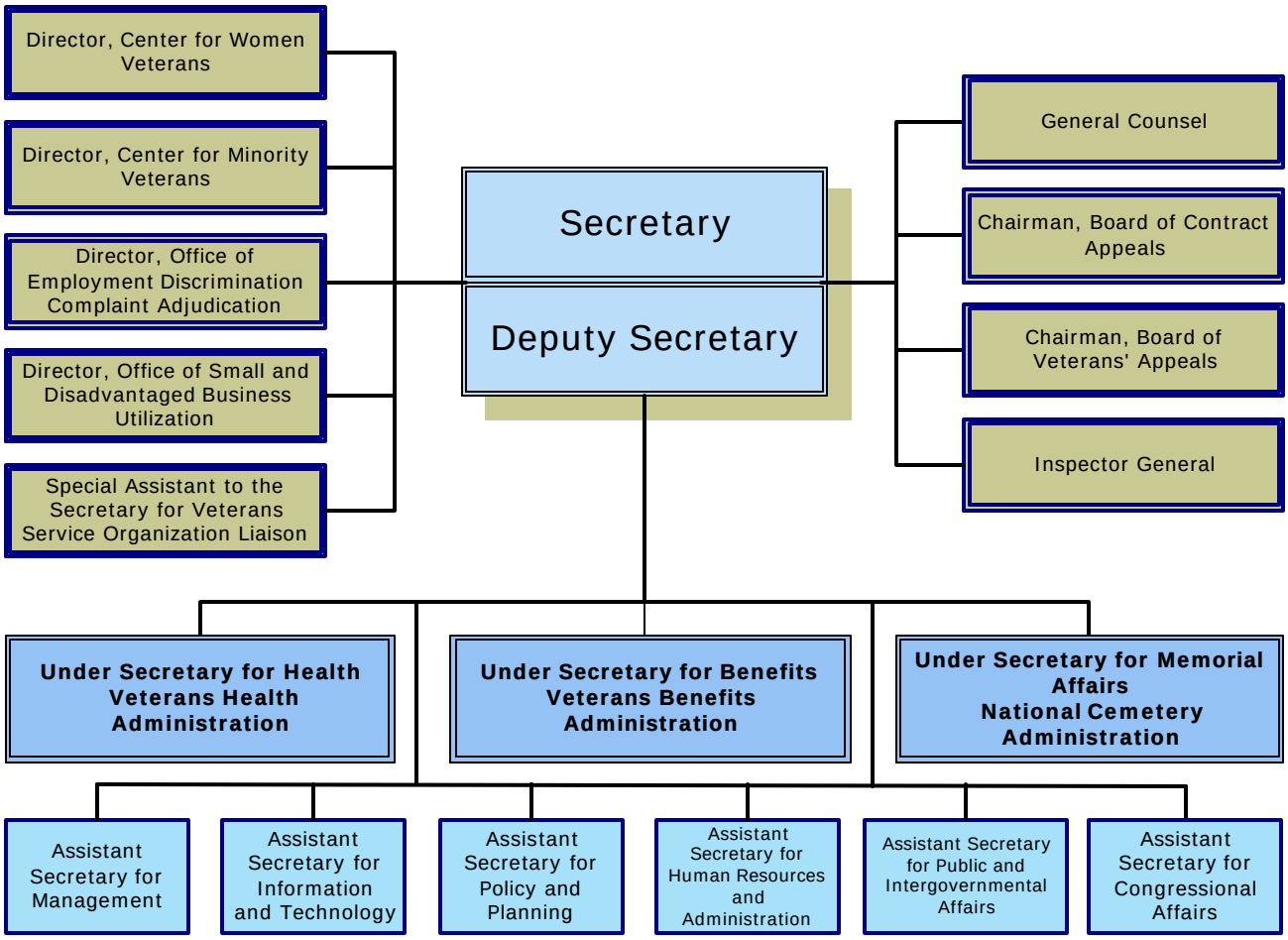
- VA's 10 major programs operated at a net cost of $106.2 billion in FY 2000, compared with a net cost of negative $50.6 billion in FY 1999. The calculation of the actuarial liability for future years' veterans compensation and burial benefits, which decreased by $95 billion in FY 1999 and increased by $62.5 billion during FY 2000, heavily impacts each year's cost. This estimate is influenced by fluctuations in the discount rate used to compute the present value of this liability. Excluding the change in this actuarial liability from the net cost would result in an adjusted net cost for VA's 10 programs of $43.8 billion for both fiscal years.



- The assets on VA's balance sheet have changed very little over the years. Veterans benefits programs, principally home loans and veterans' life insurance policy loans, dominate receivables. A change in VA policy for Property, Plant and Equipment (PP&E), which raised the dollar threshold for the capitalization of personal property, caused a decrease in the capitalized value reported for PP&E. In addition, the amounts reported for patient and third-party insurers' medical debt increased because of changes in billing. VA now bills for medical services based on "reasonable charges" rather than "reasonable cost." Amounts collected under this program are retained by VA and used for medical care.

- The Department has continued its aggressive use of the government-wide commercial purchase card program. Purchase card disbursements for FY 2000 were over $1.3 billion, covering 2.2 million transactions and earning VA credit card refunds from Citibank totaling over $13 million.
- For the period January through September 2000, $3.65 million in benefit offsets were made for debts delinquent over 90 days, and $5.85 million was collected through the Treasury Offset Program.
- Through the use of a private contractor, $8.9 million, with a $6.9 million benefit to VA, was recovered during the period June 1997 through March 2000.

WHO WE ARE



The FY 2000 Performance Report documents VA's progress in providing high-quality, timely benefits and services to the men and women who have served our country in the armed forces. This report identifies the achievements VA recorded during FY 2000 that have contributed to attaining the goals and objectives in the VA Strategic Plan and Annual Performance Plan. In so doing, we are providing detailed information—to Congress, OMB, veterans service organizations, and other stakeholders—to spell out not only what we do, but more importantly, *how well we are doing* in meeting our commitment to honor our veterans and to compensate them for their sacrifices.

Mission

"To care for him who shall have borne the battle, and for his widow and his orphan."

These words, spoken by Abraham Lincoln during his Second Inaugural Address, reflect the philosophy and principles that guide VA in everything we do in our efforts to serve our Nation's veterans and their families.

In today's environment, President Lincoln's statement reflects VA's responsibility to treat America's veterans and their families with profound respect and compassion; to be their principal advocate in promoting the health, welfare, and dignity of all veterans; and to ensure they receive the medical care, benefits, social support, and lasting memorials they deserve in recognition of their service to America.

The statutory mission authority for the Department of Veterans Affairs (VA) defines our organizational commitment to America's veterans: "to administer the laws providing benefits and other services to veterans and the dependents and the beneficiaries of veterans." (38 U.S.C. 301(b)) VA exists to give meaning, purpose, and reality to that commitment. The needs, preferences, and expectations of veterans directly shape the benefits and services we provide.

Vision

As the needs of veterans change, VA must change to address those needs by:

- Becoming an even more veteran-focused organization, functioning as a single, comprehensive provider of seamless service to the men and women who have served our Nation;
- Continuously benchmarking and improving the quality and delivery of our service with the best in business, and using innovative means and high technology to deliver world-class service;
- Fostering partnerships with veterans organizations and other stakeholders, making them part of the decision-making process;
- Cultivating a dedicated VA workforce of highly skilled employees who understand, believe in, and take pride in our vitally important mission.

Core Values

To implement our mission and achieve our strategic goals, we strive to uphold a set of core values representing the basic fabric of our organizational culture. These values transcend all organizational boundaries and apply to everything we do as *One VA*. Each member of the VA team endeavors to practice the following values when serving veterans and working with others:

Respect and Commitment

- Veterans have earned our respect and our commitment to meet their needs.
- We believe that integrity, fairness, and respect must be the hallmarks of our interactions.

Open Communication

- We are committed to open, accurate, and timely communication with veterans, employees, and external stakeholders.
- We listen to the concerns and views of veterans, employees, and external stakeholders to improve the programs and services we provide.

Excellence in Services, Programs, and People

- We continuously strive to meet or exceed the service delivery expectations of veterans and their families by delivering accurate, timely, and courteous service and benefits in an effective and efficient manner.
- We are committed to improved access for veterans and their families through facility location and design, and through innovative uses of information technology.
- We perform at the highest level of competence and take pride in our accomplishments.
- We are open to change and value a culture where everyone is involved, accountable, respected, and appreciated.
- We value teamwork and cooperation—operating as *One VA* to deliver world-class, seamless service to veterans and their families.

Background

VA directly touches the lives of millions of veterans every day through its health care, benefits, and burial programs. With facilities in all 50 states, the territories, and the District of Columbia, we provide benefits and services through our 172 hospitals, 135 nursing homes, 43 domiciliaries, 781 outpatient clinics (i.e., 601 community-based, 172 hospital-based, 4 independent, and 4 mobile), 206 Vietnam Veteran Outreach Centers (Vet Centers), 57 regional offices, and 119 national cemeteries.

The Department accomplishes its mission through partnerships among the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), the Board of Veterans' Appeals (BVA), and the Departmental staff organizations by integrating the related activities and functions of the following major programs:

Medical Care

VA meets the health care needs of America's veterans by providing primary care, specialized care, and related medical and social support services.

Medical Education

VA's health care education and training programs help to ensure an adequate supply of clinical care providers for veterans and the Nation.

Medical Research

The medical research program contributes to the Nation's knowledge about disease and disability.

Compensation

The compensation program provides monthly payments and ancillary benefits to veterans, in accordance with rates specified by law, in recognition of the average potential loss of earning capacity caused by a disability, disease, or death incurred in, or aggravated during, active military service. This program also provides monthly payments, as specified by law, to surviving spouses, dependent children, and dependent parents, in recognition of the economic loss caused by the veteran's death during active military service or, subsequent to discharge from military service, as a result of a service-connected disability.

Pension

The pension program provides monthly payments, as specified by law, to needy wartime veterans who are permanently and totally

disabled. This program also provides monthly payments, as specified by law, to needy surviving spouses and dependent children of deceased wartime veterans who die as a result of a disability not related to military service.

Education

The education program assists eligible veterans, service members, reservists, and survivors and dependents in achieving their educational or vocational goals.

Vocational Rehabilitation and Employment

The vocational rehabilitation and employment program assists veterans with service-connected disabilities to achieve functional independence in daily activities. It provides the support and assistance necessary to enable service-disabled veterans to become employable and to obtain and maintain suitable employment.

Housing

The housing program helps eligible veterans, active duty personnel, surviving spouses, and selected reservists to purchase and retain homes.

Insurance

The insurance program provides veterans and service members with life insurance benefits, some of which are not available from other providers like the commercial insurance industry, due to lost or impaired insurability resulting from military service. Insurance coverage will be available at competitive premium rates and with policy features comparable to those offered by commercial companies. A competitive, secure rate of return will be ensured on investments held on behalf of the insured.

Burial

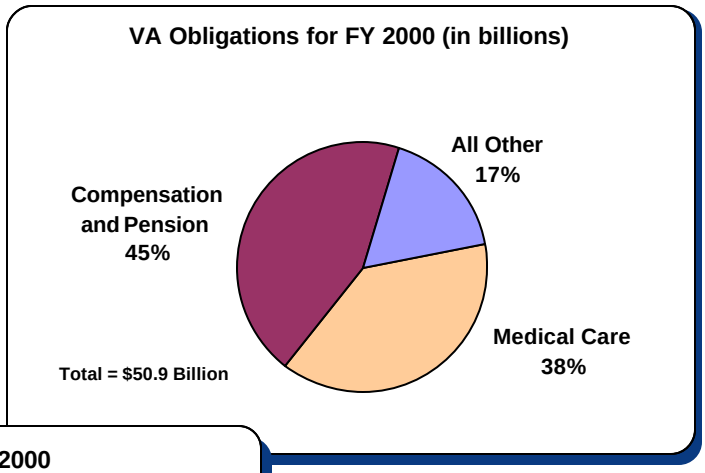
Primarily through the National Cemetery Administration, VA honors veterans with a final resting place and lasting memorials to commemorate their service to the Nation.

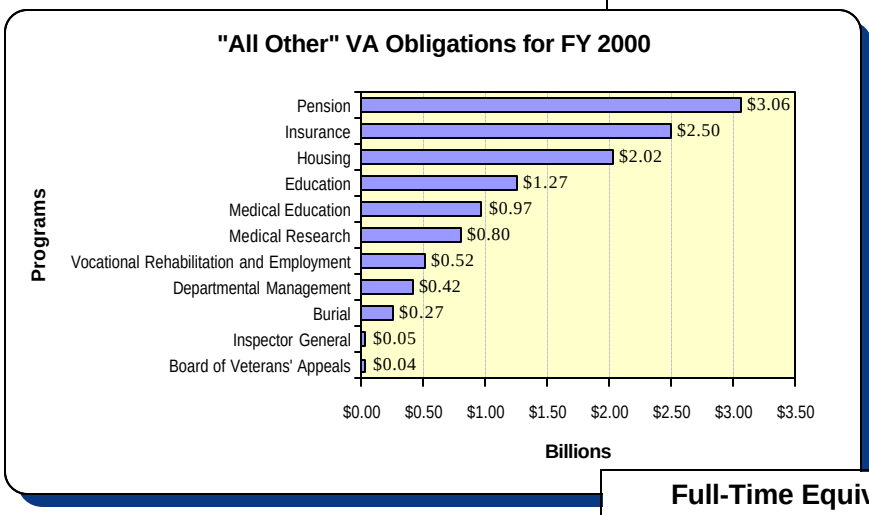
Program Participants

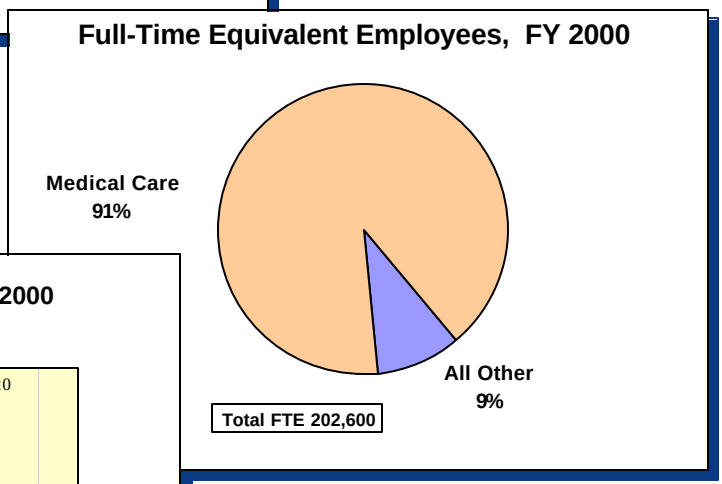
VA serves a significant portion of the veteran population. In FY 2000, more than 3.8 million patients used VA health care, over 2.6 million veterans and family members received monthly VA disability compensation payments, and nearly 2.4 million graves were maintained at our national cemeteries. The following table summarizes the number of individual veterans or dependents who received benefits or services in our major program areas during FY 2000.

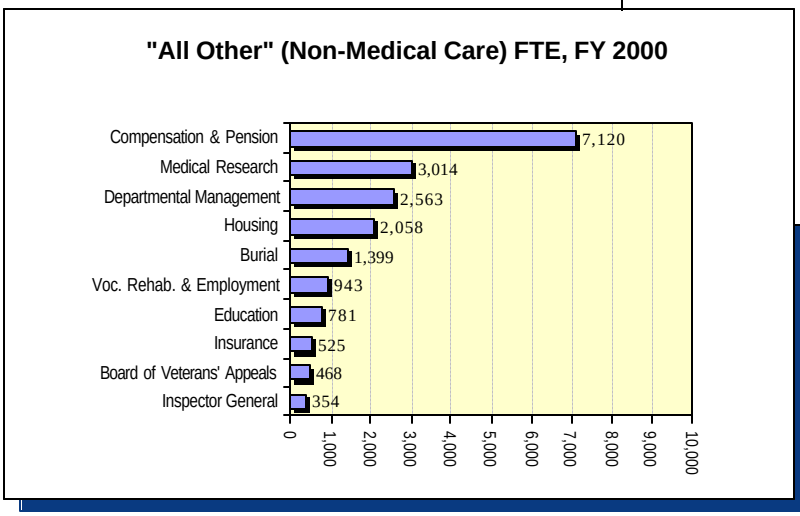
Program	Number of Participants
Medical Care	
Unique patients	3,817,000
Veterans	3,505,000
Non-veterans	312,000
Compensation	
Veterans	2,300,600
Survivors/children	306,200
Pension	
Veterans	370,400
Survivors	264,400
Education	
Veterans and service persons	283,000
Reservists	70,300
Survivors/dependents	44,800
Vocational Rehabilitation	
Veterans receiving services/subsistence	53,000
Veterans receiving services only	11,000
Housing	
Loans guaranteed	175,200
Insurance	
Administered policies (veterans)	2,206,800
Supervised policies (service members and veterans)	2,720,100
Burial	
Interments	82,700
Graves maintained	2,380,500
Headstones and markers	327,500

In FY 2000, VA resources totaled about $50.9 billion in obligations and nearly 203,000 full-time equivalent (FTE) employees. Over 95 percent of total obligations went directly to veterans in the form of monthly payments of benefits, or for direct services such as medical care. The following charts show (1) how VA spent the taxpayer funds with which we were entrusted, and (2) the distribution of FTE.









WHO WE SERVE

Our Continuous Focus on the Veteran

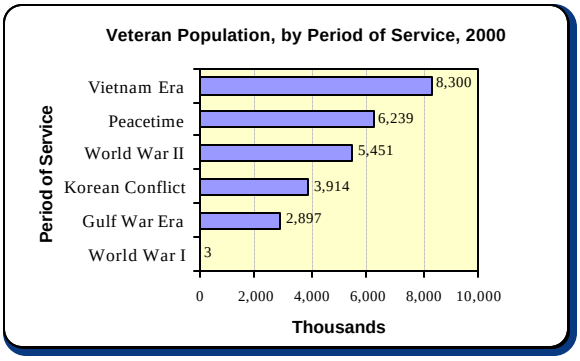
This section of the Performance Report presents social and demographic data on the veteran population. The data comparing veterans and non-veterans were obtained from the Current Population Survey (CPS) through a contract with the Bureau of the Census, and with the approval of the Department of Labor, sponsor of the survey. Data on the number of veterans by age, sex, period of service, and state of residence are from VA official estimates and projections.

Summary

Beginning with our Nation's struggle for freedom more than 2 centuries ago, approximately 42 million men and women have served their country during wartime. Most (85 percent) served in one or more of the four major conflicts of the 20th century. Today, an estimated 25.5 million veterans are living in the United States, Puerto Rico, and overseas. Of these, 19 million veterans served during wartime.

Number of Veterans and Periods of Service

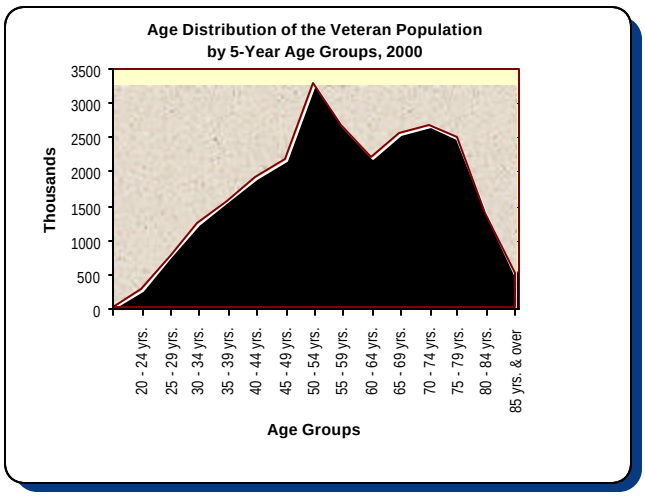
The veteran population continued to decrease in FY 2000 because of the large number of veteran deaths (657,000 between October 1, 1999, and September 30, 2000). Vietnam-era veterans account for the largest segment of the present veteran population.



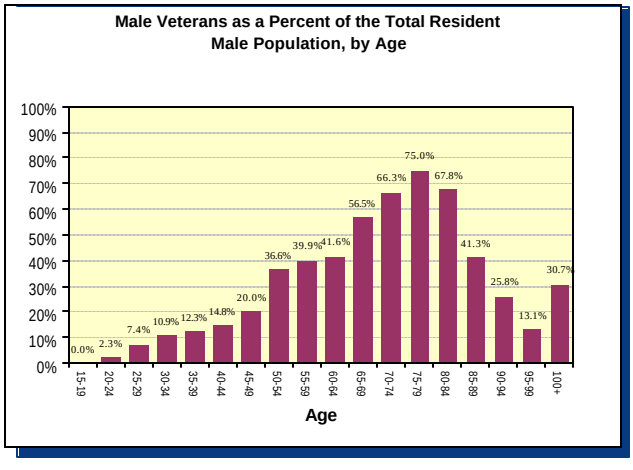
Data by period of service will add to more than total due to veterans who served in more than one period.

Age of Veterans

At the end of FY 2000, the median age of all living veterans was 57.4 years. Veterans under 45 years of age constituted 22 percent of the total veteran population; veterans aged 45 to 64 years old, 40 percent; and veterans 65 or more years old, 38 percent.



The number of veterans 85 years of age and older totals over 510,000. Ten years ago, there were as few as 155,000 veterans in this age range. This large increase in the oldest segment of the veteran population has had significant ramifications on the demand for health care services, particularly in the area of long-term care.



Female Veterans

In FY 2000, the female veteran population of 1.4 million constituted 5.5 percent of all veterans living in the Unites States, Puerto Rico, and overseas. The female veteran population as a percentage of all veterans is expected to increase, because the number of former military service women continues to grow. Generally, the demographic profile of the female veteran population stands in contrast to that of the male veteran population (e.g., differences in age and period of service).

The median age of female veterans is 13.8 years younger than that of male veterans, 44.2 versus 58.0. The growing involvement of women in the military in recent years is reflected in period-of-service differences between male and female veterans. About 58 percent of all female veterans served during the post-Vietnam era.

State of Residence

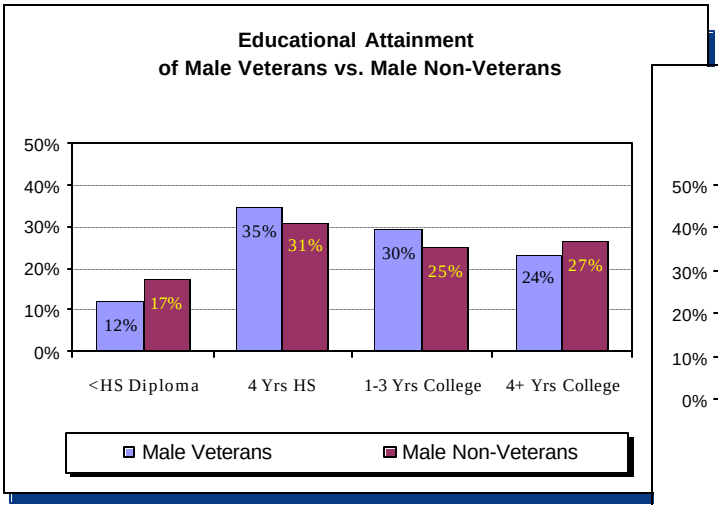
Veterans in just three states—California, Florida, and Texas—comprised nearly 23 percent of the veterans living in the United States and Puerto Rico at the end of FY 2000. The three next largest states in terms of veteran population are New York, Pennsylvania, and Ohio. These 6 states account for more than 37 percent of the total veteran population.

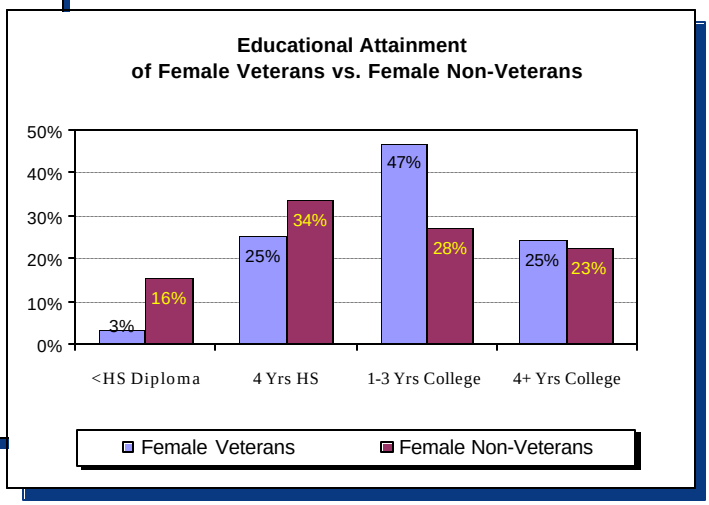
At the other end of the scale, the two least populous states in terms of veteran population—Wyoming and North Dakota—and the District of Columbia collectively accounted for less than 1 percent of the total.

Education

Education plays a critical role in the social and economic achievement of America's veterans. In FY 2000, the educational attainment of male veterans was slightly above that of male non-veterans.

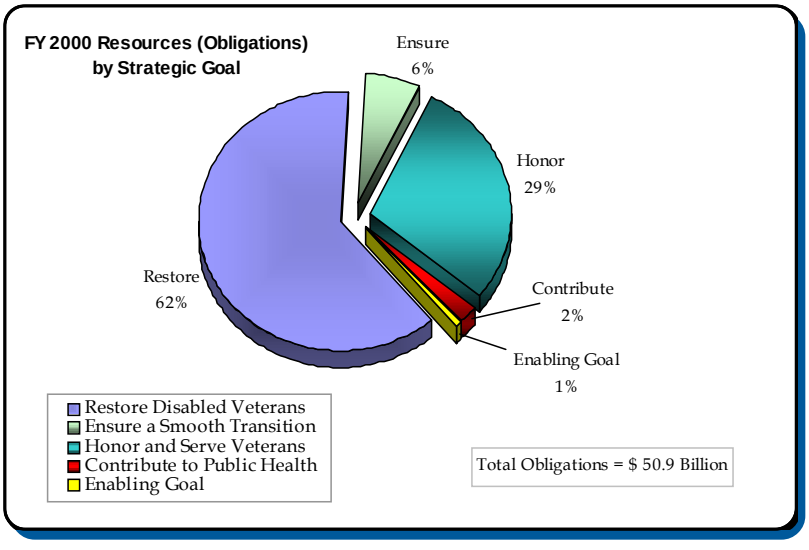
Female veterans fared much better than either male veterans or their female non-veteran counterparts in terms of educational attainment. Among female veterans, 71.4 percent had at least some college education; among male veterans, the figure is 53.3 percent; among female non-veterans, the figure is 50.1 percent.





This section of the report presents detailed information on the Department's program and financial performance during FY 2000. The discussion is structured around VA's four strategic goals, which were published in the new Strategic Plan at the end of September 2000. These goals reflect the combined effort of all organizational elements to deliver benefits and services to disabled veterans, veterans in transition from the military, the overall veteran population and their families, and the Nation at large. Each goal has a number of associated objectives that describe the actions or improvements necessary to achieve the goal. With specific performance measures, these goals and objectives form the basis for budget formulation, performance planning, and performance reporting.

In addition to our strategic goals, we have an enabling goal to create an environment that fosters world-class service. This goal and its corresponding objectives represent crosscutting activities that enable all organizational elements to carry out the Department's mission. These activities focus on improving communications, enhancing workforce assets and internal processes, and furthering a *One VA* approach to providing seamless service to veterans and their families.



VA's Key Performance Goals and Measures

VA's senior leadership identified 29 key performance goals as critical to the success of the Department. Some of these deal with program outcomes; others pertain to the manner in which we administer our programs.

The Department is committed to continuously improving the delivery of benefits and services to veterans and their families. Whether the focus is on enhancing the quality of health care, expanding access to care, reducing the time it takes to complete claims for benefits, improving the accuracy of claims processing, or providing more veterans with a burial option, our aim is to better our performance each year.

Each year, we evaluate performance for the previous year, and set new annual performance targets that demonstrate our commitment to continuous improvement. In many instances, the performance improvements we project from one year to the next, as well as the performance advancements we actually achieve, are dramatic. In other cases, the improvement is necessarily more limited. Nevertheless, we continuously strive to improve our performance in all programs every year.

While the vast majority of our performance measures remain the same from one year to the next, our

list of measures does change in response to changing circumstances.

First, we modify our strategic goals and objectives in connection with our ever-improving strategic management process. When these long-term goals and objectives change, as they did in our new Strategic Plan in September 2000, we alter some of our performance goals and measures to ensure that they are consistent with the Strategic Plan. Second, we are constantly striving for better ways to measure performance. This is an ongoing process, and every year we will introduce new measures that reflect a more sophisticated and mature performance measurement process. Third, there are instances in which our actual performance has met or exceeded our original goals, and further performance improvements are unlikely or unreasonable. In these cases, we either drop the performance measure, or replace it with a different one.

While some of VA's key performance measures support achievement of more than one strategic goal or objective, we have aligned them with the strategic goal and objective that they most closely support. Not all objectives are supported by key performance measures. For each of the key performance goals, we present:

- the performance measure or measures used to gauge progress toward achieving the goal and objective;
- historical data;
- means and strategies used to determine the actual level of performance;
- crosscutting activities with other federal and private organizations;
- descriptions of any relevant management challenges affecting goal achievement;
- the source of the performance information and how it was validated.

Other goals and measures deemed important by the program offices continue to be monitored and are presented in the data tables beginning on page 105.

STRATEGIC GOAL 1

Restore the capability of disabled veterans to the greatest extent possible and improve the quality of their lives and that of their families.

Objective 1.1

Maximize the physical, mental and social functioning of disabled veterans including special populations of veterans by assessing their needs and coordinating the delivery of health care, benefits, and services.

Objective 1.2

Improve the quality of life and economic status of service-disabled veterans, and recognize their contributions and sacrifices made in defense of the Nation.

Objective 1.3

Enable service-disabled veterans to become employable, and obtain and maintain suitable employment.

Objective 1.4

Ensure survivors of service-disabled veterans are able to maintain a minimum standard of living and income through compensation and education benefits.

To achieve this strategic goal, VA needs to maximize the ability of disabled veterans, special veteran populations (e.g., veterans with spinal cord injuries or traumatic brain injuries, blinded veterans), and their dependents and survivors to become full and productive members of society through a system of health care, compensation, vocational rehabilitation, life insurance, dependency and indemnity compensation, and dependents' and survivors' education. This system of benefits and services is aimed toward the broad outcome of restoring the individual capabilities of our Nation's disabled veterans.

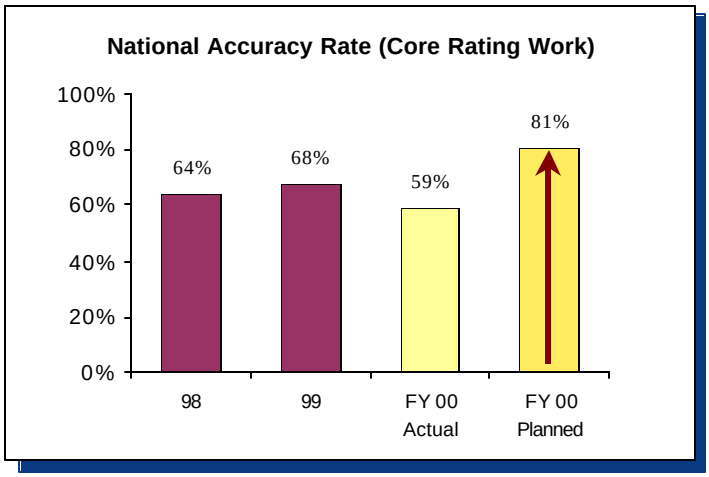
Eight key performance measures enable us to gauge progress in achieving this strategic goal:

- National accuracy rate for core rating work
- Percent of compensation and pension (C&P) claimants who are satisfied with the handling of their claim
- Average days to process rating-related actions on compensation and pension claims
- Abandoned call rate for compensation and pension
- Blocked call rate for compensation and pension
- Appeals resolution time
- Vocational rehabilitation and employment rehabilitation rate
- Compensation and dependency and indemnity compensation (DIC) program outcomes

Obtain an 81 Percent National Accuracy Rate for Core Rating Work

(This measure supports our objective to improve the quality of life and economic status of service-disabled veterans, and recognize their contributions and sacrifices made in defense of the Nation.)

Our top priority in claims processing is to improve technical accuracy. However, in spite of our best efforts and many initiatives, we have been unable to achieve this key performance goal.



Our 59 percent accuracy rate represents a significant decline from FY 1999 and is well below the target level of 81 percent. We have yet to realize the expected benefits from increased staffing, improved quality reviews, and training directed at specific quality deficiencies. Some of the performance shortfall is due to our underestimating how long it takes for our initiatives to begin having an impact. In addition, we are confronting changes in our operating environment because of new legislation and complex regulatory changes affecting the manner in which compensation and pension claims are processed.

Our current quality review methodology, Statistical Technical Accuracy Review (STAR), is a zero defect system. Each claim is reviewed for five different types of possible errors: was all information from the claimant well grounded; were all issues addressed; was the claim properly developed; was the decision to grant or deny the claim made properly, and if granted, was the payment correct; was the claimant properly notified of the decision. Any claim reviewed and found to have an error of any of these five types is considered a case in error, regardless of which component of the review contains the error. This rigorous standard helps explain why the accuracy rate is no higher than it is. The overall accuracy rate masks positive performance among the individual review areas. For example, STAR results for FY 2000 show an accuracy rate of 92 percent concerning proper grant or denial of benefits, assignment of correct evaluations and effective dates, and correct dates and rates of payment. This represents an improvement over FY 1999's benefit payment accuracy rate of 85 percent.

Means and Strategies

Throughout FY 2000, we continued to implement the STAR system that began in 1999 on both a national and local level. Although the STAR system allows us to gain an understanding of the kinds of errors that occur most frequently, it will not by itself improve performance. The information from our reviews assists management in identifying improvement opportunities and training needs, as well as areas requiring additional management intervention.

In FY 2000, we established a workgroup comprised of field and headquarters managers to develop an implementation plan for the

Systematic Individual Performance Assessment (SIPA) initiative. SIPA complements STAR, and brings performance assessment and accountability to individual employees. This tool will assist local managers in identifying individual deficiencies, ensuring maintenance of skills, promoting accuracy and consistency of claims adjudication, and restoring credibility to the system.

In an effort to improve the rating process and enhance accuracy, a new rating decision format was tested at three regional offices. During its development, the new format was shared with rating specialists, veteran service officers, and veterans. Their feedback was positive. The rating redesign project has been endorsed and incorporated into VBA's Rating Board Automation (RBA) 2000, which was deployed nationally during the fall of 2000. This is the initial phase of a process redesign that will restore a thorough analytical approach to the disability rating activity and, at the same time, provide plain language information on decisions to claimants. A stricter definition and control of data fields, and the addition of other data to capture special issues of interest, will remedy the shortcomings of the current system. By reducing the number of keystrokes needed to enter rating data, RBA 2000 will improve the accuracy of rating decisions. With the collection of more accurate rating data, decisions will be edited as they are made (i.e., inconsistent data will not be accepted by the system). Likewise, with available data regarding the profiles of pending and completed decisions, RBA 2000 will simplify the process of managing the workload.

In FY 2000, monthly quality review results identified error trends and provided information for regional offices to use in selecting areas for improvement and training. A Quality Improvement Task Team was formed in July 2000 to choose areas with the greatest potential for positive impact on overall quality. The team developed a short-term corrective measures plan for these categories of errors in an effort to cut the error rate in half for specific problem areas.

The Development and Case Management (now called MAP-D) and the C&P Benefits Replacement System will also contribute to improved accuracy in the claims process. MAP-D will provide a single processing capability that addresses complete claims development, claim status, and case management. Our systems experts are currently validating MAP-D, prior to deployment. The C&P Benefits Replacement System provides for a sequential application development effort, specifically, the incremental development and integration of functional modules pertaining to the claims process, from establishment through payment and accounting.

Other significant steps we have taken to improve our accuracy include the rewriting of 10 chapters of our claims processing manuals in plain English.

The C&P Service has recommended 12 manual changes and 2 regulatory changes based upon STAR review experience. The staff has also produced several training reports identifying areas of particular concern.

As part of our succession planning strategy to maintain an effective workforce during times of high attrition, we expanded our nationwide recruitment program to fill critical professional and technical positions at regional offices throughout the country. We recruited over 450 new employees during FY 2000. In FY 2001, we will redirect nearly 200 additional staff from other benefits programs into the compensation and pension programs, and hire nearly 250 new veterans service representatives (VSR). With full implementation, we anticipate an improvement in accuracy for core rating work and authorization work. However, the impact of these additional resources will not be felt until the staff members are fully trained—about a 3-year process.

On the basis of our experience during FY 2000, we revised our FY 2001 target downward from 85 percent to 72 percent, which we think is a more realistic short-term goal. The FY 2001 performance goal is based on targeting specific improvement opportunities that should result in higher quality.

Major Management Challenges

The General Accounting Office (GAO) has identified the quality and timeliness of claims processing as a major performance and accountability challenge. There are at least two parts to this challenge: increased complexity of the workload, and loss of highly experienced decision-makers.

The increasing complexity issue takes several forms. First, there are changes in claims processing that result from new legislative requirements. These changes improve our decision-making in the long run because veteran claimants are better served, but the process is more time-consuming. Second, VA's quality assurance program is more rigorous. Since we are holding ourselves to a higher standard, we are discovering more errors. Third, the appellate process has been changed. The concept is to provide a dynamic and highly interactive appeal process, with a focus on identifying issues and areas of disagreement for resolution at the earliest possible point. Finally, veterans are presenting more issues per claim, each of which must be adjudicated separately; this increases the time for completion and the potential for error.

Over the next 5 years, we anticipate losing over 1,100 experienced VSRs due to retirement. To avoid a skill gap, we have added a significant number of new employees and will continue to do so for the next few years. We expect our quality and timeliness will be affected as we recruit and train new employees. It takes 2 to 3 years for VSRs to achieve a full level of decision-making expertise.

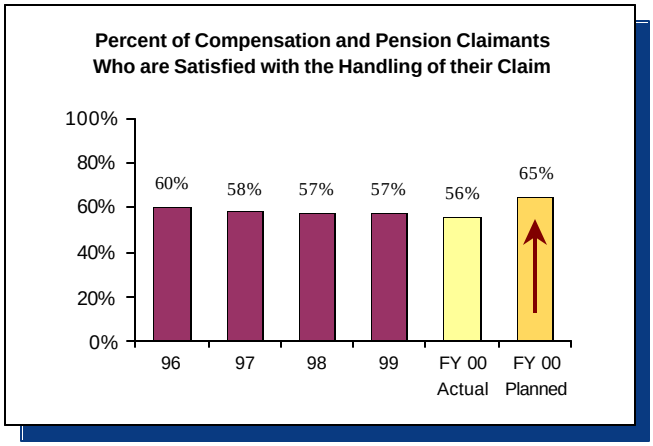
Data Source and Validation

To determine rating accuracy, the C&P Service established an independent review staff to assess a sample of completed work for each service delivery network (SDN). During FY 2000, the service reviewed 354 core rating-related cases, 325 authorization-related cases, and 140 fiduciary cases from each SDN. The sample size for rating and authorization cases allows for a 95 percent confidence factor and +/-5 percent margin of error.

Increase the Number of C&P Claimants Satisfied With the Handling of Their Claims to 65 Percent

(This measure supports our objective to improve the quality of life and economic status of service-disabled veterans, and recognize their contributions and sacrifices made in defense of the Nation.)

Overall satisfaction with the compensation and pension (C&P) claims process is measured by the percentage of respondents who indicate they are "somewhat satisfied" or "very satisfied" with the way VA handled their claim, regardless of the outcome of the claim decision. These data come from a single question from the annual *Survey of Veterans' Satisfaction with the Compensation and Pension Claims Process.*



Actual performance in FY 2000 fell short of the performance target. After reviewing recent survey results, we determined that customer satisfaction depended on our responsiveness to four key questions:

- Was the amount of time the Department took to make the decision on a claim reasonable?
- Was VA's evaluation of the claim fair?
- Was the claimant satisfied with the Department's decision regarding the claim?
- Did VA fully address all questions, concerns, and complaints?

Clearly, the quality and the timeliness of the decision-making process are the drivers of veterans' satisfaction. We did not achieve our performance goal for this key measure because we have not made improvements in the quality and timeliness of claims processing, as reported on pages 24-26.

Means and Strategies

The reengineered claims processing environment for C&P uses case management, which includes more frequent, personal, and proactive contact among VA employees and claimants and their service representatives. As claimants interact more directly with VA personnel processing their claims, we will be able to improve the quality of service and information that claimants routinely expect.

The initiatives that are being implemented should yield improvements in customer service. Case managers have the authority to interact with veterans, identify and resolve issues, and make decisions at the earliest opportunity. The full impact of case management will not be seen until FY 2002 because of the extended training schedule.

Data Source and Validation

The percent of C&P customers satisfied with the handling of their claim is determined through the annual *Survey of Veterans' Satisfaction with the Compensation and Pension Claims Process.* VBA's Surveys and Research staff oversees the survey process to make sure professional standards are met and reliable results are obtained.

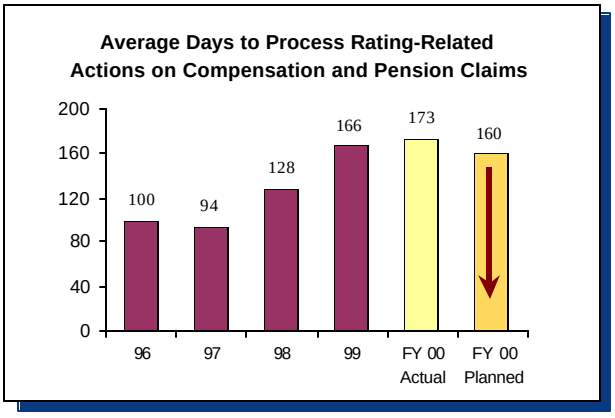
Complete Rating-Related Actions on C&P Claims in an Average of 160 Days

(This measure supports our objective to improve the quality of life and economic status of service-disabled veterans, and recognize their contributions and sacrifices made in defense of the Nation.)

Timeliness of claims processing continues to be a major problem, and we acknowledge that current performance is unacceptable. Several initiatives underway to help us improve our performance are discussed under "Means and Strategies."

Rating-related actions include the following types of claims: original compensation, original pension, original dependency and indemnity compensation, reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization. These claims represent the most complicated and time-consuming work confronting regional office staffs. For more information on the timeliness of processing the individual types of rating-related claims, refer to the table on page 111.

We expect a significant increase in workload due to (1) the Veterans Claims Assistance Act of 2000 (P.L. 106-475, also referred to as the Duty to Assist), which requires additional duties in assisting claimants; and (2) a recent regulatory change, which makes diabetes a presumptively service-connected disability for Vietnam veterans who served in Southeast Asia. As a result, we amended our FY 2001 performance target upward from 142 days to 195 days.



During the fiscal year, we completed rating-related actions in an average of 173 days, 13 days off the performance target. There are several reasons for this shortfall:

- During the last 10 years, claims processing has become a more complex activity. Our decision-makers are faced with significant changes in the body of law governing claims processing, and this has resulted in a more complicated and time-consuming process. In addition, we did not fully anticipate the impact of decisions by the U.S. Court of Appeals for Veterans Claims or changes in the nature of veterans' disabilities. The number of disability issues per claim has increased by 30 percent.
- We experienced more performance slippage than we expected as we implemented our initiatives.
- As part of our succession planning and our continuing effort to improve service delivery for veterans and dependents, we added over 450 new employees during FY 2000 to handle C&P claims processing. Many of these employees were hired during the last quarter of the year. We under-estimated the magnitude of the training hours required to teach new staff the full range of duties and skills needed to process claims. While the additional staff will assist in improving timeliness in the future, we experienced performance shortfalls last fiscal year because their training had not been completed.

Although performance over the fiscal year was short of our goal, there are some positive signs. Timeliness improved during the second half of the fiscal year, from a high of 183 days in February to 168 days in September. In addition, we added 38 pre-discharge sites, bringing the total to 88. At these sites, claims development, disability examinations, and the preparation of rating decisions are conducted for service persons awaiting discharge from active duty. Because we had all the information on hand to process these cases, we were able to complete our decision-making for over 15,100 veterans' claims in an average of 28 days from the date of their separation from active duty. This average does not include the claims processing time that occurred while the veterans were still on active duty.

Means and Strategies

This past year brought about the advent of VBA's first on-line application for benefits. The Veterans' On-line Applications (VONAPP) initiative was fully tested and went live for all regional offices in October 2000. VONAPP allows veterans to apply for compensation, pension, vocational rehabilitation, and health benefits via the Internet. Original rating claims filed this way are processed more quickly than claims filed the traditional way. We anticipate that improvements in claims processing timeliness will result from this initiative.

We are in the midst of the Manual Rewrite project. By rewriting our manuals in an easy-to-understand format, which enables readers to find information quickly, we expect that claims processors will be able to handle claims more rapidly. We have completed the rewrite of 10 chapters to date.

The Compensation and Pension Record Interchange (CAPRI) initiative was developed and has undergone pre-production testing. Developed jointly by VHA and VBA, the CAPRI software acts as a bridge between the two Administrations' systems and provides on-line access to VA medical data. On-line access to data will improve the timeliness of rating-related actions by providing decision-makers with immediate information necessary to make decisions on claims.

VBA and VHA are working together to improve the timeliness and quality of medical examinations to evaluate disabilities. VBA and VHA have jointly designed improved worksheets to guide physicians in performing examinations that meet VBA's needs. In addition, VBA has provided training to VHA physicians on the requirements associated with processing disability claims.

The Veterans' Benefits Improvement Act of 1996, Public Law 104-275, authorized VA to conduct a pilot project to measure the effectiveness of contracting with a non-VA medical source for medical exams associated with disability claims processing, and its potential impact on veterans. The pilot provided a comparison of VHA and non-VA performance in timeliness, quality, cost, and customer satisfaction of medical exams. Results show that a vendor can conduct VA disability examinations at performance levels equivalent to that provided by VHA. The second year of the pilot began in May 2000.

In FY 2000, we completed the merging of veterans' service functions with adjudication functions in Veterans Service Centers, where VSRs now use a case manager approach to complete claims for veterans' benefits. Initially, the merging of functions has adversely affected our ability to complete claims in a timely manner, but in the long term, we will be able to provide more timely and accurate service.

Crosscutting Activities

In FY 2000, the Department increased to 31 the number of employees placed at the National Personnel Records Center (NPRC) to process

claims for service records. During the first 9 months of this change, the time to process requests averaged 103 days, an improvement of 19 days. Due to the additional staff, we were able to process 74,304 requests, compared to the 49,385 completed in the 9 months before this change.

Training, Responsibility, Involvement and Preparation (TRIP) of claims is a joint initiative establishing a working partnership between VBA and VSRs to enhance claims processing. This partnership will provide service organization representatives with additional training on VA benefits and access to VBA systems. In return, VBA will receive assistance in the gathering of evidence needed for timely and accurate decisions. Level one of the TRIP training package was deployed to all regional offices in May 2000. Most stations completed level one training by the end of calendar year 2000. Currently, the level one training package is being revised to reflect new legislative requirements.

Major Management Challenges

GAO and VA's Office of Inspector General (OIG) report that timeliness of adjudication decisions and slow appellate decisions continue to be major challenges in VA's compensation and pension programs. We have taken several steps to address these challenges, but so far have met with little success. VBA continues to pursue the redefined claims processing concepts outlined in its *Roadmap to Excellence*. For more discussion of this management challenge, see pages 89-91.

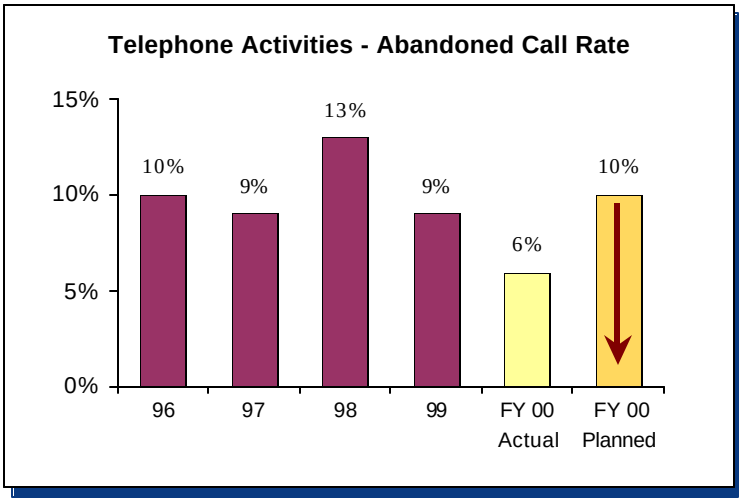
Data Source and Validation

Timeliness of rating-related actions is measured using data captured automatically by the Benefits Delivery Network as part of claims processing.

In its September 1998 report, the OIG found that three key compensation and pension timeliness measures lacked integrity. They reported that the information system was vulnerable both to reporting errors and to manipulation by regional office personnel to show better performance than was actually achieved. As a result of VA's aggressive steps to address these problems, our data are now more accurate and reliable. Since October 1997, we have maintained a database of all end-product transactions that are analyzed, on a weekly basis, to identify questionable actions by regional offices. The C&P Service reports quarterly on its findings and calls in cases for review from stations with the highest rates of questionable practices.

Reduce the Abandoned Call Rate to 10 Percent and Reduce the Blocked Call Rate to 15 Percent

(This measure supports our objective to improve the quality of life and economic status of service-disabled veterans, and recognize their contributions and sacrifices made in defense of the Nation.)

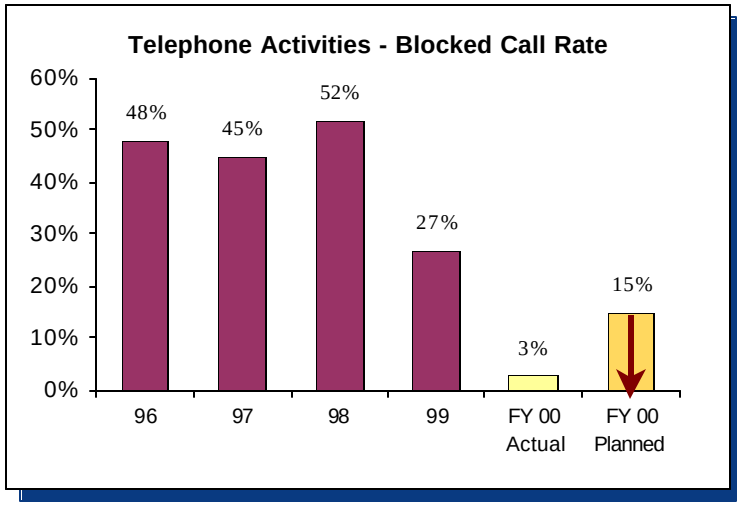


VA made significant improvement in its telephone service from FY 1999 to FY 2000. Our abandoned call rate dropped from 9 percent to 6 percent; our blocked call rate fell even more dramatically, from 27 percent to 3 percent.

Means and Strategies

One reason for our overall improvement in telephone service during FY 2000 was the expanded implementation of the National Automated Response System (N-ARS) to additional regional offices. This system serves as the point of entry for veterans and their families seeking information or services from any VBA activity. The automated system is a menu-series of programmed messages that allow a caller to access general benefits information and includes an interactive voice response capability. In FY 2000, over two million telephone calls were answered using interactive voice response.

VA has successfully piloted a Virtual Information Center (VIC) in service delivery network (SDN) 2. Although calls are distributed through a Primary Equipment Location to several regional offices in the VIC, they are first routed to the office that serves the area from which the veteran is calling. If all veteran service representatives (VSR) at that location are busy, the call is routed to a VSR at another regional office. Case-specific calls are routed directly to the regional office with claims jurisdiction and remain in the local queue until answered. A centralized control point monitors incoming calls and regional staffing levels. This monitoring allowed SDN 2 to balance telephone customer service workload and staffing and



eliminated blocked calls. Using VIC technology, SDN 2 also reduced abandoned calls to approximately 1 percent, compared to 6 percent nationally.

Some of the improvement in telephone service is due to shifting calls concerning education claims to education regional processing offices, thus relieving regional offices of this workload.

Data Source and Validation

The abandoned call rate is based on data collected at regional offices using automated call distribution equipment, which is then entered into a national database. There is no independent validation of these data.

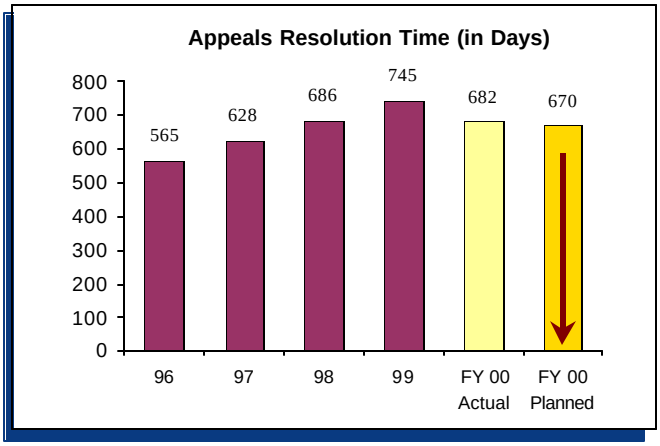
The blocked call rate is based on data collected by the carrier, Sprint, 24 hours a day, 7 days a week, and reported to VA every month. VA does not validate Sprint reports.

Reduce Appeals Resolution Time to 670 Days

(This measure supports our objective to improve the quality of life and economic status of service-disabled veterans, and recognize their contributions and sacrifices made in defense of the Nation.)

Appeals resolution time was adopted at the beginning of FY 1999 as a principal measure of the overall length of time it takes VA to handle all types of claims. Although compensation and pension cases make up the vast majority of appeals, this measure includes all appeals regardless of program. Adopted jointly by the Board of Veterans' Appeals (BVA) and the Veterans Benefits Administration (VBA), appeals resolution time takes into account cases resolved by either a final regional office decision or by Board determination. This measure, expressed in days, is a composite average of the time elapsed from receipt of a Notice of Disagreement filed by a claimant through resolution, whenever that may occur. Not included are cases returned to the Department as a result of a remand action by the United States Court of Appeals for Veterans Claims.

For FY 2000, the performance goal was to reverse the previous years' upward trend, and reduce the appeals resolution time to 670 days. We made



considerable progress in achieving that result, as the appeals resolution time was reduced to 682 days. Although we fell short of our target by 12 days, this performance reflects a reduction of 63 days, or 8.5 percent, from our FY 1999 performance. The FY 2001 target remains at 650 days.

Means and Strategies

Remand rate reduction is a central component of our strategy for reducing appeals resolution time.

Remands from BVA to regional offices represent a rework phase of the appellate cycle and typically add 2 years to the processing time for an appeal. Remands delay more than the individually affected cases. By law, we must process the oldest cases first; therefore, processing of newer appeals is delayed when remanded appeals are returned to the Board for readjudication. BVA issued over 34,000 decisions in FY 2000. The percentage of remand decisions was reduced from 36.3 percent in FY 1999 to 29.9 percent in FY 2000. This 6.4 percent reduction in the Board's remand rate contributed to the progress made in reducing the appeals resolution time for FY 2000.

A continued decline in the number of remands would further reduce the resolution time. However, as a result of the Veterans Claims Assistance Act of 2000 (Public Law 106-475), we expect the remand rate to increase for the current fiscal year, and possibly future years. Continually changing laws relating to veterans' claims result in increasingly complex cases. During FY 2000, the counsel time spent per decision increased by more than 12 percent. Case reviews are taking more time, decisions are longer, and court decisions often require that cases be reworked to comply with a new ruling.

One of the primary remand rate reduction strategies is to improve appellate processes through information sharing between BVA and field adjudication staff, using regularly scheduled information exchange sessions conducted via interactive video-conference systems. A second strategy has been the ongoing development and refinement of improved bases of information. We are now tracking and categorizing the types of issues appealed to the Board to better analyze trends concerning the types of cases remanded. Understanding why certain types of cases are remanded helps to improve current casework and avoid future remands.

In an effort to alleviate the need for BVA to remand cases for additional medical information, we established a VHA medical opinion program. The Board maintains a list of participating hospitals and their specialty, if any. When a case requires a medical opinion, a hospital is selected according to the particular need, and a specialist prepares an opinion answering the Board's questions. This program cuts the cost and time—sometimes six to nine months— to obtain an independent outside medical opinion.

Continued quality improvements in BVA's appellate decision-making process can systematically affect VA claims adjudication processes in a positive manner. For FY 2000, we obtained a deficiency-free decision rate of 85.8 percent, which is an improvement of 2.3 percent from our FY 1999 performance. However, due primarily to preventable errors, we fell short of our FY 2000 target. We are committed to ensuring that our attorneys and Board members recognize the need to devote sufficient attention to details, as well as to legal and factual content.

Although some improvements in timeliness can be achieved unilaterally by BVA, such as those realized from reductions in administrative overhead and initiatives involving internal procedural changes, others can result only from coordinated efforts undertaken by both BVA and VBA. Such an approach acknowledges that claims and appeals processing must be viewed as a continuum, rather than as a series of discrete activities. VA is committed to this approach; both VBA and BVA continue to work collaboratively to reduce appeals resolution time.

Data Source and Validation

The Veterans' Appeals Control and Locator System, which serves as VA's appeals tracking system and BVA's main business system, was the exclusive source of all data used to compute

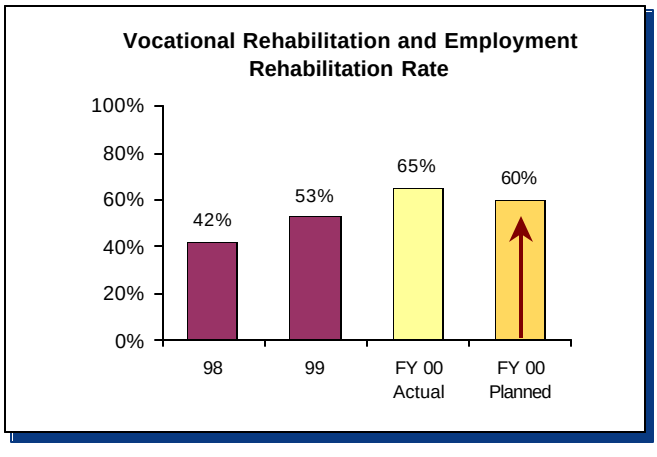
appeals resolution time. The system includes all of the information necessary to effectively and efficiently track, monitor, and report on appeals, regardless of their stage of development, and is sufficiently dynamic to allow the addition of enhancements and modifications, if and when they are needed.

Where feasible, edits have been built into the system to prevent data entry errors. There are checks and balances throughout the system to detect such errors, and procedures in place to correct them. We believe the system edits and continuous quality review of data entry provide reasonable assurance of data validity and reliability.

At Least 60 Percent of Veteran Participants Who Exit the Vocational Rehabilitation Program Will Be Rehabilitated

(This measure supports our objective to enable service-disabled veterans to become employable, and obtain and maintain suitable employment.)

For the second year in a row, VA exceeded its annual target for rehabilitating disabled veterans by returning to employment over 10,600 service-disabled veterans. The average annual income of these veterans prior to program participation was $4,942. The average annual income of those veterans who were rehabilitated through suitable employment in FY 2000 was $28,671.



Means and Strategies

The following initiatives or activities contributed to the performance improvement of the rehabilitation rate:

- Refocused the program to the primary goal of suitable employment.
- Developed the Employment Specialist Pilot Program, in which employment specialists worked directly with prospective employers and Vocational Rehabilitation and Employment (VR&E) case managers to cultivate partnerships and identify career opportunities.
- Improved communications for veterans and stakeholders to make sure they understand the employment focus.
- Improved assessment of work-related skills that can be transferred to the civilian labor market.

- Increased the number of placements in suitable jobs through cooperative training and networking with the Department of Labor's (DOL) Disabled Veteran Outreach Program and local veterans' employment specialists.

Crosscutting Activities

VA's VR&E Service and DOL's Veterans' Employment and Training Service joined together to provide an annual training program for staff from both Departments involved in the placement of disabled veterans in interim and permanent employment. In the future, this training program will include the Small Business Administration.

Data Source and Validation

Data are from VBA's balanced scorecard and from VR&E workload and management reports. Data are validated by the quality assurance review conducted by each station, as well as by VR&E Service staff.

We have implemented a quality assurance process of casework in which a sample of cases is reviewed for quality and scored at the station level. VR&E Service conducts a validation review of a sample from each service delivery network. VR&E continually obtains extracts from the database and evaluates management data (including the balanced scorecard) for validity and reliability. Where discrepancies are found, action is taken to correct the data or clarify policy and procedures, as needed.

Compensation and Dependency and Indemnity Compensation (DIC) Program Outcomes

(This measure supports our objective to ensure survivors of service-disabled veterans are able to maintain a minimum standard of living and income through compensation and education benefits.)

VA is in the process of developing outcomes and performance measures for the disability compensation and the dependency and indemnity compensation (DIC) programs. As a result, there were no performance targets for FY 2000.

Means and Strategies

Disability Compensation

For several years, VA officials have met regularly with our key stakeholders in Congress, OMB, and veterans service organizations to discuss a variety of issues related to our Strategic Plan, Annual Performance Plan, and Annual Performance Report. These "Four Corners" consultation sessions are an extremely useful way of ensuring that our major planning and performance documents reflect the views of our stakeholders.

VA published a set of interim outcomes and associated outcome performance measures with the FY 2001 Budget sent to Congress in February 2000. Following a series of consultation sessions with Congressional staff, OMB representatives, veterans service organization officials, and VA representatives, the C&P Service modified the outcome statements to incorporate comments offered by our key stakeholders. The Under Secretary for Benefits approved these statements in April 2000.

VA Disability Compensation Program Mission
The mission of the disability compensation program is to provide monthly payments to veterans in recognition of the effects of disabilities, diseases, or injuries incurred or aggravated during active military service, and to provide access to other VA benefits.

VA Disability Compensation Program Outcomes
Outcome 1: The disability compensation program improves the security of disabled veterans by making payments that offset the average loss of earning capacity resulting from service-connected disability or disease.

Outcome 2: Service members and veterans understand and have easy access to all benefits for which they are eligible, based on service-connected disability or disease.

Outcome 3: Disability compensation recognizes veterans' loss of quality of life and supports pursuit of maximum individual potential.

Outcome 4: Service members and veterans are confident that VA will properly compensate them for service-related disability.

In September 2000, VA signed a contract to obtain expert technical assistance in developing program outcome performance measures that support each of the outcome statements. The final report was received in December 2000. This report will be used as the basis for designing specific measures. We anticipate that specific program outcome performance measures will be available by the end of FY 2001. In addition, we are developing an initiative to begin collecting, analyzing, and reporting program outcome performance data.

DIC
As with the disability compensation program, VA published a set of interim outcomes and associated outcome performance measures for the DIC program, along with the FY 2001 Budget sent to Congress in February 2000. Using contractor assistance, the Department is conducting a detailed program evaluation of the DIC program. In collaboration with our key stakeholders, the C&P Service will use the results of this program evaluation to modify the interim outcomes and performance measures. This evaluation of the DIC program, which also studies the insurance programs and the way insurance and DIC benefits assist the survivors of disabled veterans, will be completed during FY 2001. The program outcomes, goals, and measures will then be finalized for approval by the Under Secretary for Benefits.

Data Source and Validation

While VA has data on veterans' satisfaction with the compensation and pension claims process, we do not yet have data on the impact the programs have on the quality of veterans' lives. Data validation procedures will be established at the time the data collection vehicles are developed.

STRATEGIC GOAL 2

Ensure a smooth transition for veterans from active military service to civilian life.

Objective 2.1

Ease the reentry of new veterans into civilian life by increasing awareness of, access to, and use of benefits and services during transition.

Objective 2.2

Assist veterans in readjusting to civilian life by enhancing their ability to achieve educational and career goals.

Objective 2.3

Improve the ability of veterans to purchase and retain a home through a loan guaranty program.

Veterans will be fully reintegrated into their communities with minimum disruption to their lives through transitional health care, readjustment counseling services, employment services, vocational rehabilitation, education assistance, and home loan guaranties.

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

- Montgomery GI Bill (MGIB) usage rate
- Average days to complete original education claims
- Average days to complete supplemental education claims
- Foreclosure avoidance through servicing (FATS) ratio

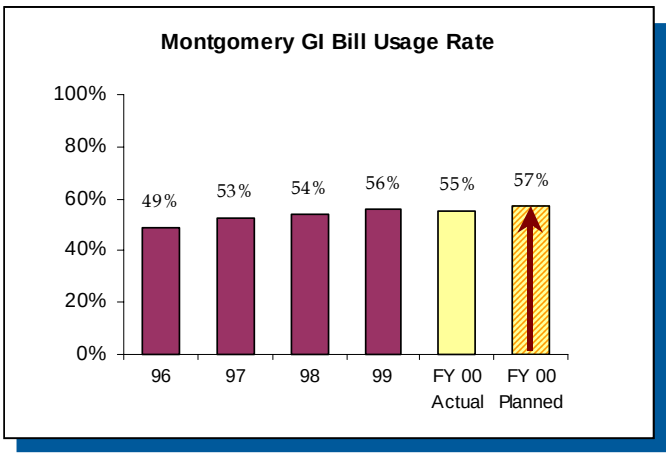
Improve the Montgomery GI Bill (MGIB) Active Duty Usage Rate to 57 Percent

(This measure supports our objective to assist veterans in readjusting to civilian life by enhancing their ability to achieve educational and career goals.)

Although VA is awaiting final military separations data from the Department of Defense (DoD), the estimated usage rate is 55 percent, near last year's rate and slightly below our performance target. The number of new users (i.e., those who began receiving education benefits for the first time) declined in FY 2000, while the number of military separations appears to be steady.

In addition to providing educational benefits to veterans, the MGIB enhances the Nation's competitiveness through the development of a more highly educated and productive work force. In part, this is achieved through greater numbers of capable workers who can perform the jobs created by new international markets and constant technological change. Users of the MGIB have more success in the labor market than non-users, an indication that this education program contributes to enhancing the Nation's competitiveness.

A comprehensive evaluation of VA's educational assistance programs, completed in 2000 by Klemm Analysis Group, addressed usage and other issues surrounding the administration of VA education benefits. In general, the programs show success in meeting the intended purposes of the legislation, while returning over $2 to the economy for every $1 in taxpayer funding. The MGIB—the centerpiece of VA education programs—has echoed the success of the more comprehensive World War II-era GI Bill of Rights. Compared to those who have not taken advantage of the MGIB, veterans who furthered their education under the program have lower unemployment, increased career and education goals, and higher earnings. However, the evaluation showed that VA education benefits do not cover all education costs at all schools, do not reflect the increased diversity in available education and training programs, and are not communicated effectively. The consultant's findings generated specific recommendations under three broad categories:



- Raise the level of VA education benefits. (A significant benefit increase of about 20 percent was enacted after the evaluation.)
- Become more customer-focused by embracing broader definitions of education and flexible payment options, and by employing technology tools that are right for the times. (Significant flexibilities were enacted after the evaluation.)
- Lead the communication effort in providing information to beneficiaries, ensuring that messages are correct, consistent, and coordinated across agencies of the Federal Government.

Means and Strategies

Although the usage rate did not improve, we have taken steps to improve access and outreach to service members and veterans.

Education beneficiaries throughout the Nation now receive toll-free telephone service by dialing 1-888-GIBILL1 (1-888-442-4551). They are first connected to an automated response system that provides general information; answers to frequently asked questions; recent payment information; and limited, beneficiary-specific, master record information. Callers can choose to speak to an Education Case Manager at any time during the call. Two issues have hampered customer service improvements thus far. First, automated responses have not reduced the number of callers seeking to speak with an Education Case Manager. Second, call volumes were larger in FY 2000 than originally anticipated. As a result, resource requirements were understated and an inordinate number of callers could not complete their calls. VBA staff is reviewing resource requirements and call patterns to determine possible solutions.

VA's Education Service began mailing a brochure, "Focus on Your Future with the Montgomery GI Bill," to men and women in the Armed Forces. Similar mailings are planned at specific points throughout each individual's military career. The brochure provides a general description of VA education benefits, including information to help service members in making a decision to enter training and use their MGIB benefits.

VBA has tested two interactive Internet applications designed to improve service to veterans and to facilitate information exchanges between education institutions and VA. The first, Web Automated Verification of Enrollment (WAVE), was installed in FY 2000 with limited success. Although veterans praised its ease of use, they complained about system instability and security issues (passwords had to be changed too frequently). WAVE was removed from production for improvements. When fully operational, WAVE will allow MGIB beneficiaries to verify their continued enrollment each month over the Internet instead of mailing the verification form.

The second application, VA Internet Certification (VANETCERT), was not installed in FY 2000 as planned. It has undergone more rigorous testing because of the difficulties encountered with WAVE. When installed in FY 2001, it will provide an Internet vehicle for school certifying officials to submit student enrollment information to VA.

Both applications, when fully operational, will reduce the amount of paper coming to the regional processing offices and speed the benefit payment process, thus encouraging veterans to use their benefits.

External Factors

The cost of education has risen faster than the Consumer Price Index for the past several years. Some veterans who lack sufficient savings to cover the difference between the monthly benefit and the cost of attending the school of their choice appear to be postponing their educational or training objectives. Others might be postponing additional education to take jobs in the strong economy.

Legislation enacted in late calendar year 2000, at the end of the 106th Congress, dramatically affects VA education benefits. Some of the following provisions begin to address issues raised in the program evaluation. For instance, higher monthly payment rates help to restore lost purchasing power. Payments for licensing and certification tests expand the definition of a program of

education or training. Collectively, these provisions will positively impact program usage:

- The monthly rate of benefits increased by more than 20 percent for the MGIB and the Dependents' Educational Assistance programs. The new full-time monthly rates, effective November 1, 2000, are $650 and $588, respectively.
- An active duty service member, who agrees to have his or her military pay reduced, may contribute an additional amount, up to $600, to receive a higher basic monthly benefit. For example, an individual who contributes the maximum amount of $600 will receive a full-time rate of $800 monthly, or $150 per month more than the basic benefit.
- VA may now pay a veteran for the cost of taking licensing and certification tests, which are needed to enter, maintain, or advance into employment in a civilian vocation or profession.
- An active duty service member who receives tuition assistance from the military may now receive payment from VA for the difference between the tuition and fees charged for the courses taken and the amount of tuition assistance actually paid by the military.

Crosscutting Activities

Increasing the MGIB usage rate requires coordination among VA and other organizations currently disseminating MGIB information, or planning to do so. State approving agencies have expressed interest in conducting outreach to separating service members during transition assistance briefings. VA has initiated a few pilots like a joint training program with the Navy to provide recruiters with accurate MGIB information so prospective sailors receive correct and consistent messages on future VA benefits. The Army has also expressed interest. Finally, VA began supporting military base counseling activities by furnishing a guide for education specialists working with service members who may need MGIB assistance to pursue educational or vocational objectives.

Data Source and Validation

The MGIB usage rate is calculated by dividing the cumulative number of individuals who began a program of education under the MGIB (taken from VBA's Education Master Record File) by the overall number of potentially eligible veteran beneficiaries (taken from DoD's Defense Manpower Data Center separation records). We do not independently validate the DoD information.

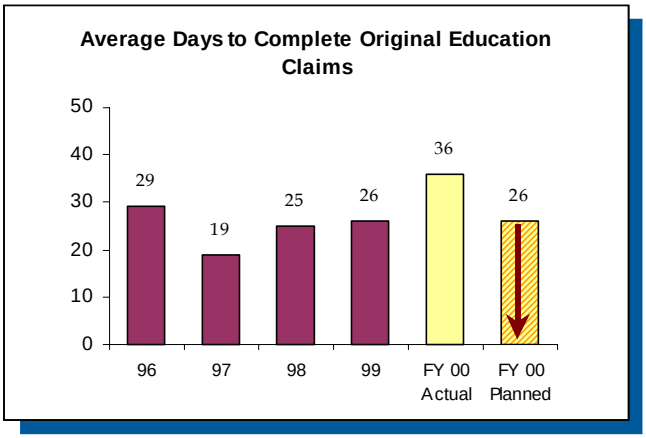
Process Original and Supplemental Education Claims in an Average of 26 Days and 17 Days, Respectively

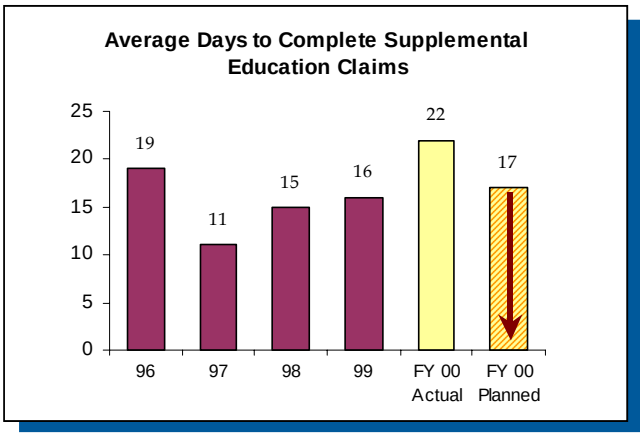
(These measures support our objective to assist veterans in readjusting to civilian life by enhancing their ability to achieve educational and career goals.)

Performance for the year did not meet expectations. It took an average of 36 days to process an original education claim and 22 days to process a supplemental education claim. The two most important reasons for our shortfall were:

- the heavy volume of callers using the education toll-free telephone network;
- problems with the conversion of imaging hardware and software (i.e., enhanced paperless office environment) in the education regional processing offices.

The inordinate volume of education toll-free telephone calls requiring the attention of case managers necessitated a shifting of some staff to the phones from claims processing in an attempt to mitigate the high number of blocked and abandoned calls. The volume of calls grew from an average of 250,000 a month in the first six months of operation to almost 350,000 a month a year later.





Education toll-free telephone service was implemented nationwide for two reasons. First, VBA management wanted to divert calls unrelated to compensation and pension claims processing away from the service centers, and reduce the VBA-wide blocked call rate of 60 percent. Second, education callers deserve to speak with VA employees who have expertise in education-related issues. The decision was successful to the extent that the 1-800-827-1000 blocked call rate has fallen to less than 5 percent. Unfortunately, we underestimated the call volume for education, as evidenced by the rapid growth after implementation of the toll-free telephone service.

The imaging management system (TIMS) encountered various technical problems shortly after conversion to the latest platform. Each office suffered through critical systems downtime (sometimes hours or days at a time), compromising operational performance and resulting in significant backlogs. Technical problems with TIMS installation impaired our ability to process claims in a timely manner. Contract issues with the vendor limited our

flexibility in adjusting schedules. For example, one office lost 10 consecutive workdays while the vendor corrected an image conversion miscue. That office lost almost 4 full weeks of effective production between May and July. Other offices experienced lost production time, although not as debilitating. With each period of downtime, pending workload grew. When the first conversion began in July 1999, there were fewer than 50,000 education claims pending nationwide. By the time the final station was successfully converted in August 2000, the nationwide pending workload had grown to more than 80,000, just as the traditional peak processing period of the year (i.e., when incoming work is the highest) was about to begin. The fiscal year ended with the highest education backlog in 5 years: over 100,000 pending claims.

Means and Strategies

The installation of an imaged environment, in concert with the merging of claims processing and veterans' services functions, was intended to improve customer service without degrading processing timeliness. With the difficulties outlined above, improvements could not occur. However, projects were initiated during the year that are designed to improve customer service over the long term:

- We are developing and installing electronic data interchange/electronic funds transfer (EDI/EFT) by implementing The Education Expert System (TEES). The early phases of EDI/EFT have been implemented. Beneficiaries under the MGIB-Active Duty program can have their monthly benefits deposited electronically into the account of their choice. About 70 percent of them now do so. In FY 2000, this feature was made available to beneficiaries under the MGIB-Selected Reserve. Participation among this group is expected to be high as well. EFT makes funds available 3 to 5 days earlier than if a check is mailed. In addition, some enrollment information received electronically from educational institutions is processed by a prototype, rules-based expert system without human intervention. VA received an assessment in FY 2000 of how to process up to 90 percent of all education claims automatically. A capital investment application was approved, and we are proceeding with the initiative.
- The Veterans' On-line Application (VONAPP) project, a part of the TEES initiative, began in FY 2000. VONAPP allows veterans to access a benefits application on-line and send it to VA electronically.
- We began to merge veterans' services functions with adjudication functions in the education divisions by using a case manager approach to complete claims for veterans' education benefits. Initially, this merging of functions adversely affected our ability to complete claims in a timely manner, but the long-term effect will be to provide more timely and accurate service to our veteran customers.

Crosscutting Activities

Overall processing timeliness is affected to some extent by the quality of the enrollment information and certification received from school officials. Several years ago, VA tested an initiative, VA Certification, with selected school certifying officials in the electronic transmission of enrollment data. The initiative proved to be successful and was made available to all education institutions. Many began using the application. To encourage more electronic submissions, VA developed and tested an Internet application, VA Internet Certification, which will be deployed in FY 2001. In addition, we will continue improving

relationships with institutions through better liaison and assistance.

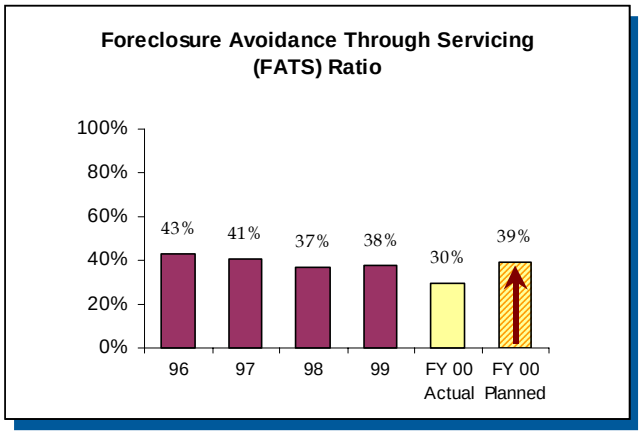
Data Source and Validation

Education claims processing timeliness is measured by using data captured automatically through the Benefits Delivery Network. The Education Service staff in VA Central Office confirms reported data though ongoing quality assurance reviews conducted on a statistically valid sample of cases. Specifically, dates of claims are examined to ensure that they are reported accurately.

Improve the Foreclosure Avoidance Through Servicing (FATS) Ratio to 39 Percent

(This measures supports our objective to improve the ability of veterans to purchase and retain a home through a loan guaranty program.)

Although VA did not meet its goal to assist veterans who are in default on a VA-guaranteed home mortgage as measured by the FATS ratio, the variance from plan is not as great as it appears. Before this year, the different means to avoid foreclosure were weighted to favor some means over others. For FY 2000, we determined that the best way to measure our efforts was for each of the means to be weighted equally. However, our FY 2000 performance target was based on the old methodology.



The FATS ratio measures the extent to which foreclosures would have increased had VA not pursued alternatives to foreclosure. Alternatives to foreclosure can help veterans either save their home or avoid damage to their credit rating, while reducing costs to the Government.

VA's home loan guaranty program has a significant impact on the housing economy of the United States. Over 16 million veterans and their families have used a guaranty since 1944; there are currently 3.1 million active loans. Veterans are able to purchase homes with little or no down payment, providing them with terms not generally available to non-veterans. This benefit stimulates home buying, which spurs economic activity for builders, construction workers, realtors, appraisers, and the real estate finance industry. It impacts on the sale of appliances, furniture, the market for home improvement materials and products, and the small businesses that provide these services.

Means and Strategies

There are four alternatives to foreclosure:

1. **Successful Intervention—**VA may intervene with the holder of the loan on behalf of the borrower to set up a repayment plan or take other action that results in the loan being reinstated.

2. **Refunding—**VA may purchase the loan when the holder is no longer willing or able to extend forbearance, but VA believes the borrower has the ability to make mortgage payments, or will have the ability in the near future.

3. **Voluntary Conveyance—**VA may accept a deed in lieu of foreclosure from the borrower, if it is in the best interest of the Government.

4. **Compromise Claim—**If a borrower in default is trying to sell the home, but it cannot be sold for an amount that is greater than or equal to what is owed on the loan, VA may pay a compromise claim for the difference in order to complete the sale.

To improve VA's ability to assist veterans who are delinquent with their mortgages, the Loan Service and Claims (LS&C) system was developed and implemented in late FY 1999. The goal of the LS&C system is to avoid a foreclosure and help veterans retain their homes. With the automated features of the LS&C system, VA can better assist veterans and oftentimes avoid a foreclosure. This system tracks the variety of actions taken by VA, lenders, and borrowers during the default period. It automates routine and redundant activities and gives the loan-servicing representatives a "real-time" snapshot of the current loan situation. As a result, employees can concentrate on supplemental loan servicing. The LS&C system also allows for an earlier analysis of the different alternatives to foreclosure. During FY 2000, VA made nearly 264,000 servicing contacts with veterans in an effort to help them avoid foreclosure.

In FY 2000, VA completed consolidation of the loan servicing function to nine regional loan centers. This consolidation allows for the most efficient use of resources to help veterans in default on their mortgage loans. Because of this restructuring, we are better positioned to meet future performance targets.

To be consistent with the new methodology used in computing the FATS ratio, we have changed the FY 2001 performance target to 33 percent, down from the original target of 40 percent.

Major Management Challenges

Over the past 13 months, the LS&C application has been enhanced to support the full range of current lending industry practices, including a financial counseling module to assist VA staff in determining the best way to help veterans keep their homes. Along with these current and planned changes, extensive reporting capability is being developed. Planned enhancements will give the LS&C managers a better picture of productivity and timeliness. The overall results will increase the utility of the system, provide more accurate data for workload management, and improve service to veterans and the lending industry.

The challenges previously identified for VA's housing program have been greatly reduced. GAO made seven specific recommendations for VA's housing program. Two have been fully implemented, another has been substantially completed, and the other four have seen VA initiate procedural changes, which will be ongoing to ensure adequate control and accounting over the direct loan and loan sales activities.

Data Source and Validation

Data to calculate the FATS ratio come from the LS&C system. In FY 2000, the OIG conducted an audit to determine whether VBA officials accurately reported the FATS ratio. The OIG attempted to verify each of the five components of the computation. The auditors randomly selected a sample of records in each category and

reviewed corresponding loan folders to determine whether records in the LS&C system were properly categorized. The OIG found that records in four of the five categories were correctly categorized. However, records categorized as successful interventions could not be verified because supporting documentation was not available. Evidence of defaults, intervention efforts, and cures was generally not retained in loan folders. Employees did record intervention efforts as electronic notes in the LS&C; however, the system did not retain the notes. Consequently, the OIG could not attest to the accuracy of the FATS ratio.

During the audit, VA activated a new computer system for loan servicing activities that retains electronic notes, which are used to document successful interventions. Because this should have corrected the only material deficiency identified, the OIG did not make any recommendations and considers the matter resolved.

STRATEGIC GOAL 3

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

Objective 3.1

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

Objective 3.2

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

Objective 3.3

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

Objective 3.4

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

Objective 3.5

Provide veterans and their families with symbolic expressions of remembrance.

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

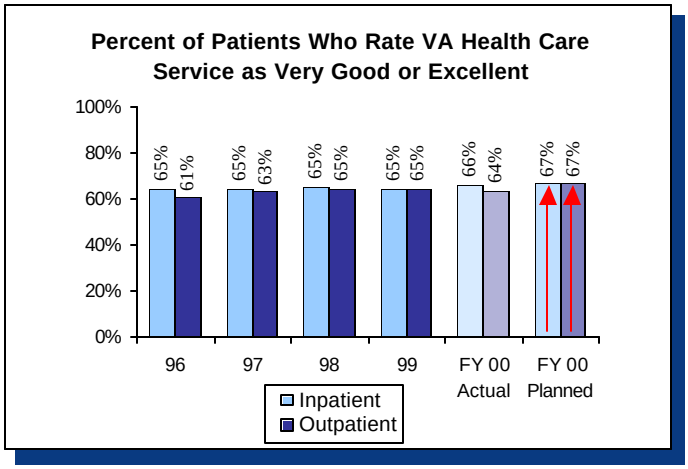
Several key performance measures enable us to gauge progress toward achieving this strategic goal:

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

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

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

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



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

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

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

Means and Strategies

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

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

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

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

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

Crosscutting Activities

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

Data Source and Validation

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

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

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

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

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

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

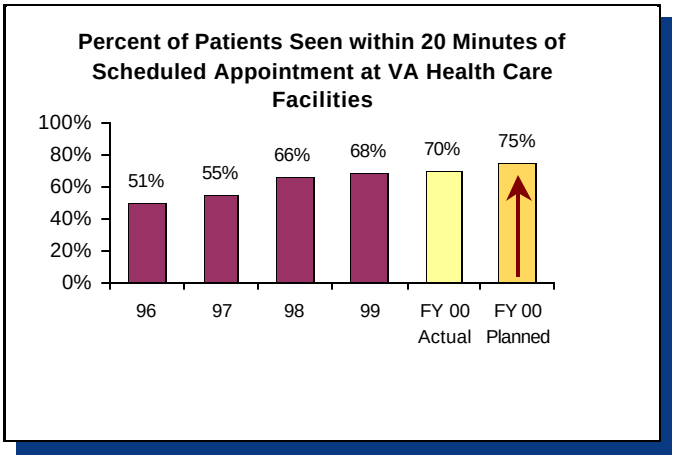
In FY 2000, data on the first two components of VA's 30-30-20 strategy were not collected in a format that provided information on the percentage of patients obtaining an appointment in 30 days. Efforts continue to refine the data collection vehicles required to capture the information in the desired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

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

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

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

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



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

Means and Strategies

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

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

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

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

Data Source and Validation

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

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

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

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

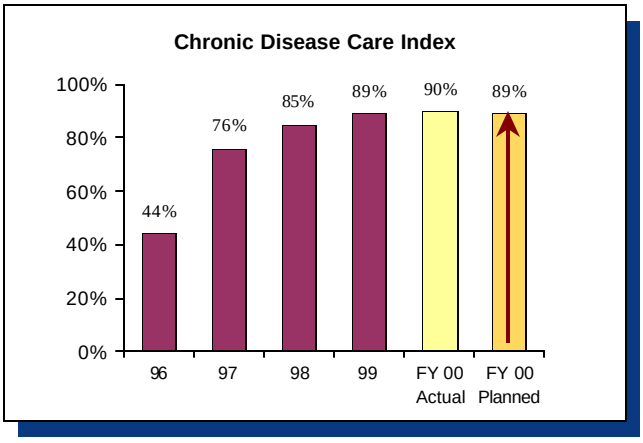
The source of data for the 20-minute waiting time at VA facilities is the *Annual National Ambulatory Care Satisfaction Survey* conducted by the National Performance Data Feedback Center. The numerator is the percentage of outpatients who report they were seen within 20 minutes of their scheduled appointment.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

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

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

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

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



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

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

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

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

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

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

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

Means and Strategies

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

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

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

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

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

Crosscutting Activities

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

Data Source and Validation

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

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

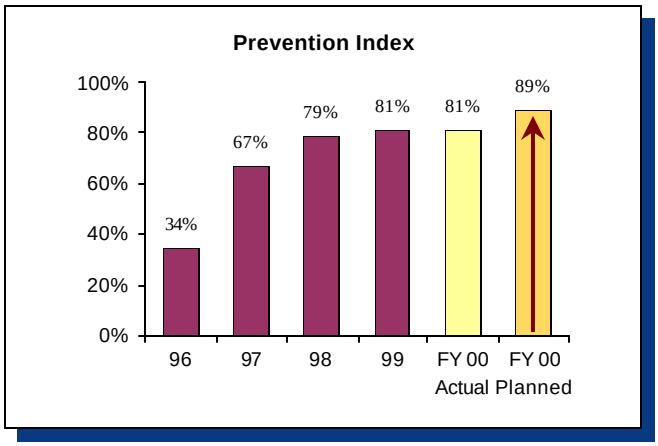
Data are abstracted monthly. The West Virginia Medical Institute conducts measurements of performance through medical record abstraction. They statistically evaluate the data to ensure validity and reliability. For each abstractor involved in the review process, the West Virginia Medical Institute uses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

Increase the Score on the Prevention Index to 89 Percent

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

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

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



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

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

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

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

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

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

Means and Strategies

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

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

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

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

Data Source and Validation

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

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

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

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

The principal findings of this audit were:

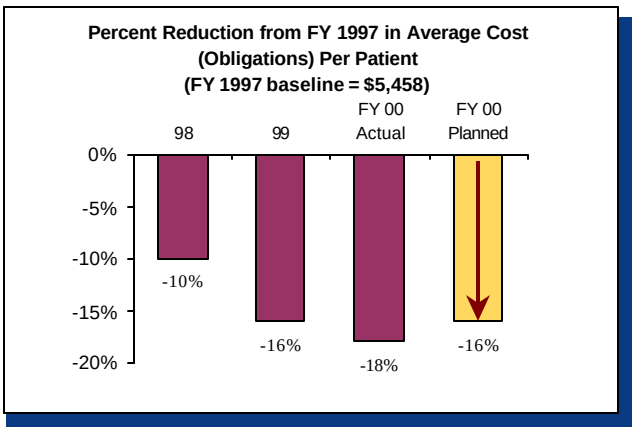
- Procedures used by VA to compute the CDCI and PI indices were adequate;
- The sampling methodology was appropriate;
- Reliability controls, edit checks, and other controls were adequate and functioned properly;
- Security controls over data maintained in computers need to be strengthened;
- Disclosure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

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

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

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

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



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

Means and Strategies

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

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

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

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

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

Crosscutting Activities

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

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

Major Management Challenges

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

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

Data Source and Validation

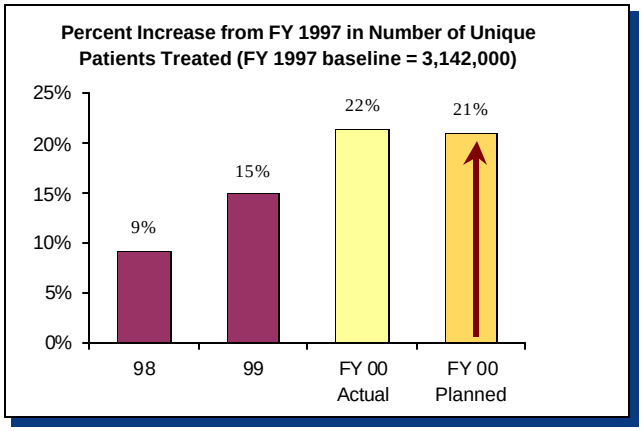
Data for calculating the cost of per-patient care are derived from the National Patient Care database and the various network plans. These databases contain the relevant workload, unique social security numbers, and dollars spent on providing health care for VA patients.

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

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

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

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



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

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

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

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

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

Means and Strategies

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

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

Crosscutting Activities

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

Major Management Challenges

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

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

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

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

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

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

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

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

VA has taken several actions to address these recommendations:

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

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

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

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

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

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

For more information, refer to pages 100-101.

Data Source and Validation

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

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

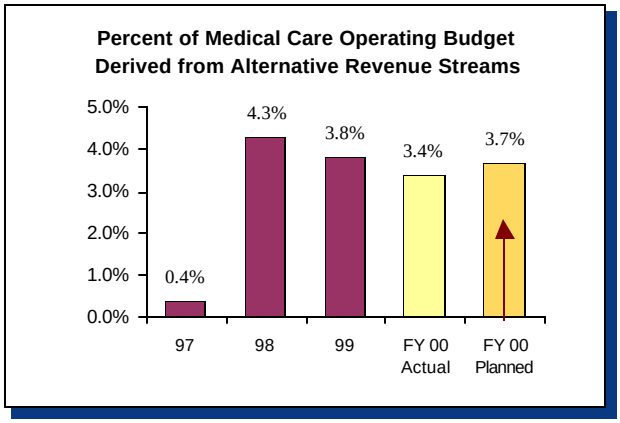
data systems, VHA implemented edit checks in automated data processing systems to correct input errors and improve the quality of data used to report the number of unique patients. In addition, a major enhancement to the Veterans Health Information Systems and Technology Architecture is a primary VHA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

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

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

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

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



Means and Strategies

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

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

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

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

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

Data Source and Validation

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

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

Pension Program Outcomes

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

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

Means and Strategies

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

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

VA Pension Program Purpose

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

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

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

VA Pension Program Outcomes

Access

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

Income

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

Security

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

Dignity

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

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

Data Source and Validation

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

Insurance Program Outcomes

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

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

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

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

Means and Strategies

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

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

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

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

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

Data Source and Validation

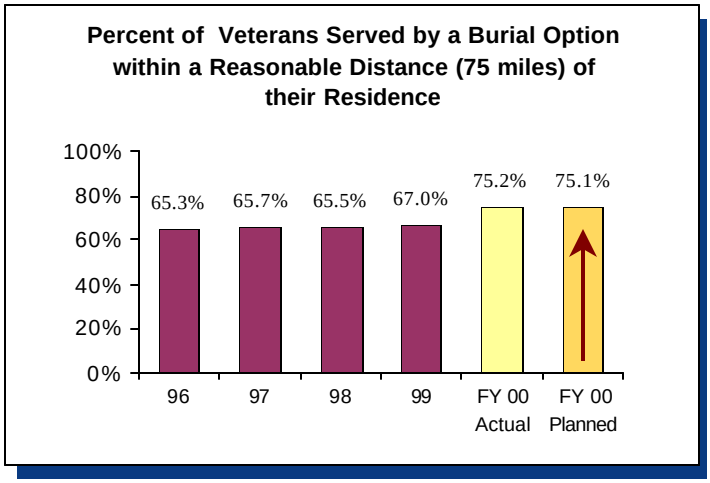
An evaluation of the insurance programs is currently underway. The results of the program evaluation will be used to assess the appropriateness of our interim outcomes, and as a source of additional information about the impact of the programs on veterans and their families. This evaluation of the insurance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

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

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

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

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



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

Means and Strategies

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

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

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

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

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

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

Crosscutting Activities

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

Data Source and Validation

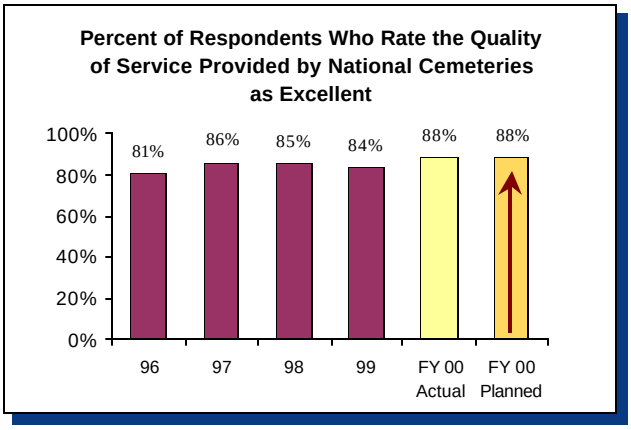
The percent of veterans served by a burial option within a reasonable distance of their residence was determined by analyzing census data, the number of new national or state veterans cemeteries opened, and changes in the service delivery status of existing cemeteries. Multiple counts of the same veteran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

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

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

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

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



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

Means and Strategies

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

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

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

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

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

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

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

Crosscutting Activities

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

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

Data Source and Validation

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

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

STRATEGIC GOAL 4

Contribute to the public health, socioeconomic well being and history of the Nation.

Objective 4.1

Advance VA medical research and development programs to better address the needs of the veteran population and to contribute to the Nation's knowledge of disease and disability.

Objective 4.2

Ensure an appropriate supply of health care providers for veterans and the Nation through sustained partnerships with the medical education community.

Objective 4.3

Improve the Nation's response in the event of a national emergency or natural disaster by providing timely and effective contingency medical support and other services.

Objective 4.4

Enhance the socioeconomic well being of the Nation through veterans' benefits and business assistance programs.

Objective 4.5

Ensure that national cemeteries are maintained as shrines dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice veterans have made.

VA supports the public health of the Nation as a whole through conducting medical research, offering medical education and training, and serving as a resource in the event of a national emergency or natural disaster. VA supports the socioeconomic well being of the Nation through the provision of education, vocational rehabilitation, and home loan programs. VA preserves the memory and sense of patriotism of the Nation by maintaining our national cemeteries as national shrines, and hosting patriotic and commemorative events.

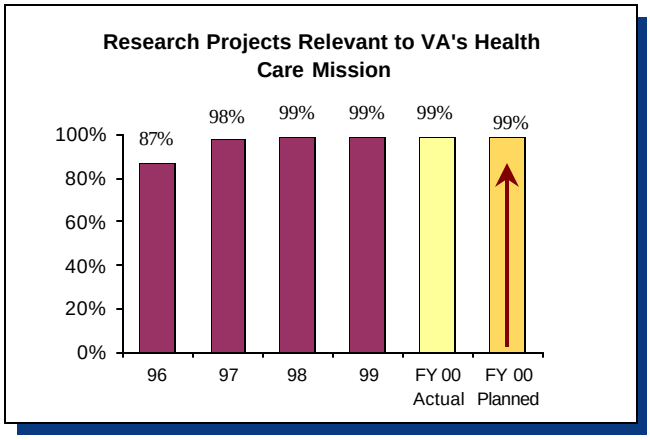
Three key performance measures enable us to gauge progress toward achieving this strategic goal:

- Research projects relevant to VA's health care mission
- Percent of residents trained in primary care
- Percent of respondents who rate the appearance of national cemeteries as excellent

The Share of Research Projects Relevant to VA's Health Care Mission Will Remain at 99 Percent

(This measures supports our objective to advance VA medical research and development programs to better address the needs of the veteran population and to contribute to the Nation's knowledge of disease and disability.)

VA's Research and Development (R&D) program benefits not only veterans, but also the Nation as a whole and the international community. The scope of VA's R&D portfolio extends from basic laboratory research on the cause, treatment, and cure of a variety of diseases, disorders, and disabilities to clinical research on patient care management. Many modern medical technologies—including the cardiac pacemaker, the CT scan, magnetic resonance imaging, and drug therapy for the mentally ill—have their roots in VA research.



The research performance database indicates that in FY 2000, 99 percent of the studies met the criteria for the third consecutive year. VA's outstanding performance history in medical research projects is due primarily to Departmental research management policies. The superior results reflect the R&D program's continuing commitment to improve the health of America's veterans. Without the continued breakthroughs and innovations that have come out of our R&D program, VA's commitment to deliver excellence in health care service and value would be undermined. The following are examples of medical advances to which VA contributed in FY 2000:

- Researchers at 12 VA medical centers are working with scientists throughout the United States and Canada on a large-scale, multi-center, randomized controlled study of patients with coronary heart disease. The purpose of the study is to compare the effectiveness of angioplasty with medical therapy to medical therapy alone. This international six-and-a-half-year trial, Clinical Outcomes Utilizing Revascularization and Aggressive Drug Evaluation (COURAGE), involves 37 hospitals—12 VA, 12 U.S. non-VA, and 13 Canadian—and more than 3,000 patients.
- VA researchers completed a seven-year study that showed treatment of low high-density lipoprotein (HDL) cholesterol significantly reduces heart disease deaths, heart attacks, and strokes. The study revealed that the drug gemfibrozil caused a 6 percent increase in HDL cholesterol, reducing coronary heart disease deaths by 22 percent, non-fatal heart attacks by 23 percent, and strokes by 29 percent.
- Three popular types of hearing aids that account for 70 percent of the market were subjected to rigorous scientific testing in a clinical trial conducted by VA researchers and the National Institute on Deafness and other Communication Disorders. The study's results may assist doctors in helping millions of Americans to cope with hearing loss more

effectively. This was the first account of a clinical hearing aid trial in medical literature, and shows that hearing aids substantially help users in both quiet and noisy environments. Primary care doctors will now have greater access to information about how hearing aids help many patients, especially those with mild to moderate hearing loss. About one-third of all people 65 years of age or older have nerve-related hearing loss that can often be helped by hearing aids. Presently, only about 20 percent of people who can benefit from hearing aids actually wear them, partly because primary care doctors have not been adequately informed of the benefits. Last year, 85,000 patients were fitted for hearing aids at VA medical centers.

- VA is conducting a large-scale clinical trial that may determine whether intensified blood-sugar control can prevent the major vascular complications that lead to most of the deaths, illness, and treatment costs for patients with Type II diabetes. This seven-year VA Diabetes Trial, started in FY 2000, involves more than 20 VA medical centers across the country.

- VA researchers announced plans for a Tri-National clinical trial to determine optimal anti-retroviral therapy for fighting human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). Researchers from the United States, the United Kingdom, and Canada will jointly develop an international study to determine the most effective treatment for persons with AIDS for whom all other treatments have not worked.

Means and Strategies

R&D's policy is to consider for scientific review projects that fit within one or more of VA's nine Designated Research Areas (DRAs) and are highly relevant to the health care of veterans: (1) aging and age-related changes; (2) acute illness and traumatic injury; (3) military occupational environmental exposures; (4) chronic diseases; (5) sensory disorders and loss; (6) mental illness; (7) substance abuse; (8) special populations; (9) health services and systems. Federally chartered review boards—composed of content experts in medical subspecialties, rehabilitation engineering, clinical trials, and the economics of health care delivery—meet semi-annually to review biomedical research proposals submitted nationwide from VA clinician investigators.

Portfolio analysis is an ongoing process as management assesses the quantity and quality of VA's research efforts among its DRAs. Where areas are underrepresented, requests for proposals and special solicitations are sent out seeking applications from VA researchers. The newly constituted National Research Advisory Council, whose members are external to VA, will assist the Department in determining which parts of the DRA portfolio need augmentation or reduction.

During FY 2001, VA will implement a national research investigator satisfaction survey that will allow for comparisons among the 22 networks. Beginning in FY 2002, VA will track DRAs as the percent of research that is relevant to, and will have an impact on, the clinical needs of veterans.

Crosscutting Activities

Although there is a VA presence on the chartered scientific review board, the preponderance of membership comes from outside the Department. Biomedical experts are drawn from universities and medical schools across the country. In addition, specialists from other government agencies, such as the National Institutes of Health, contribute to the review board's membership. The Department seeks membership from different

geographic areas, diverse ethnic and racial backgrounds, and both sexes. This diversity is representative of both the board membership and the veteran population. Written ad hoc reviews that contribute to the deliberations of the board are sought from experts wherever they can be found—nationally and internationally.

Data Source and Validation

Data come from the Research and Development Information System (RDIS), the internal merit review board records, and an annual portfolio analysis. Maintained by our R&D program, RDIS is continually updated by the Research administration offices located in VA's health care facilities. Additional sources of data come from internal program review files.

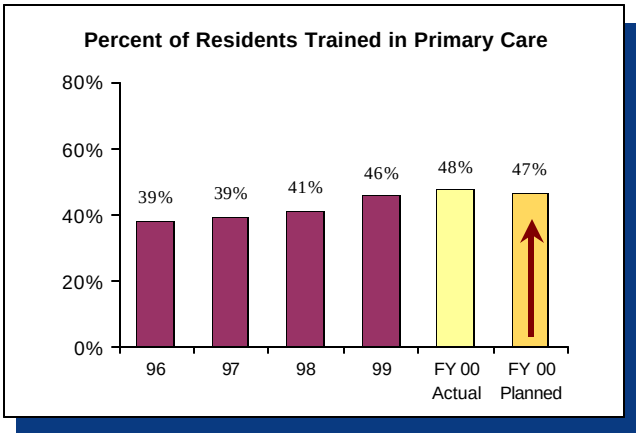
An annual portfolio analysis of all VA-funded research projects conducted by the four research services determines the validity of the data. The measure for this goal is the number of VA-funded projects fitting into one or more of the DRAs, divided by the total number of VA-funded projects. The R&D office produces an annual report that is national in scope.

More detailed information about VA's research program, including summaries of recent research in each of the nine DRAs, may be found on the World Wide Web at http://www.va.gov/resdev.

Increase the Number of Residents Trained in Primary Care to 47 Percent

(This measure supports our objective to ensure an appropriate supply of health care providers for veterans and the Nation through sustained partnerships with the medical education community.)

FY 2000 marks the third consecutive year in which VA has exceeded its performance target for this measure. In future plans and reports, this key measure will be replaced by the following key measure for the medical education program: "Medical residents' and other trainees' scores on a VHA survey assessing their clinical training experience."



Means and Strategies

VA conducts an extensive education and training program to enhance the quality of care provided to veterans within the VA health care system. Education and training efforts are accomplished through coordinated programs and activities for health professions' students and residents by means of partnerships with affiliated academic institutions. The presence of health professions'

trainees improves veterans' care by fostering an academic milieu, while enhancing staff recruitment and retention.

Crosscutting Activities

VA continued to build on its long-standing relationships with the Nation's academic institutions and intends to take a leadership role in reshaping the education of future health care professionals.

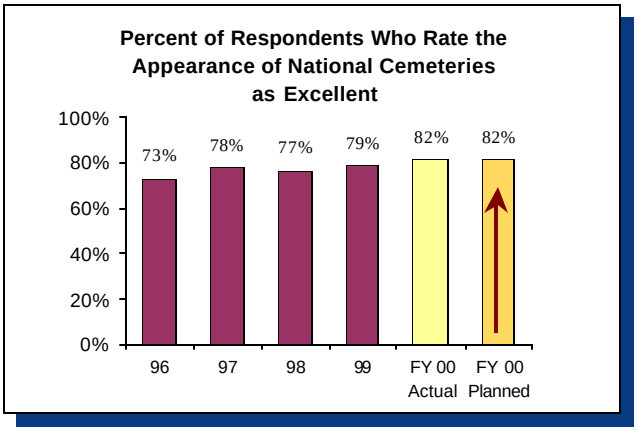
Data Source and Validation

The data source is residency allocation records maintained in the Office of Academic Affiliations. These data are kept by academic and fiscal year. The measure for this goal is the number of residency positions classified in primary care (including general internal medicine, family practice, geriatric medicine, obstetrics and gynecology, preventive medicine, and occupational medicine) at the end of the fiscal year as compared against all VA-funded residency positions. A national report is prepared annually documenting these changes.

Increase the Number of Respondents Who Rate the Appearance of National Cemeteries as Excellent to 82 Percent

(This measure supports our objective to ensure that national cemeteries are maintained as shrines dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice veterans have made.)

Our Nation's veterans have earned the appreciation and respect not only of their friends and families, but also of the entire country. National cemeteries are enduring testimonials to that appreciation and should be places to which veterans and their families are drawn for a dignified burial and lasting memorial. Veterans and their families expect national cemeteries to have well-maintained gravesites, buildings, facilities, and headstones and monuments.



Satisfaction with the appearance of national cemeteries remained at a very high level. Cemetery appearance goals are set consistent with the high expectations of veterans and the general public.

Means and Strategies

To make sure the appearance of national cemeteries meets the standards our Nation expects of its national shrines, VA performed a wide variety of grounds management functions. Headstones were set, aligned, or realigned to maintain uniform height and spacing. Headstones that became soiled were cleaned. In-ground gravesites (casket and cremain) required maintenance to prevent and correct ground sinkage. To preserve columbaria, VA cleaned stains from stone surfaces, maintained the caulking and grouting between the units, and repaired the surrounding walkways. While attending to these highly visible aspects of our national shrines, VA also maintained roads, drives, parking lots, and walks; painted buildings, fences, and gates; and repaired roofs, walls, and irrigation and electrical systems. For example, a construction project was completed in FY 2000 to restore a deteriorating historic brick wall surrounding Memphis National Cemetery. At Golden Gate National Cemetery, improvements were made to increase handicapped accessibility to the administration building and chapel.

Cemetery acres that have been developed into burial areas, and other areas that are no longer in a natural state, also required regular maintenance. In FY 2000, VA maintained nearly 6,800 developed acres and 2.4 million graves.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directs VA to contract for a study on improvements to national cemeteries. The report to Congress will include a demographic study, an assessment of one-time repairs needed at all 119 national cemeteries, and an assessment of the feasibility of making standards of appearance equal with the finest cemeteries in the world. NCA has awarded a contract to conduct the study. When completed, this report will include key data which VA can use in its planning processes for maintaining national cemeteries as national shrines.

Numerous ceremonies and memorial services were held during FY 2000 at national cemeteries to honor those who made the supreme sacrifice. For example, ceremonies were held at Houston and San Joaquin Valley National Cemeteries and at the National Memorial Cemetery of the Pacific in remembrance of the Korean War's 50th Anniversary. Memorial Day 2000 saw thousands of visitors across the Nation gather at national cemeteries to honor Americans who served our country. Dignitaries spoke of honor and sacrifice, relatives remembered loved ones, wreaths were laid, honor guards paraded, planes flew over, and patriotic music played. Miss America 2000, Heather French, addressed approximately 2,000 people attending the ceremony at Calverton National Cemetery. A ceremony was held at Riverside National Cemetery dedicating the National Medal of Honor Memorial. The memorial, honoring the 3,409 Americans who received the country's highest combat medal for valor, includes polished granite panels engraved with the names of all medal recipients. These engraved panels surround a rectangular pool and fountain.

NCA completed a project, started in 1994, to include each of the Civil War-era national cemeteries in the National Register of Historic Places. With the inclusion of San Antonio, Texas, and Natchez, Mississippi, National Cemeteries in FY 2000, all 59 Civil War-era national cemeteries are now listed.

To ascertain how our customers and stakeholders perceive the appearance of national cemeteries, VA annually seeks feedback from them through visitor comment cards and focus groups. This information is used to determine expectations of cemetery appearance as well as specific

improvement opportunities and training needs. VA is developing a nationwide mail-out survey to better measure the public's perception of the appearance of national cemeteries. NCA will use the information gathered as part of the strategic planning process to develop additional strategies for improvement. VA will continue to conduct focus groups to collect data on stakeholder expectations and their level of satisfaction with the appearance of national cemeteries.

Crosscutting Activities

VA continued its partnerships with various VA and civic organizations that provide volunteers and other participants to assist in maintaining the appearance of national cemeteries. For example, an Interagency Agreement with the Bureau of Prisons provided for the use of selected prisoners to perform work at national cemeteries.

Under a joint venture with VHA, national cemeteries provide therapeutic work opportunities to veterans receiving treatment in the Compensated Work Therapy/Veterans Industries (CWT/VI) program. The national cemeteries are provided a supplemental work force; the veterans have the opportunity to work for pay, regain lost work habits, and learn new skills. Veterans in one medical center's CWT/VI program not only maintain a nearby national cemetery's grounds, but prepare sites for burial; clean, set, and repair headstones; and assist visitors at the cemetery. The knowledge that the cemetery is being cared for by local veterans has enhanced community pride and interest in the cemetery.

Data Source and Validation

The source of data to measure the appearance of national cemeteries is the NCA Visitor Comment Card. Data are collected annually for a period of 90 days. The measure for cemetery appearance is the percentage of respondents who rate the appearance of the cemetery as "excellent." Respondents are asked to rate the appearance of cemetery grounds, headstones and markers, gravesites, and facilities. Cemetery appearance is considered the average of excellent scores in each of the four areas rated.

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

ENABLING GOAL

Create an environment that fosters the delivery of One VA world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources

Objective E-1

Improve communications with veterans, employees, and stakeholders to share the Department's mission, goals and results, and to increase awareness of benefits and services for veterans and their families.

Objective E-2

Recruit, develop, and retain a competent, committed, and diverse workforce that provides high quality service to veterans and their families.

Objective E-3

Implement a One VA information technology framework that supports the integration of information across business lines and provides a source of consistent, reliable, accurate, and secure information to veterans and their families, employees, and stakeholders.

Objective E-4

Improve the overall governance of VA and the management of its business processes.

VA's enabling goal is different from our four strategic goals. This goal and its corresponding objectives represent crosscutting activities that enable all organizational elements to carry out the Department's mission. VA's functions and activities focus on improving communication, enhancing the workforce assets and internal processes, and furthering a *One VA* approach to providing seamless service to veterans and their families. As such, many of these functions and activities are not apparent to veterans and their families. However, they are critical to our stakeholders and VA managers and employees who implement our programs.

Although no key performance measures are associated with the enabling goal, some of the Department's achievements in support of this goal are discussed on pages 78-80 in the section of this report titled "Other Significant Achievements."

OTHER SIGNIFICANT ACHIEVEMENTS

In addition to the accomplishments associated with our key performance goals, the Department recorded many other notable achievements during FY 2000. The following summary of accomplishments, organized by VA's strategic and enabling goals, reflects our recent progress in providing accessible, timely, high-quality, and courteous service to veterans.

Strategic Goal 1: Restore the capability of disabled veterans to the greatest extent possible and improve the quality of their lives and that of their families.

- VA hosted 200 "stand downs" in 47 states, the District of Columbia, and Puerto Rico, nearly doubling the number of past years. Stand downs are traditionally held before the onset of winter to provide homeless veterans with warm clothing, medical screenings, and other assistance.

- VA awarded nearly $11.5 million in grants to 65 public and private non-profit groups to develop or expand programs to assist homeless veterans. These grants provide up to 65 percent of the cost of acquiring or renovating facilities that will be used for housing or service centers, or for procuring a van to transport veterans to needed services.

- VA is the only federal agency that provides substantial hands-on assistance directly to homeless persons. In FY 2000, VA dedicated nearly $150 million to its specialized homeless programs, including health care, rehabilitation, outreach, and counseling programs.

- VA is the Nation's largest provider of care to individuals infected with HIV. VA treats about 18,000 HIV patients per year. As of FY 2000, the Immunology Case Registry clinical database on HIV information housed data on nearly 50,000 patients with HIV. This registry is used as a tool to continually improve HIV care across all VA settings. In addition, VA conducted multiple HIV clinical update conferences to educate VA clinicians about advances in treatment.

- Nationally, the number of inpatients discharged with a mental illness diagnosis grew from 28,000 in FY 1998 to 47,000 in FY 2000. Despite this dramatic increase, almost all VISNs showed clear upward trends in the percent of patients provided follow-up care within 30 days of discharge. The share of 30-day follow-up after hospitalization for mental illness improved from 72 percent in FY 1998 to 83 percent in FY 2000. The 1999 national average for private sector HMOs reported by the National Committee on Quality Assurance was 70 percent.

- Through the combined efforts of VHA and VBA, the Department met its internal goal of completing medical exams associated with claims for compensation and pension benefits in an average of 35 days.

Strategic Goal 2: Ensure a smooth transition for veterans from active military service to civilian life.

- VA and DoD are providing a new facility at Camp Lejeune, North Carolina, to ease the transition from active duty to civilian life. At the facility, departing military personnel can apply for veterans' benefits before they actually leave the service. In the past, departing service members had to have a physical exam performed by an active-duty physician before leaving the service, then

another exam when they applied for veterans' benefits and services. They also had to apply for benefits in the state where they planned to live, a process that could take several months. At the new Camp Lejeune facility, the process has been shortened to 25 days, and everything can be done at that site.

- Approximately 70 percent of the 279,900 beneficiaries who used VA education benefits during FY 2000 qualified under the provisions of the MGIB; reservists accounted for nearly 18 percent; the program for certain eligible dependents of veterans accounted for about 11 percent.

- A study of VA's property management function has begun, and involves the joint efforts of internal program experts and contractor assistance. The study will determine the best practices in the industry and the most cost-efficient source of providing these services, such as the acquisition, inventory management, and distribution of medical and surgical supplies inside the medical center. The project, scheduled for completion in FY 2001, will include a decision regarding whether the property management work should remain in-house or be contracted out.

Strategic Goal 3: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.

- VA has taken the lead in National Patient Safety Partnership efforts to increase awareness of the need for appropriate measures to alleviate potential risks. In collaboration with a public-private consortium of organizations, VA developed new safety strategies and processes to improve patient safety and prevent future health care errors. About 3 of every 4 employees in VHA received 40 or more hours of continuing education; 54 percent had 20 or more hours of education specifically on patient safety.

- Hepatitis C infection is a major concern for VA. During FY 2000, VA screened about 386,500 veterans for Hepatitis C. Of this total, about 4,500 patients tested positive and began therapy.

- In FY 2000, all 22 VISNs put in place telephone care access for veterans at least 8 hours a day, 5 days a week.

- Smoking is the leading preventable cause of death in the United States, resulting in more than 400,000 deaths a year. Research indicates that advice from a physician is one of the more effective anti-smoking interventions developed to date. In FY 1996, 33 percent of current smokers' medical charts documented a physician's advice to stop smoking (based on counseling once annually). In FY 2000, the rate rose to 59 percent (based on counseling three times a year).

- VA embarked on a new strategic planning process, the Capital Asset Realignment for Enhanced Services (CARES) program, to improve access and quality of health care services to veterans by realigning capital assets.

- In FY 2000, the VA insurance program covered more than 4.5 million individuals, with coverage totaling more than $451 billion.

- The National Defense Authorization Act of 2000, Public Law 106-65, requires DoD to provide military funeral honors for all eligible veterans, upon request. A military funeral honors ceremony consists of the

folding and presentation of the American flag and the playing of Taps. A detail to perform honors consists of two or more uniformed members of the Armed Forces, including Reserve Component members, with at least one member from the military service in which the deceased veteran served.

- VA provided over 327,000 headstones and markers for the graves of eligible persons in national, state, and other public and private cemeteries. Over 322,000 Presidential Memorial Certificates, conveying the Nation's gratitude for the veteran's service and signed by the President of the United States, were issued to veterans' next of kin and other loved ones.

- As we strive to increase efficiency through the use of modern information technology, VA encourages other federal and state veterans cemeteries to place their orders for headstones and markers directly into AMAS-R, NCA's electronic monument ordering system. In FY 2000, 88 percent of the monuments for other federal and state veterans cemeteries were ordered electronically, far exceeding our target of 75 percent.

Strategic Goal 4: Contribute to the public health, socioeconomic well being and history of the Nation.

- VA's efforts to advance knowledge about the elderly and improve care for seniors include identifying the unique characteristics of the aging process and developing strategies to treat or prevent age-related health problems. Scientists have focused on the different nutritional needs of older adults, treatment and prevention of frailty, immobility and falls, and end-of-life issues.

- Many individuals with amputations across the shin or thigh lack endurance because of the extreme effort simply to walk with today's prosthetic limbs. To combat this problem, VA researchers developed an artificial muscle and tendon to replace the lost musculature of the lower limb. The resulting powered prosthetic limb, which will enter clinical testing soon, is expected to reduce patient fatigue and produce greater propulsive forces for walking.

- A VA research initiative involving microcomputer technology will modernize the design of electric-powered upper limb prostheses. VA researchers are developing a position-sensitive controller that will improve functional performance, fitting flexibility, and ease of operation. By providing sensory feedback from the prosthesis to the amputee, the new controller gives the amputee a better feel for the position of the prosthetic limb in space. This important research by VA will help assure better prostheses and better controllers for all upper-limb amputees.

- VA researchers are working toward understanding the biological causes of sensory loss, restoring or improving lost function for affected individuals, and improving health services and rehabilitation aids.

- The Florida National Cemetery received the prestigious Hammer Award for its involvement in the Reclaimed Water Project. Together with the Southwest Florida Water Management District, the Florida Department of Corrections, Withlocooche River Basin Board, and King Engineering Associates, Inc., the Florida National Cemetery found a creative solution to the problem of providing sufficient water to irrigate the national cemetery grounds by using reclaimed water from nearby prison water treatment plants.

The cemetery gained the nutrient-rich water needed, the prison gained a solution for disposing its excess reclaimed water, the community gained protection for its natural water source, and veterans gained the assurance that their cemetery would continue to be maintained as a national shrine.

- VA Directive 0320, Emergency Preparedness Planning, and VA Handbook 0320, Emergency Preparedness Planning Procedures and Operational Requirements, were published. These documents contain the Department's Continuity of Operations Plan (COOP), which was developed within the one-year time frame mandated by Presidential Decision Directive 67. The goal of the Department's COOP is to ensure a viable continuity of VA operations under all circumstances and against a wide range of possible threats.

The Enabling Goal: Create an environment that fosters the delivery of One VA world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources.

- VA developed a *One VA* employee orientation package to provide employees a better understanding of VA programs, benefits, and services. This package includes a *One VA* Learning Map, which is an interactive learning tool for employees to help them better understand the history of the Department and the needs of veterans.

- VA also began development of a *One VA* Learning Map for veterans to enhance their knowledge about potential entitlement to benefits and services provided by VA. The map will be available to VA field facilities, national and local veterans service organizations, State Department of Veterans Affairs, military discharge centers, and other facilities.

- A comprehensive workforce planning initiative is essential for VA to remain as a provider of quality services to America's veterans. An anticipated upswing in retirements, rapid changes in technology, an increasingly diverse labor and beneficiary pool, and different expectations of younger workers are forces that strongly suggest the need for new recruitment and retention practices to meet program goals. VA has made great strides in establishing a workforce planning process, and is in the beginning stages of developing and implementing a workforce forecasting system.

- VA and its unions worked together to craft a major policy directive on using Alternative Dispute Resolution (ADR), particularly mediation, to resolve workplace conflicts at the earliest stage possible. VA encouraged the use of ADR throughout the various stages of the discrimination complaint process, up to and including the Equal Employment Opportunity Commission (EEOC) hearing stage. By the end of the fiscal year, VA's rate of settlement of formal discrimination complaints increased from 15 percent to 25 percent.

- VA's Office of Resolution Management (ORM) partnered with the EEOC to refine the equal employment opportunity investigative process. As a result, in FY 2000, ORM reduced its investigative backlog of cases pending over 180 days by more than 50 percent, and the number of cases pending procedural reviews over 120 days by 90 percent.

- VA began implementing a new integrated financial system, known as the core Financial and Logistics System (coreFLS). This system

will provide timely, easily accessible financial and logistical information in a context meaningful to users. CoreFLS will provide information rather than data, increase knowledge sharing, and greatly reduce reconciliation efforts as well as operating, maintenance, and life cycle costs. CoreFLS will use commercial off-the-shelf software, employ best practices, and implement a Department-wide solution.

- VA's new human resources information system, HR LINK*$*, is consolidating, integrating, and standardizing human resources and business processes across the Department. The first of those processes, Employee Self Service (ESS), was implemented VA-wide in February 2000. ESS allows employees to use either Web-based technology or touch-tone telephones to initiate their own personal and personnel transactions (e.g., tax and address changes, Combined Federal Campaign elections, savings bond campaign enrollment, and health insurance coverage), which are then automatically forwarded to the Shared Service Center in Topeka, Kansas, for processing.

- Implementation of ESS was followed by the phased introduction of Self-Service for Managers. HR LINK*$* will provide expert systems that allow managers to create position descriptions, classify positions, request and approve personnel actions, approve leave, and certify time cards—all from their desktop computers. The first of these expert systems, Position Classification, was implemented VA-wide in May 2000.

- VA successfully transitioned into the Year 2000 without any significant interruptions. VA remained on a "green" operational status during the January 1 date rollover period and the leap year date rollover. VA benefits were paid on time, and VA health care facilities remained open throughout the date rollovers.

- VA implemented a new Intranet-based tool, the Intranet Benefits Delivery Network/ Beneficiary Identifier and Records Locator System Access, that gives staff faster, easier access to veteran information needed to determine eligibility, entitlement, and amount of benefits.

- Several activities related to Electronic Government were initiated that give veterans quick, easy, and secure access to on-line services. The 10-10 EZ and Veterans' On-line Applications allow veterans to apply for medical, compensation, pension, and vocational rehabilitation benefits through the Internet. The Net Certification system enables schools or training establishments to submit enrollment forms from veterans on-line. The Web Automated Verification of Enrollment application allows veterans to submit their Monthly Verifications of Enrollment forms on-line. The Insurance Self-Service initiative will provide VA policyholders with the capability to access their own insurance master records and make inquiries, certain account changes, and disbursement via their Web browser.

- VA processed over 2.2 million credit card transactions, representing almost $1.3 billion in purchases. The all-electronic billing and payment process for centrally billed card accounts earned over $13 million in credit card refunds, an increase of approximately 32 percent from FY 1999.

- Revenues in the Franchise Fund increased from $95 million in FY 1999 to over $137 million in FY 2000 *(see definition, page 131)*.

- An OMB report on the quality and completeness of agencies' acquisition information praised VA for making the most progress in implementing both the principles and practices of performance-based acquisition management. Of the 15 major agencies reviewed by OMB for the report, VA was the first to develop an agency-wide capital planning process that allows for investment tradeoffs among categories of assets, such as medical and non-medical equipment, infrastructure, and information technology.

- VA prepared and administered contracts for pharmaceuticals, medical equipment and supplies, and subsistence for federal agencies. These contracts are managed as Federal Supply Schedules, National Contracts, and competitive contracts for special purchases; all reflect savings from commercial prices. These savings allow VA to best utilize the resources available through our annual appropriations. Other federal agencies are also able to take advantage of these contracts. In addition to the savings from commercial prices, discounts are negotiated and competed on items VA purchases in high volumes. These contracts reflect the best values available to VA. The general public receives benefits through sound management practices of purchasing the best possible product at the lowest price.

ASSESSMENT OF DATA QUALITY

Improving data quality will remain a high priority for VA. Our stakeholders have spoken clearly about our data quality—it is not very good and they want it improved. We take their message seriously and will continue to work hard to turn this around.

During the past several years, we have made significant progress in improving the quality of our most important performance measures, the ones we consider our key measures. Our efforts have taken many forms: each Administration initiated specific improvement actions; the Office of the Inspector General (OIG) conducted a series of audits to determine the accuracy of our data; we established a Department-level Chief Actuary to assist program officials in assessing the validity and accuracy of performance data; and the Office of Management worked with program officials to prepare an assessment of each key measure.

As we identified specific deficiencies, we took corrective action. For example, when the current Under Secretary for Benefits assumed office, he put senior executives on notice that he would not tolerate manipulation of performance data. What appeared to be an immediate worsening of timeliness and accuracy of claims processing turned out to be a dramatic improvement in the reliability of the reported information. When the OIG found that timeliness of claims processing was misreported by a significant amount, the Compensation and Pension Program Director instituted a review process to identify potential problem cases and ensure accurate reporting.

During its audits, the OIG frequently found that underlying data were in error or that documentation was missing. In every case, responsible program officials have taken necessary steps to prevent recurrence of the problem. For example, the OIG determined that the number of unique patients treated in VA health care facilities was overstated because of input errors and incorrect social security numbers. The Under Secretary for Health initiated an acceptable implementation plan to establish system edits to prevent future errors.

For each of our programs, the Department collects a great deal of information from veterans and other users through customer satisfaction surveys. Generally, these surveys are conducted using appropriate survey research methods. We are continually improving our survey processes and standards. For example, NCA is developing a new instrument to conduct a nationwide mail-out survey to measure the public's perception of the appearance of national cemeteries and the quality of service provided. This new survey instrument will enhance the validity of NCA survey data.

Our data quality is not yet where we want it to be, but we are confident that it is much better than it was before we started this effort over 7 years ago with enactment of the Government Performance and Results Act. The improvement process is a long-term project that VA will continue to address. The following discussion describes in specific detail the actions of each VA Administration to improve its data quality.

Veterans Health Administration

The principles of data reliability, accuracy, and consistency are recognized as integral to VHA's efforts to provide excellence in health care. In 1998, the Under Secretary for Health convened a Data Quality Summit and directed the Chief Information Officer to lead VHA's effort to address data quality issues. Outcomes and ongoing initiatives of the Summit workgroups and the Office of Information (OI) staff are described on the following page.

Major reporting entities within VHA formed the Data Consortium in FY 2000 to address organizational issues and basic data quality assumptions. The Data Consortium works collaboratively to improve information reliability and customer access for the purposes of quality measurement, planning, policy analyses, and financial management. The ongoing initiatives and strategies focus on data quality infrastructure, training and education, personnel, policy guidance, and data systems.

In July 2000, VHA hired a full-time Data Quality Coordinator. The Coordinator, along with data quality workgroups, provides guidance on data quality policies and practices.

Initiatives that support the integrity and data quality of coding currently in progress include:

- Development of strategies and standard approaches to enable field staff to understand the data content and meaning of specific data elements in VHA databases.
- Development of coding resources for the field, which includes the purchase of knowledge-based files/edits from Ingenix for use within the Veterans Health Information Systems and Technology Architecture (***V***ist***A***). ***V***ist***A*** supports the use of national code sets, Current Procedural Terminology, 4th Edition (CPT-4), and Health Care Financing Procedural Coding System (HCPCS) Level II. The availability of these code sets will enable VHA to describe accurately the outpatient and other professional services provided to our patients.
- Complete revision of ***V***ist***A*** software to accommodate the use of national code set modifiers, giving providers the ability to document care more completely and accurately.

To support the need for guidance in medical coding, VHA established the Health Information Management (HIM) Coding Council. Comprised of a panel of credentialed expert coders, with support from VHA HIM Headquarters' staff, the Council researches and responds within 24 hours to coding questions, citing official references. The Council also updates the national Coding Handbook, which provides expert guidance to the field facilities. This handbook standardizes guidelines for complete and accurate coding within VHA codes.

VHA's OI sponsors two newsletters: *Close Encounters*, which provides expert guidance to the field facilities on encounter forms, insurance billing, coding, and Medicare compliance; and *Data Quality Highlights*, which provides data quality facts and tips.

Training and education opportunities are provided to support data quality initiatives and compliance, such as the airing of national satellite broadcasts on data quality issues. Currently, the satellite broadcasts are scheduled through September 2001. Future topics include external impacts to data reliability, Health Care Financing Administration guidance, national standards issuance, and internal data requirements of the Veterans Equitable Resource Allocation funding model.

In an effort to improve the reliability of the Decision Support System data, VHA issued a directive on standardization, which was sent to all VA medical facilities. The directive provides guidance for the basic model for standardization that facilities will use for managerial accounting and clinical information to assess the delivery of medical care.

In addition to guidance, training, and education, OI is involved in several key projects targeted to improve data quality and system reliance. These

include the Meta Data Registry (MDR) and the Master Patient Index (MPI).

MDR is in progress with data from 49 VHA databases. This registry contains definitions, business rules, names of database stewards, and descriptive information about the data elements contained in ***V***ist***A*** databases. Scheduled for release in FY 2001, MDR will provide a single source of data element description to users and technical staff. It will also help eliminate data redundancies and improve standardization.

VHA will complete the implementation of a national MPI by March 2001. The MPI provides the access point mechanism for linking patients' information from multiple clinical, administrative, and financial records across VHA health care facilities to enable an enterprise-wide view of individual and aggregate patient information. Responsibility for MPI data integrity exists on both corporate and facility levels. This effort will be accomplished through the use of software reporting tools and interaction between sites of care and external authoritative sources. The MPI provides the ability to view clinical data from various VA medical facilities via the remote data view functionality within the Computerized Patient Record System.

Veterans Benefits Administration

The Under Secretary for Benefits has consistently focused VBA's efforts toward improving its data systems and the integrity of the data contained within these systems. This focus was succinctly stated in the document describing VBA's strategic direction, *Roadmap for Excellence:* "VBA's data systems will be reliable, timely, accurate, integrated, honest, and flexible." In 1998, the Data Management Office (DMO) was established to ensure that VBA incorporates this theme into its business lines and field operations and to focus on data integrity and quality matters.

The DMO reflects VBA's efforts to facilitate the availability and use of quality information to support current and future business needs and improved service delivery. The DMO has established organizational components to focus specifically on VBA business line information and veterans' information, as well as improving delivery of all types of information through better information systems. Since its establishment, the DMO has worked with the VBA organizational elements to identify strategies and initiatives to address the collection, processing, and storage of quality data. Several of these initiatives are described below:

- A Data Integrity Task Force was formed to help assess the quality of existing key business indicators and to identify any missing information relevant to the management of VBA's core business processes. In February 1999, the group presented its findings and recommendations. As a result, the Under Secretary directed the program services and the Office of Field Operations to develop action plans. The DMO is responsible for monitoring progress until all milestones have been completed. The status of each recommendation is documented in the Data Integrity Matrix, accessible to employees through the VBA Intranet.
- In an effort to create a single, consistent, accurate, and accessible source of information about veterans, VBA is developing the Veterans Information Solution (VIS). The current prototype displays veteran data customized to meet the information needs of multiple benefit programs, or business lines. This Web-based solution, once fully developed, will be accessible to all VA organizations. The prototype display screens presently include veteran profile information, military history, compensation

and pension utilization, and hospital enrollment information.

- To assist in addressing VBA's known data integrity issues, VBA has begun constructing an enterprise Data Warehouse. This initiative focuses on the areas of workload management, performance measurement, cost analyses, business line/program area management analyses, and customer (veteran) profiling.
- The Data Warehouse and its various modules have already improved the delivery of vital business information to VBA business analysts, managers, and executives. Key reports and analyses, previously unavailable, have been automated and are readily accessible to end-users. Procedures that once involved weeks of effort to collect and consolidate data can now be completed in a timely and inexpensive manner through on-line analytical and ad-hoc capabilities over the VBA Intranet.
- VBA initiated a comprehensive inventory process to restore confidence in the integrity of reports and data. During Phase I of implementation, report sponsors will complete report templates to ensure the reports add value and are necessary. The template provides information about the report, such as description, purpose, decisions supported, data vulnerability issues, procedural reference materials, external and internal users, report frequency, reporting system, source system, and report identification numbers. This review exercise will also help users identify redundant and obsolete reports, and adhere to VA's reports management procedures. In addition, a significant portion of this effort includes the construction of a fully automated on-line system that will be accessible via the VBA Intranet.
- Several initiatives focus on the validation and verification of social security numbers (SSNs) used in VBA systems and benefits delivery. Currently, efforts are underway to identify and reduce the number of duplicate SSNs in VBA's Corporate Database. When VBA resolves all of the duplicates for each category, program logic will be installed to eliminate future duplication. In addition, a memorandum of agreement permits VBA to use a read-only, case-specific, real-time query to read limited data elements contained in certain Social Security Administration Privacy Act Systems of Records. VBA will use the read-only information to verify SSNs and income information submitted by beneficiaries.
- To ensure proper management and oversight of information security and infrastructure protection, VBA created the Security Infrastructure Protection Office. A contractor is assessing the current security risks, threats, policies, and program goals. In addition, a master security plan is being developed.
- The Veterans Service Network (VETSNET) Phase I implementation project will replace the existing compensation and pension payment system. Currently, efforts are underway to replace the finance and accounting code in the Benefits Delivery Network with a standardized, on-line accounting and payment system that will interface with VA's Financial Management System.

VBA will continue working toward improving the delivery of all types of information through better information systems and data quality. Recent efforts to form strategic alliances and partnerships with external organizations have resulted in access to more timely and accurate data.

National Cemetery Administration

NCA workload data are collected monthly through field station input to the Management and Decision Support System, the Burial Operations Support System (BOSS), and the Automated Monument Application System-Redesign (AMAS-R). After reviewing the data for general conformance with previous report periods, headquarters staff validates any irregularities through contact with the reporting station.

NCA began implementing a reorganization from three geographic National Cemetery Area Offices to five Memorial Service Networks (MSNs). The new structure will strengthen oversight and accountability of cemetery operations, provide a more balanced workload among the MSNs, and centralize selected administrative activities.

During FY 2000, NCA conducted a project to review and improve the codes used for ordering replacement headstones or markers. When headstones or markers are lost or damaged, it is important to determine both the cause and the party responsible for the expense of a replacement. NCA developed codes and published a users' guide with definitions for the codes, including the replacement reasons. Use of these new codes will enhance the BOSS and AMAS-R databases so that they produce reliable and accurate data on replacement actions, and provide management with an effective tool for improving the overall process.

Efforts continue in expanding the use of information technology to collect performance data for recently developed performance measures. The NCA Data Validation Team is working to ensure that performance data collected and reported for timeliness of scheduling interments and marking graves at national cemeteries are accurate, valid, and verifiable. The team's major tasks include defining performance measurement terms to ensure standard interpretation and application throughout NCA; identifying training needs to ensure accuracy of data and consistent data entry processes; and recommending necessary changes to BOSS to ensure accurate data entry. NCA developed and implemented additional computer edits as a result of the team's recommendations.

Role of the Actuary

During FY 2000, the Chief Actuary within the Office of Policy and Planning assisted the staff from the Office of Management to initiate a Department-wide data validation and verification process, with the Administrations acting as full partners. Each Administration prepared a "Validation of Data Used in Performance Measures" worksheet for each of its key performance measures. While these worksheets have not been finalized, they provide a great deal of information about our measures and data, including possible areas for improvement. The key elements are:

- Qualitative definition
- Functional definition describing sources of data and frequency of collection
- Formula for the performance measure
- Baseline data
- Data system information
- Methods used to determine accuracy, validity, and reliability of data
- Improvement plan
- Responsible official

For the most part, responsible officials recognize our data have significant quality shortcomings that they are working to eliminate. A review of the initial worksheets indicates that efforts have been, and are continuing to be, made to improve the data underlying most of the key performance measures.

Office of Inspector General (OIG) Performance Audits

The OIG continued its assessment to validate the accuracy and reliability of VA's key performance measures in accordance with the Government Performance and Results Act. During FY 2000, the OIG assessed the accuracy of data used to calculate the Foreclosure Avoidance Through Servicing (FATS) ratio, and completed an initial audit of the Chronic Disease Care Index (CDCI) and Prevention Index (PI).

To assess the accuracy of VA's computation of the FATS ratio, the OIG attempted to verify each of the five components: refundings, voluntary conveyances, compromises, foreclosures, and successful interventions. Records in four of the five components were categorized correctly, but records categorized as successful interventions could not be verified because supporting documentation was not available. Evidence of defaults, intervention efforts, and successes was not generally retained in loan folders, but was recorded in electronic notes in the Liquidation and Claims System. Unfortunately, the system did not retain the notes. Therefore, with neither supporting documentation in the loan folders nor electronic notes, the OIG could not determine whether the successful interventions recorded actually occurred, and could not attest to the accuracy of the FATS ratio reported. During the audit, VA activated a new computer system for its loan servicing activities that does retain the electronic notes to document successful interventions. The OIG considered the issue resolved and offered no recommendations in the audit report.

The OIG assessed the validity of VHA's CDCI and PI performance measures to determine the accuracy of the data reported in VA's 1999 Annual Accountability Report. Audit results demonstrated that the procedures used by VHA to compute the CDCI and PI indices were adequate, but review of the source documents to determine the validity of data used in computing the CDCI and PI was not included. As a result, the OIG will re-evaluate these measures during FY 2001. OIG audit results also showed inconsistencies in VHA's reported periods for both measures. VHA agreed to report on a 12-month period instead of an 11-month period.

To date, the OIG has conducted eight audits encompassing six key measures, with several others on the agenda for the near-term. These include the vocational rehabilitation and employment rehabilitation rate; percent of patients who rate VA health care service as "very good" or "excellent"; national accuracy rate for core rating work; appeals resolution time; and percent of compensation and pension claimants who are satisfied with the handling of their claims.

MAJOR MANAGEMENT CHALLENGES

Management Challenges Identified by VA's Office of Inspector General

The following is an update prepared by VA's Office of Inspector General (OIG) summarizing the ten most serious management problems facing VA, and assessing the Department's progress in addressing these problem areas. Although VA does not have specific quantifiable goals and performance measures in place to help resolve these problem areas, the Department does have corrective action plans in various stages of implementation. Progress will be monitored until each management challenge has been successfully addressed. Department officials have stated their agreement with the conditions the OIG reported. (On pages 89 to 101, the word "we" refers to the OIG.)

1. Health Care Quality Management (QM) and Patient Safety

Of the many challenges facing VA, one of the most serious, and potentially volatile, is the need to maintain a highly effective health care QM program. The issues that punctuate the importance of this challenge are VA's need to ensure the high quality of veterans' health care and patient safety, and to demonstrate to Department overseers that VA health care programs are effective.

One example of a particularly difficult and complex undertaking is the need to provide safe, high quality, patient care in an environment that is rapidly evolving from the traditional specialty-based inpatient care to the ambulatory care/ outpatient primary care setting. The more rapid pace of ambulatory care presents increased opportunities for clinicians to make errors in treating patients. The health care industry, including VHA, has not yet devised effective ways to quickly or accurately identify and correct such treatment errors. Thus, while patients are less vulnerable to hospital-acquired pathogens when they receive care in the ambulatory setting, they are increasingly vulnerable to incurring other medical treatment errors and threats to their safety.

Part of the problem is VHA management's inability to provide strong and consistent clinical quality management leadership at all levels of the organization. The devolution of management authority to the Veterans Integrated Service Networks (VISNs) and individual VA medical centers (VAMCs), coupled with resource reductions associated with the Veterans Equitable Resource Allocation (VERA) model, have led to greatly reduced numbers of clinical managers who are available to identify, evaluate, and facilitate the correction or elimination of clinical quality and patient safety issues. To complicate this problem, VHA managers have not devised any coherent functional descriptions and have not prescribed any consistent staffing patterns for medical center QM departments throughout the country. Thus, no two VAMC QM departments focus on the same issues in the same way. These functional and resource disparities severely impede the Department's ability to identify or measure the extent of possibly widespread unsatisfactory clinical care practices and to devise procedures to correct or eliminate such problems.

A fully functional QM program should be able to monitor patients' care to ensure their safety and to safeguard, to the extent possible, against the occurrence of inadvertent adverse events. This risk management function is intended to assure patients that they will be cared for in a manner that promotes their maximum safety while providing them with optimal medical treatment. Although VHA managers are vigorously addressing the Department's risk management and

patient safety procedures in an effort to strengthen patients' confidence while they are under VA care, patients continue to be injured in the course of their treatment. In particular, mentally or cognitively impaired patients continue to disappear from VAMCs, and several of these patients have died before searchers could locate them. Six VISNs have developed various patient safety initiatives to address this issue, but resolution of the problem does not appear to be imminent.

Current Status: This year, VHA responded to many of our recommendations to improve patient safety and QM activities. Although VHA has generally been responsive to our recommendations, some of the recommendations have gone unimplemented. We continue to work with VHA toward resolving the issues. To illustrate, in February 1998, we recommended that VHA determine whether its medical centers are effectively complying with policy and using the National Practitioners Data Bank during their credentialing and privileging reviews. VHA concurred with the recommendation and informed us that their Office of the Medical Inspector (OMI) would complete an internal review; however, this recommendation remains unimplemented. OMI recently received additional resources to complete this and other tasks, and we will continue to track this until all issues are resolved.

Conversely, VHA's establishment of the National Center for Patient Safety (NCPS) and national training on the principles of root-cause analysis represent an aggressive response to recommendations we made in past OIG Office of Healthcare Inspections reports. The focus that NCPS has placed on the issue of patient safety and on resolving long-time patient vulnerabilities will go a long way toward making sure that VA patients receive proper care in a safer environment.

In our report on VHA's policies and procedures for managing disappearing patients and associated search procedures, we made seven recommendations to improve VHA missing patient policies and controls. The Under Secretary for Health has concurred with our recommendations and provided responsive implementation plans.

We continue to review certain aspects of QM activities, specifically patient care and safety issues in VHA's community-based outpatient clinics (CBOCs), as part of our Combined Assessment Program reviews. We focus on making sure that medical center QM managers are monitoring CBOC patient care and safety data, and that corrective actions and follow-up activities are effective. These efforts fulfill our oversight responsibility to ensure that patients receive the same quality care at the CBOCs that they receive at the medical center-based clinics.

2. Resource Allocation

Resource allocation continues to be a major public policy issue. VHA management is addressing staffing and other resource allocation disparities as part of various initiatives to restructure the VA health care system. Some of the most significant initiatives include:

Resource Allocation Model

VHA hopes to correct resource and infrastructure imbalances by changing the method used to fund VAMCs. This methodology, called the Veterans Equitable Resource Allocation (VERA) model, was phased-in during fiscal years 1997-1999. VERA allocates funding to the VISN level based on workload (patients treated), rather than providing incremental increases based on prior year allocations. Such allocations have resulted in reduced funding to some VISNs that have seen significant reductions in workload.

Clinical Staffing Reductions and Adjustments

VHA has given VISN directors new authority to reduce physician levels in overstaffed specialties. Some networks have begun trimming and shifting staffing as part of consolidations, attrition, and

reductions-in-force. VHA is also reducing and reallocating its 1,000 resident training positions. We will continue to monitor VHA's progress in improving the balance in the distribution of staffing and other resources.

Improved Management Information/ Performance Measurement

In FY 1998, VHA began implementing a new cost-based data system to provide more useful performance measurement information on the resources (inputs) and workload produced (outputs) for clinical and administrative production units. Development of cost and performance measures for clinical and administrative activities will enable managers to evaluate their productivity and efficiency.

Current Status: In FY 2001, we will begin an audit to determine whether VERA equitably distributes operating budgets, furnishes sufficient funding to meet medical care needs, provides all veterans equal access to care, and identifies opportunities for VHA to enhance its resource allocation methodology.

Our review of the Decision Support System (DSS) standardization found that the potential usefulness of DSS and its data was compromised because some medical center staff had diverged from the system's basic structural standard. Where detected, such divergence had prevented medical center data from being accurately aggregated with data from facilities adhering to the standard. We were also concerned that undetected data divergences may have resulted in inaccurate data being aggregated into roll-up reports. Additionally, facilities diverging from the DSS structural standard could not perform a variety of analyses that adhering to the structural standard provides.

VHA's installation of DSS was intended to provide the types of management information that would have met the intent of the audit recommendations. Control of DSS standardization has been assigned to VHA's DSS Steering Committee and its Standardization Subcommittee. As of November 2000, implementation of the OIG recommendations regarding DSS standardization was still underway.

The OIG has an audit in progress to evaluate the process used by the Department to fill prescriptions written by private physicians and to quantify the number of priority veterans that use the Florida/Puerto Rico Veterans Integrated Network health care facilities for filling prescriptions. This work is expected to address the adequacy and availability of health care services in one VISN, result in recommendations that make additional resources available for the benefit of all enrolled veterans, and enhance the delivery of prescription services.

3. Claims Processing, Appeals Processing, and Timeliness and Quality of Compensation and Pension (C&P) Medical Examinations

VBA needs to continue improving the timeliness of benefits claims processing. Numerous studies, reviews, and audits have addressed timeliness and quality issues with VBA's C&P claims processing system, used for the annual administration of almost $23 billion in compensation and pension payments to veterans.

Claims Processing

For the past quarter century, VBA has struggled with timeliness of claims processing. Although some improvement has occurred in recent years, VBA still has a high workload backlog and takes an unacceptably long time to process claims. The inventory of pending compensation claims for FY 2000 averaged about 360,000; it took an average of 185 days for claims to be processed.

VBA has sought to address claims processing timeliness through improved training, organizational changes, and modernization efforts. Since 1996, the Department has completed two major reviews to devise ways to improve claims processing and restructure field operations. This effort was criticized by veterans service organizations, which were concerned that geographic reorganizations and consolidations would make it more difficult to provide veterans with effective representation.

Current Status: Because VA continued to fall short of achieving its claims processing goals, the Department is taking action to improve the accuracy of reported timeliness of claims processing. An OIG audit found that actual timeliness was well above reported timeliness. The Under Secretary for Benefits is taking aggressive action to assure that performance data covering benefits programs are accurately reported by all VA regional offices (VAROs).

Our 1997 "Summary Report on VA Claims Processing Issues" identified opportunities for improvement in the timeliness and quality of claims processing and in veterans' overall satisfaction with VA claims services. VBA is currently putting into effect its Business Processing Reengineering rules and the pension simplification team report that was highlighted in our audit report. The audit identified 18 regulatory changes considered necessary for full implementation of the Business Processing Reengineering. In response to the report recommendation, VBA has also developed an automated checklist to document evidence requests concerning each claim. The automated checklist is being used in the case management pilots at six VAROs. Unfortunately, VBA has not been able to take advantage of all these opportunities because of the long phase-in schedule projected for completing key improvements in processing claims. However, VA is firmly committed to implementing the remaining Business Processing Reengineering changes that have been evaluated and accepted.

Appeals Processing

Veterans have historically had to wait a long time to receive a decision on appeals of benefit claims. Large claims backlogs have continued to impact the Department's ability to provide veterans with timely service; in some cases, veterans have had to wait years for decisions on their claims. Increased appeals processing time has also resulted from the 1988 Judicial Review Act that established the U.S. Court of Appeals for Veterans Claims and expanded VA due process requirements. During FY 2000, the Board of Veterans' Appeals completed 34,028 appeal decisions.

Current Status: No Change.

Timeliness and Quality of C&P Medical Examinations

Disability benefit payments are based, in part, on interpretations of medical evidence by VBA disability rating specialists. That evidence is developed by VHA physicians, VHA-supervised physicians, or private contractors through examination of the claimant. Before receiving examination results, VBA cannot complete payment on claims. When a medical examination is not performed correctly, the veteran's claim is delayed until another examination is completed. This usually results in significant claim processing delays.

Our 1997 report, "Review of C&P Medical Examination Services," followed up on our 1994 recommendations to improve the timeliness of C&P examination services. We found that management had made some changes, but they had resulted in little improvement. We recommended that the Under Secretaries for Benefits and Health improve the quality and timeliness of C&P examinations by:

(i) establishing performance measures for their field facilities with the objective of reducing the number of incomplete examinations; (ii) requiring VBA area directors and VHA VISN directors to monitor progress in reducing the percentage of incomplete examinations; (iii) requiring VBA and VHA directors to work together to reduce the number of incomplete examinations.

Current Status: VHA and VBA have implemented our recommendations. In addition, VBA is collecting data in conjunction with a self-initiated contract disability examination pilot project.

4. Inappropriate Benefit Payments

VBA needs to develop and implement an effective method to identify inappropriate benefit payments. Recent OIG audits found that the appropriateness of C&P payments has not been adequately addressed.

Dual Compensation of VA Beneficiaries

A review of VBA procedures, in place to ensure disability compensation benefits paid to active military reservists were properly offset from their training and drill pay, determined the need for improvements to prevent dual compensation. We found that 90 percent of the potential dual compensation cases reviewed had not had their VA disability compensation offset from their military reserve pay. We estimated that dual compensation payments of $21 million were made between FY 1993 and FY 1995. If this condition is not corrected, estimated annual dual compensation payments of $8 million will continue. Dual compensation payments have occurred since at least FY 1993 because procedures established between VA and DoD were not effective, or were not fully implemented.

Current Status: VBA implemented two recommendations, but has not completed implementing the recommendation to follow-up on the dual compensation cases (fiscal years 1993 through 1996) to ensure either VBA disability payments are offset or DoD is informed of the need to offset reservist pay. VBA has also submitted a legislative proposal to allow the concurrent payment of reservists' drill pay and VA disability compensation for reservists with less than 100 days of drill pay in 1 year.

Payment to Incarcerated Veterans

Our review of benefit payments to incarcerated veterans found that VBA officials did not implement a systematic approach to identify incarcerated veterans and dependents and adjust their benefits, as required by Public Law 96-385. A prior audit conducted in 1986 found that controls were not in place to cut off benefits to veterans when they were incarcerated. In that audit, we recommended that a systematic approach be applied, but actions were not taken to implement those recommendations.

According to the Department of Justice, Bureau of Justice Statistics, federal and state prison populations more than doubled between 1986 and 1995, from 522,100 to 1,085,400. In addition, about 4.6 million individuals have been incarcerated and about 4.1 million inmates have been released from federal and state prisons between 1986 and 1995.

The current evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in 6 states. Results showed that VA ROs had not adjusted benefits in over 72 percent of the cases requiring adjustment, resulting in overpayments totaling $2 million. Projecting the sample results nationwide, we estimate that about 13,700 incarcerated veterans have been, or will be, overpaid about $100 million. If VBA does not establish a systematic method to identify these prisoners, additional overpayments totaling about $70 million will be made over the next 4 years to newly incarcerated veterans and dependents.

Current Status: Our recommendation that VBA enter into a matching agreement with the Social Security Administration (SSA) for prison records was implemented. However, our recommendations that VBA (i) identify and adjust the benefits of incarcerated veterans and dependents, (ii) establish and collect overpayments for released veterans and dependents that did not have their benefits adjusted, and (iii) establish a method to ensure that VAROs process identified cases timely and properly adjust benefits, are all unimplemented.

Payment to Deceased Beneficiaries

A February 1998 audit of VBA's current procedures to terminate beneficiary C&P benefits, based on information about veterans' deaths received from SSA, found that VBA needs to develop and implement a more efficient method to identify deceased beneficiaries and to terminate their C&P benefits. Based on information about veterans' deaths received from SSA, audit results showed that only 156 of a sample of 281 veterans reported by SSA as deceased were, in fact, deceased. C&P benefit awards for 42 of 156 deceased claimants were (i) still running, (ii) had incorrect termination dates, or (iii) had incorrect suspense dates. Overpayments in these 42 cases totaled $340,000. We estimate approximately $4 million in erroneous payments were made throughout VBA.

Current Status: VBA has implemented three recommendations, but has not completed implementation of the recommendation to correct errors in the electronic beneficiary database and to link other electronic beneficiary databases, where necessary.

Benefit Overpayments Due to Unreported Beneficiary Income

VBA's Income Verification Match (IVM) is a significant internal control and financial risk area because it did not produce the required benefit payment adjustments and identification of program fraud. Our audit found that opportunities exist for VBA to increase significantly the number of potential overpayments recovered through greater efficiency and effectiveness; ensure better program integrity and identification of program fraud; and improve delivery of services to beneficiaries.

To resolve these and other problems, VBA needs to address the following key findings: (i) increase the oversight and tracking of the IVM process; (ii) make the claims examina-tion process more effective; (iii) establish IVM-related debts; (iv) do not grant waivers of IVM-related debts when fraud is identified; (vi) increase recoveries by reducing the number of unmatched records; (vii) increase the number of referrals to the OIG for fraud. In conclusion, we found that the IVM process represents a potential material weakness area that should be monitored by the Department.

The potential monetary impact of these findings to the Department was $806 million. Of this amount, we estimate potential overpayments of $773 million associated with benefit claims that contained fraud indicators, such as fictitious social security numbers or some other inaccurate key data elements. The remaining $33 million is related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. We also estimate that $300 million in beneficiary overpayments involving potential fraud had not been referred to the OIG for investigation.

Current Status: VBA agreed to implement the following recommendations: (i) increase program oversight of the results of IVM actions completed; (ii) eliminate the review of selected pension cases because they result in no benefit overpayment recoveries; (iii) eliminate review of IVM cases with income discrepancy amounts of less than $500 because they result in little or no benefit overpayment recoveries; (iv) complete necessary

data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA; (v) ensure that accounts receivable are established to recover IVM-related debts from beneficiaries; (vi) ensure that waivers of beneficiary IVM-related debts are not granted when fraud is identified; (vii) refer potential fraud cases to the OIG based on the established referral process; (viii) report the IVM for consideration as an Internal High Priority Area that needs monitoring.

Benefit Overpayment Risks Due to Internal Control Weaknesses

In the past year, the Under Secretary for Benefits asked for our assistance to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. The request followed the discovery that three VBA employees had embezzled nearly $1.3 million by exploiting internal control weakness in the C&P benefit program. Our vulnerability assessment identified 18 categories of vulnerability involving numerous technical, procedural, and policy issues. The Under Secretary agreed to initiate actions to address these weaknesses.

To test the existence of the control weaknesses identified in the vulnerability assessment, we conducted an audit at the VARO in St. Petersburg, FL. The St. Petersburg office was selected for review because it was one of the largest regional offices, accounting for 6 percent of C&P workload, and it was the location where 2 of the 3 known frauds took place. The audit confirmed that 16 of 18 categories of vulnerability reported in our vulnerability assessment were present at the regional office.

Current Status: VBA agreed to address the internal control weaknesses identified in the vulnerability assessment and the 15 recommendations included in the St. Petersburg regional office audit. Implementation action on these recommendations is currently in process.

5. Government Performance and Results Act (GPRA)-Data Validity

GPRA requires federal agencies to set goals, measure performance against those goals, and report on their accomplishments. In accordance with the law, VA has set goals for each of its major business lines, identified related performance measures, and established procedures for compiling and reporting results.

Prior OIG audits have found erroneous data in many VA financial and management systems — medical care ($21 billion annually), compensation ($19.7 billion annually), pension ($3.1 billion annually), and education ($1.5 billion annually). Reliance on inaccurate data results in faulty budget and management decisions and adversely impacts program administration.

At the request of the Assistant Secretary for Policy and Planning, we initiated a series of audits to assess the quality of data used to compute the Department's key performance measures. We have completed audits of five performance measures[1]:

- average days to complete original disability compensation claims;
- average days to complete original disability pension claims;
- average days to complete reopened compensation claims;
- percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence;
- foreclosure avoidance through servicing (FATS) ratio.

[1] The three claims processing timeliness measures we audited have now been incorporated into a new key measure called average days to process rating-related actions.

After we identified deficiencies in each of the measures, VBA and VHA began taking action to correct the deficiencies.

VA has made progress in implementing GPRA, but additional improvement is needed to ensure stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation. However, we continue to find significant problems with data input, and Department-wide weaknesses in our information system security limit our confidence in the quality of data output.

Current Status: Audits of two performance measures, the Prevention Index and the Chronic Disease Care Index, are in process.

6. Security of Systems and Data

VA needs to improve physical and electronic security over its information technology (IT) resources. The Department requires automated data processing (ADP) to manage transactions valued at over $28 billion annually and maintain over 40 million sensitive veteran records. Security risk increases as we share data with other departments and organizations. Multiple architectures and complex mission-specific systems throughout VA increase the risk of inappropriate access and misuse of sensitive data.

Historically, sufficient security has not been provided to safeguard VA IT resources. For example:

- risk assessments were not developed and maintained;
- center-wide and certain system security plans were not established;
- systems were not certified;
- numerous physical and electronic security controls needed to be implemented.

Current Status: Ongoing assessment of ADP controls is taking place. We are continuing our assessment of ADP controls as part of our audit of VA's FY 2000 Consolidated Financial Statements (CFS). In addition, we have initiated a nationwide audit of VA's Information Security Program to assess VA's efforts to address information security control weaknesses and establish a comprehensive integrated security management program. This audit will be completed, as required by the Computer Security Act and the new Government Computer Security Reform Act. The actions necessary to reduce risk to an acceptable level require a long-term, sustained effort. To address the VA-wide ADP security and control issues, VA established a centrally managed security group in FY 1999 and an information security working group, in which we participate. In October 2000, the Department issued a revised Information Security Management Plan that identified a number of security enhancement actions that are being accelerated to improve enterprise-wide information security. VA's Information Security Budget Program identifies 10 areas that VA plans to address during fiscal years 2000-2005, at an estimated cost of over $114 million.

In our audit of VA's FY 1998 CFS, we reported VA-wide information system security control as a material internal control weakness. The General Accounting Office (GAO) reached similar conclusions. Audit tests associated with our 1999 CFS audit demonstrated that widespread system security control weaknesses continue to exist in VA. As part of this audit, we contracted for "penetration tests" of VBA systems to assess the effectiveness of information system general controls. The review concluded that significant control weaknesses made VBA systems vulnerable to unauthorized access and misuse.

Additional penetration testing of VA systems will be completed as part of our nationwide audit of VA's Information Security Program. Our audit of C&P internal controls at the VARO in St. Petersburg, FL, also identified information security control weaknesses. In addition, we are evaluating the adequacy of Information Security Program controls as part of our cyclic Combined Assessment Program reviews of VA facilities. These reviews continue to identify security control weaknesses.

7. VA Consolidated Financial Statements

Some VA assets may not be adequately protected and resources may not be properly controlled. We issued an unqualified opinion on the Department's Consolidated Financial Statements for FY 1999, an improvement from FY 1998, when our audit opinion was qualified concerning Housing Credit Assistance (HCA) program accounts. While the Department achieved an unqualified audit opinion on the FY 1999 financial statements, three material internal control weaknesses remained, and VA remained noncompliant with the Federal Financial Management Improvement Act (FFMIA) in three areas.

The three material internal control weaknesses were: (i) VA-wide information system security controls; (ii) HCA program accounting; (iii)fund balance with Treasury reconciliations. The Department had made significant improvement, but needed to continue efforts to correct the remaining open information security and HCA recommendations and implement the new recommendations concerning fund balance with Treasury reconciliations. These internal control weaknesses expose VA to significant risks.

Our report on Compliance with Laws and Regulations stated noncompliance with FFMIA requirements concerning HCA program financial management information systems, information system security, and cost accounting standards. We also reported, as we had in previous years, noncompliance with one law that, while not material to the financial statements, warrants disclosure: the requirement for charging interest and administrative costs on compensation and pension accounts receivable.

Current Status: The Department has provided corrective action plans for the ADP security and control issues, with complete corrective action not planned until FY 2002. The audit of VA's FY 2000 Consolidated Financial Statements includes assessment of completed and in-process corrective actions by the Department on the other issues reported: Housing Credit Assistance and Treasury reconciliations.

8. Debt Management

As of September 1999, debt owed to VA totaled over $3.2 billion. This debt resulted from home loan guaranties, direct home loans, medical care cost fund receivables, compensation and pension overpayments, and educational benefits overpayments.

Current Status: The OIG has issued 15 reports over the last 6 years to address the Department's debt management activities. The recurring themes are that the Department needs to be more aggressive in collecting debts, improve debt avoidance practices, and streamline credit management and debt establishment procedures. Through improved collection practices, the Department can increase receipts from delinquent debt by tens of millions of dollars each year.

Over the past 30 months, audit coverage of VA's debt management program has focused on billing and collection of medical care copayments owed by veterans, or their insurance companies, for medical care of non-service-connected conditions, and overpayments

of compensation and pension benefits.

Our review of debt prevention, debt consolidation, and debt collection issues identified opportunities to avoid overpayments, establish debt, or improve collection of $260 million:

- establishment of $30 million in debts;
- prevention of new debts caused by benefit overpayments of about $81 million annually;
- need to enhance debt collection by about $130 million;
- need to streamline operations and achieve annual cost efficiencies of about $19 million.

In addition to realizing significant monetary benefits, these audits identified opportunities to enhance service to veterans by discovering benefit underpayments of about $14 million, and preventing the inappropriate billing or income verification of about 14,000 veterans.

We have issued several reports addressing income verification match issues. In our "Evaluation of VHA's Income Verification Match Program," a follow-up to implementation of our recommendations from prior income verification match audits, we reported that prior recommendations had not been fully implemented and that opportunities existed for VHA to conduct the program in a more efficient and cost-effective manner. We recommended that the Under Secretary for Health improve the income verification match program activities by: (i) requiring VHA's Chief Network Officer to ensure that VISN directors establish performance standards and quality monitors, and strengthen procedures and controls for means testing activities and billing and collection of Health Eligibility Center (HEC) referrals; (ii) requiring VHA's Chief Information Officer to develop performance measures and monitor periodic performance reports; (iii) expediting action to centralize means testing activities at the HEC. Our recommendations have not been implemented.

At the request of the Under Secretary for Health, we are auditing VHA's means testing and income verification program to: (i) ensure the HEC has purged all income information received from the Internal Revenue Service from electronic and hard copy records; (ii) review the steps taken by local VHA facility management to ensure compliance with legal requirements associated with controlling means testing data since January 1999, and whether additional measures are warranted; (iii) review the financial and administrative impact on VHA if an extended period of time elapses without income verification.

We have also issued several reports addressing ways to improve VHA's Medical Care Cost Fund program. VHA has reported implementation of all of our recommendations; however, we have not completed follow-up work to document the improvements.

We are currently auditing VA's Debt Management Center (DMC) to determine whether the DMC is: (i) pursuing all reasonable debt collection avenues to maximize collections; (ii) collecting from Federal employee debtors by establishing Federal salary deductions; (iii) using standards and criteria appropri-ately to write-off, waive, or suspend debts; (iv) operating according to the provisions of the Debt Collection Improvement Act of 1996.

9. Workers Compensation Costs

The 1916 Federal Employees' Compensation Act (FECA) authorizes benefits for disability or death resulting from an injury sustained in the performance of duty. The Department of Labor (DOL) administers the FECA program for all Federal agencies. The benefit payments have two components: salary payments, and payments for

medical treatment for the specific disability. Medical treatment includes all necessary care, including hospitalization. DOL indicates that payments made to injured Federal workers is about $1.8 billion annually for all Federal agencies, of which approximately $140 million goes to injured VA workers. These benefit payments are at risk to fraud, waste, and abuse.

After auditing VA's FECA program in 1998, we concluded the program was not effectively managed and that by returning current claimants to work who are no longer disabled, VA could reduce future payments by $247 million. (DOL calculates savings based on the age of the recipient at the time of removal up to age 70, the life expectancy of these individuals.) From our random sample, we also identified 26 potential fraud cases that were referred to our Office of Investigations. After reviewing the sample results, we estimated that over 500 fraudulent cases were being paid about $9 million annually. Similar conditions were reported in a 1993 OIG report.

In 1999, we completed a follow-on audit of high-risk areas in VHA's Workers Compensation Program (WCP). The audit found that VHA was vulnerable to abuse, fraud, and unnecessary costs associated with WCP claims in three high-risk areas reviewed: dual benefits, non-VHA employees, and deceased WCP claimants. We estimated that VHA has incurred, or will incur, about $11 million in unnecessary costs associated with WCP claims in these high-risk areas.

Current Status: The OIG developed a protocol package and handbook for enhanced VA oversight and case management of the WCP. Both documents discussed key elements of case management and fraud detection. The protocol package was customized for individual VISNs and included a list of specific cases for review.

The OIG continues to work with the Department to reduce WCP costs through individual VISN case management reviews, staff training, and aggressive investigation of identified fraudulent cases. Individual cases of suspected fraud have been referred to our Office of Investigations for review. After investigation and successful prosecution, judicial actions returned to VA monies fraudulently received.

The Department is also providing WCP staff training and assistance to selected VISNs and has held national conferences to provide a forum for training and discussion of WCP issues. While the Department has taken a number of positive steps to address WCP issues, implementation of recommendations included in our 1998 and 1999 audits have not been completed. Key actions remaining include:

- One-time review of all open/active cases. (VHA is in the process of initiating required case review work that is scheduled to be completed in FY 2001. These reviews will include cases identified in both the 1998 and 1999 audits. We have participated in training sessions for newly appointed VISN WCP Coordinators who will be overseeing case review work at their respective VISN facilities. The one-time review effort will use the case review methodologies that we recommended in the protocol and handbook packages.)
- Implementing the system modifications discussed in the report. (Implementation action has been delayed due to budget constraints.)
- Issuing policy and guidance on recording, tracking, and using "continuation of pay" information. (Implementation action cannot be completed until the HR LINK$ system platform is completed.)
- Removing Veterans Canteen Service and NCA employees from VHA's WCP rolls.

(Implementation action will be completed once the one-time review of cases is completed.)

Implementing these recommendations is essential for the Department to strengthen WCP case management and reduce program costs. Given the significance of the audit findings and the risk of program abuse and fraud, WCP continues to be a high priority area.

10. Procurement Practices

The Department spends over $5.1 billion annually for supplies, services, construction, and equipment. VA faces major challenges to implement more efficient and effective ways of ensuring the Department's acquisition and delivery efforts to acquire goods and services. A more coordinated and integrated approach is needed to make sure the benefits of acquiring goods and services outweigh the costs. High-level monitoring and oversight need to be recognized as Department priorities, and efforts must continue to maximize the benefits of competition and to leverage VA's full buying power. VA must also ensure that adequate levels of medical supplies, equipment, pharmaceuticals, and other supply inventories are on hand. At the same time, VA should avoid tying up funds in excess inventories.

Historically, procurement actions are at high risk for fraud, waste, abuse, and mismanagement. Vulnerabilities and business losses associated with theft, waste, and damage of information technology are known to be significant. Recent OIG reviews have identified serious problems with the Department's contracting practices and acquisitions. These reviews have identified the need to improve the Department's procurement practices in areas of acquisition training and oversight to ensure the competency of the acquisition workforce. Previous audits also support the need to provide adequate acquisition planning on a corporate basis, and to improve and coordinate national and regional acquisition planning efforts. Recent business reviews conducted by the Office of Acquisition and Materiel Management and the OIG at four VA facilities have identified significant problems relating to acquisition planning, training, inventory management, management oversight, and contract administration.

Inventory Management

OIG audits have found that excessive inventories are being maintained, unnecessarily large quantity purchases are occurring, inventory security and storage deficiencies exist, and controls and accountability over inventories need improvement. We found that, at any given time, the value of VHA-wide excess medical supply inventory was $64 million, 62 percent of the $104 million total inventory. Audits at 4 VAMCs found that about 48 percent of the $2 million pharmaceutical inventories were excess. Another audit at 5 VAMCs concluded that 48 percent of prosthetic supply inventories were excess.

Excess inventories occurred because VAMCs relied on informal inventory methods and cushions of stock as a substitute for structured inventory management. As a result of the successful transition to prime vendor distribution programs for pharmaceuticals and other supplies, VAMCs have substantially reduced their pharmacy inventories from previous levels. However, inventories continue to exceed current operating needs for many items. Recent reviews of prime vendor programs have identified acquisitions obtained at increased costs and waste.

Purchase Card Use

OIG reviews at selected VAMCs have identified significant vulnerabilities in the use of purchase cards. Work requirements have been split to circumvent competition requirements, and some goods and services have been acquired at

excessive prices and without regard to actual needs. Risk will escalate as purchase card use increases throughout the Department.

Scarce Medical Specialist Services

OIG reviews of scarce medical specialist contracts have expressed serious concerns about whether these contracts or agreements are necessary and whether costs are fair and reasonable. Our reviews have identified conflict of interest issues and proposed sole source contracts that lack an adequate business analysis, justification, or cost/ benefit assessment. Management attention is needed to develop policies that will ensure consistency in the use of VA's statutory authority and proper oversight of such activities.

Current Status: The OIG is working with VA and VHA logistics staff to improve procurement practices within the Department. The OIG continues to perform contract audit and drug pricing reviews to detect defective and excessive pricing; and to provide improved assurance over the justification, prioritization, accountability, and delivery of pharmaceuticals and other goods in VA's operations. VHA has made the development of an Advanced Acquisition Plan a priority.

Investigation of selected construction contracts, purchase card activities, and vehicle administration at the VAMC in Clarksburg,WV, is in progress.

VA's Response to the Office of Inspector General's Assessment

The Department has the following comments to add to the OIG's assessment of the management problems facing VA.

Dual Compensation of VA Beneficiaries

We have been communicating with DoD's Defense Manpower Data Center to reach a solution on this issue. Although experiencing some difficulty in obtaining accurate data from the military services, DoD is working on ways to capture the information we need to offset VA disability compensation against military reserve pay.

Payment to Incarcerated Veterans

We have initiated a project, scheduled for completion by the spring of 2001, for the programming necessary to conduct a match with SSA, using existing procedures. The system to identify and adjust the benefits will be identical to the existing system used for the Federal Bureau of Prisons.

Payment to Deceased Beneficiaries

We have placed a high priority on running a one-time match between the Beneficiary Identification and Records Locator System (BIRLS) and the compensation and pension master records to gauge the extent of the problem. To determine whether a First Notice of Death was processed, we will review every match between a BIRLS record with a date of death and a running compensation or pension award. We will then implement appropriate corrective measures.

GPRA — Data Validity

Inconsistencies identified in NCA's estimate of the percent of the veteran population served by a burial option within a reasonable distance of place of residence have been corrected.

Workers Compensation Costs

VHA recently completed its portion of outstanding actions regarding workers compensation costs. We have notified the OIG and are awaiting their response to our last update of the action plan.

Procurement Practices

The following additional actions have been taken to address this management challenge:

A task force composed of high-level personnel from the OIG, VHA, and VA logistics staff was formally chartered to tackle weaknesses in VA's procurement practices. On November 20, 2000, the group completed its findings and issued recommendations, which are now being studied for appropriate action.

VA has been working diligently to resolve problems in this area. Teams of experts have conducted business reviews of all acquisition and materiel management functions at our medical centers. An assessment by VA logistics staff of VHA's Inventory Management Program found that coordination and operation efficiencies provided by an integrated materiel management system have been adversely affected by VISN and medical center reorganizations. The Department believes implementation of the task force's recommendations will address the deficiencies that have resulted from VHA decentralization.

Also, VA is evaluating the acquisition training program to identify ways to improve the program's effectiveness. Identifying additional training methods beyond the classroom setting will strengthen the skills of our acquisition workforce.

Inventory Management

We accept the OIG's findings of the management challenges associated with procurement practices. However, the Department believes the OIG's finding of excessive VHA inventories is somewhat overstated. As we have discussed with the OIG, VA must be prepared to handle any medical procedure regardless of how rare it may be. Thus, many medical items must be kept on hand even though there may be little likelihood for use. Further, hospitals must have an adequate safety stock to make sure there is no outage of supplies. For these reasons, medical supply inventories will be higher than expected.

Management Challenges Identified by the General Accounting Office

In addition to those major management challenges previously discussed, the Department is facing other serious management problems identified by the General Accounting Office (GAO). The following discussion summarizes our efforts in FY 2000 to resolve identified problem areas. Some of the recommendations are taking considerable time to implement; monitoring will continue until implementation is completed. The background descriptions provided for these major management challenges came directly from GAO documents.

VA Lacks Outcome Measures and Data to Assess Impact of Managed Care Initiatives

Background: VA does not know how its rapid move toward managed care is affecting the health status of veterans because measures of the effects on patient outcomes or of changes in its service delivery have not been established. VA has recognized the necessity for, and the difficulty of, creating such measures. VA's challenge in assessing outcomes is further complicated by poor data. GAO and others have reported numerous concerns about VA's outcome data, including

inconsistent, incompatible, and inaccurate databases; changes in data definitions over time; and the lack of timely and useful reporting of information to medical center, VISN, and national program managers.

GAO's work on health care for Persian Gulf War and homeless veterans has resulted in eight open recommendations related to this management challenge. They involve the development and uniform implementation of a process to integrate diagnostic services, evaluate the effectiveness of treatment, and periodically reevaluate veterans with undiagnosed illnesses.

Status: In 1998, VA initiated five clinical demonstration projects for case management and multidisciplinary specialized Gulf War clinics. These projects complement a prior case-managed care initiative designed to improve service to veterans experiencing complex medical problems. In FY 2000, each Demonstration Project Principal Investigator submitted a final report addressing responsiveness to the initial proposal, scientific merit, innovative approaches, and relevance to Gulf War veterans' health.

The Gulf War Field Advisory Group met in December 1999 to create an evidence-based clinical practice guideline on Post-deployment Health Concern Evaluation and Management. A task force of this group met in July 2000 to develop another clinical practice guideline for the most common symptoms and difficult-to-diagnose, ill-defined, or medically unexplained conditions of Gulf War veterans. This effort is expected to result in a guideline that defines diagnostic and treatment strategies for care of patients with chronic fatigue syndrome and fibromyalgia. These clinical practice guidelines are joint VA-DoD initiatives.

In FY 2000, VA established national outcome measures to look at the functional status of all special population programs, except the seriously mentally ill. An outcome measure for this area is under development and should be available in FY 2001.

VA Faces Major Challenges in Managing Non-Health Care Benefits Programs

Background: In managing non-health care benefits programs, VA needs to overcome a variety of difficulties. Currently, VA cannot ensure that its veterans' disability compensation benefits are appropriately and equitably distributed because its disability rating schedule does not accurately reflect veterans' economic losses resulting from their disabilities. Also, VA is compensating veterans for diseases that are neither caused nor aggravated by military service. In addition, claims processing in VA's compensation and pension program continues to be slow, and the vocational rehabilitation program has had limited success. The data to measure compensation and pension program performance are questionable. Furthermore, VA has inadequate control and accountability over the direct loan and loan sales activities within VA's housing program.

Status: This challenge consists of several distinct elements and crosses program lines. We consider the first two challenges—ensuring that compensation benefits are appropriately and equitably distributed, and compensating veterans for diseases that are not caused by military service—to be policy issues requiring legislative or regulatory changes to effect. We do not consider them to be management challenges. The challenges concerning compensation and pension claims processing and data quality are addressed on pages 20-26, 83-84, and 89-91 of this report. The results of the vocational rehabilitation and employment program can be found on page 30. GAO made seven recommendations for VA's housing program. The two recommendations which address reconciliation of records in the

contractor's database with VA's general ledger are fully implemented; the one regarding prompt delivery of data to VA by servicers and trustees is substantially completed; and the other four, in connection with data base development and monitoring activities, are at various stages of implementation.

VA Needs to Manage Its Information Systems More Effectively

Background: VA lacks adequate control and oversight of access to its computer systems and has not yet institutionalized a disciplined process for selecting, controlling, and evaluating information technology investments as required by the Clinger-Cohen Act. While VA has progressed in addressing Year 2000 challenges, it still has a number of associated issues to address.

Status: VA fully implemented a capital investment process to track its major investments, including those for information technology (IT). Before being approved for funding, submitted proposals are reviewed by the VA Capital Investment Board (VACIB). Funded IT investments continue to be tracked within the context of the capital planning process through three primary means: (1) execution reviews, which provide for quarterly updates of project progress and comparison against planned costs and schedule; (2) in-process reviews, which independently assess progress of projects at discrete points during their development; (3) post-implementation reviews, which evaluate how well projects actually did against what was intended.

These tracking mechanisms produce information that is assessed by the Chief Information Officers' (CIO) Council for projects that significantly deviate from intended targets, defined as variances of more than 10 percent from planned costs and schedule goals. The CIO Council will determine appropriate remedial action, including making recommendations to the VACIB to either change the scope of project funding or terminate the project altogether. Such information also allows the VA CIO to provide the Secretary accurate and timely information on the status of investments in key information systems.

VA successfully transitioned into the Year 2000 (Y2K) without any significant computer-related incidents. VA benefits were paid on time, and our health care facilities remained open throughout the January 1 rollover.

VA completed health checks at our headquarters offices, medical centers, regional offices, national cemeteries, and data processing centers. These health checks found the facilities to be fully operational; no Y2K problems were encountered. VA has continued to deliver benefits and health care without any Y2K interruptions.

This successful transition into the Year 2000 reflects the hard work performed nationwide by VA employees to make our systems Y2K compliant. VA's Y2K program serves as a model for effectively managing IT needs throughout the Department.

PERFORMANCE MEASURES

BY ORGANIZATION AND PROGRAM

In addition to VA's key performance goals, there are other performance measures, identified and discussed in the following tables, by which VA evaluates its success. The tables show trend data for a 5-year period and associated target levels of performance grouped by organization and program, including the total amount of resources (number of full-time equivalent employees and obligations) for each program. The performance targets are based on the FY 2000 column of our FY 2001 Performance Plan, which was sent to Congress in February 2000. Within each group, the performance measures are structured as follows:

1. *Target was met or exceeded (green);*
2. *Target was not met, but the deviation did not significantly affect goal achievement (yellow);*
3. *Target was not met, and the difference significantly affected goal achievement (red).*

For each measure that resulted in non-achievement of a performance target (highlighted in red), we provide a brief explanation as to why there was a significant deviation between the actual and planned performance level, and identify what steps are being taken to assure goal achievement in the future.

VA uses the balanced measures concept to monitor program and organizational performance. Rather than focusing attention solely on one or two types of performance measures, we examine and regularly monitor several different types of measures to provide a more comprehensive and balanced view of how well we are performing. While each of our major program elements uses a balanced family of measures, the specific measures vary somewhat from organization to organization, and thus, from program to program. The performance measures for each organization have been tailored to fit the strategic goals of the programs for which each organization is responsible.

For example, VHA has developed performance measures corresponding to their "6 for 2006" strategic goals:

- put quality first until first in quality;
- provide easy access to medical knowledge, expertise, and care;
- enhance, preserve, and restore patient function;
- exceed customers' expectations;
- save more dollars to serve more veterans;
- build healthy communities.

VBA has implemented a balanced scorecard of performance measures. This balanced scorecard contains the major service delivery performance measures that mean the most to the veterans we serve, our stakeholders, and our employees:

- timeliness of claims processing;
- accuracy;
- customer satisfaction;
- unit cost;
- employee development.

NCA evaluates its performance in those areas identified by veterans and their family members as being most important to service delivery:

- reasonable access to veterans' cemeteries and burial program information;
- quality of service provided;
- satisfaction with the appearance of national cemeteries as national shrines.

Taken together, the measures in the following tables and the Department's key measures demonstrate the balanced view of performance VA uses in assessing how well we are doing in meeting our strategic goals, objectives, and performance targets.

The GPRA program activity structure is somewhat different from the program activity structure shown in the program and financing (P&F) schedules of the President's Budget. However, all of the P&F schedules (budget accounts) have been aligned with one or more of our programs to ensure all VA program activities are covered. The program costs (obligations) represent the total resources available for each of the programs, regardless of which organizational element has operational control of the resources. The performance measures and associated data for each major program apply to the entire group of schedules listed for that program.

Veterans Health Administration Performance Measures

Medical Care

P&F ID Codes: 36-0160-0-1-703; 36-0160-0-2-703; 36-5287-0-1-703; 36-5287-0-2-703; 36-5014-0-2-703; 36-2431-0-1-703; 36-5014-0-1-703; 36-0152-0-1-703; 36-0163-0-1-703; 36-4014-0-3-705; 36-4048-0-3-703; 36-4138-0-3-703; 36-8180-0-7-705; 36-0110-0-1-703; 36-0111-0-1-703; 36-0181-0-1-703; 36-4538-0-3-703; 36-4018-0-3-705; 36-0144-0-1-703; 36-4537-0-4-705; 36-4258-0-1-704

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	201,610	192,347	188,705	186,595	183,396	N / A
Medical care costs ($ in millions)	$16,112	$16,775	$17,623	$17,859	$19,395	N / A

Performance Measures

	Goal Achieved					
Percent of patients reporting coordination of care problems in the outpatient customer feedback survey	N / A	19%	17%	16%	15%	15%
Percent of patients reporting problems on courtesy questions in the annual outpatient customer feedback survey	16%	9%	9%	7%	7%	7%
Percent of permanent VHA employees receiving necessary level of education time and other learning experience	N / A	N / A	N / A	50% / 30 hrs.	74% / 40 hrs.	50% / 40 hrs.
Percent of VA-managed Federal Coordinating Centers that complete at least one National Disaster Medical System (NDMS) casualty reception exercise every three years	N / A	N / A	N / A	50%	66%	65%

	Goal Not Achieved -- Minimal Difference					
Percent of patients who use tobacco products	N / A	32%	29%	27%	25%	24%
Percent of patients with terminal diagnoses or advanced, progressive, incurable illnesses receiving ongoing care through VA who have a documented individualized plan for palliative care services	N / A	N / A	91%	96%	96%	97%
Percent of patients who know there is one provider or team in charge of their care	72%	77%	78.2%	76%	77%	80%
Number of community-based outpatient clinics (CBOC)	N / A	267	362	519	601	622

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Veterans Health Administration Performance Measures

	Goal Not Achieved -- Significant Difference					
Percent of outpatients who rate the quality of VA health care as equivalent to or better than any other health care provider	77.9%	78.4%	79.3%	84%	84%	89%

Although the FY 2000 performance level for this measure fell short of the projected target, it equaled the performance level for FY 1999. We do not believe this indicates any adverse effect on overall program or activity performance, particularly since VA outpatient care received an ACSI score (78) which exceeds the ACSI (71) recorded by private sector hospitals. For FY 2001 and beyond, this measure will be dropped. VHA feels the primary purpose for which this goal was set has been essentially achieved.

Special Emphasis Programs

	Goal Achieved					
Percent of patients queried on the National Blind Rehabilitation Customer Satisfaction Survey who are satisfied or completely satisfied	N / A	N / A	97.7%	98%	99%	98%
Percent of medical centers with at least one clinician trained in problems, diseases, and experiences prevalent in former prisoners of war	N / A	N / A	40%	66%	80%	80%
Percent of medical facilities that have at least one clinician trained in primary care for Gulf War veterans	N / A	N / A	N / A	92%	99%	95%
Percent of veterans using Vet Centers who report being satisfied with services and saying they would recommend the Vet Center to other veterans	N / A	N / A	N / A	99.6%	99.7%	95%
Percent of prosthetic orders not placed within five work days	2%	2%	2%	2%	1%	2%
Proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings	N / A	N / A	N / A	93%	97%	94%
Percent of hospitalized first admission traumatic brain injury (TBI) patients discharged to the community setting (FY 1997 baseline = 305 patients)	N / A	60%	63%	65.8%	68%	66%
Percent of veterans currently enrolled in the National Post-Traumatic Stress Disorder (PTSD) Outcomes Monitoring System who were successfully followed-up by the fourth month after discharge (FY 1998 baseline = 2,275 veterans)	N / A	N / A	N / A	51%	68%	52%

Veterans Health Administration Performance Measures

	Goal Not Achieved -- Minimal Difference					
Percent of diabetic patients, at risk for foot amputations, who are referred to a foot care specialist	N / A	N / A	81%	86%	87%	88%
Percent of SCI respondents to the National Customer Feedback Center Survey who rate their care as very good or excellent - Outpatient	N / A	57%	55.2%	55%	56%	57%
Mammography examination rate among appropriate and consenting women veterans	N / A	87%	89%	91%	90%	92%
Cervical cancer screening examination rate among appropriate and consenting women veterans	N / A	90%	93%	94%	93%	94%
Percent of patients seen in specialized substance abuse treatment settings who have an initial Addiction Severity Index (ASI) and six month follow-up (FY 1997 baseline = 38,000 patients)	N / A	N / A	N / A	56%	56%	60%
Average number of months in which the veteran received VA mental health services during the six months after the first PTSD visit	N / A	N / A	4.28	4.32	4.17	4.36

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

	Goal Not Achieved -- Significant Difference					
Rate of prophylaxis for human immune-deficiency virus (HIV) related, opportunistic infections	N / A	N / A	N / A	65%	61%	70%

The use of highly active anti-retroviral therapy (HAART) has resulted in clinical improvements in many HIV patients. As a result, the previously required prophylaxis for opportunistic infection is often no longer necessary. Therefore, VA's rate of prophylaxis declined from 65 percent in FY 1999 to 61 percent in FY 2000. We now believe this performance measure is unreliable, difficult to measure, and no longer relevant. We are considering replacement of this measure in FY 2001 with one in which performance levels can be more reliably projected.

Veterans Health Administration Performance Measures

Percent of veterans who acquired independent living arrangements at discharge from a Domiciliary Care for Homeless Veterans (DCHV) Program or a community-based contract residential care program (FY 1997 baseline = 8,502 veterans)	N / A	N / A	50.5%	50.0%	48.0%	53.4%

There are two reasons for the lower percentage of homeless veterans housed at discharge. First, due to a data error, the original FY 1998 base was slightly higher than it should have been. The actual FY 1998 base was 50.5 percent, not 52 percent. Not realizing the error, we projected a 0.7 percent annual increase to bring the FY 2000 projection up to 53.4 percent. Had we worked from the correct baseline figure of 50.5 percent, we would have projected 51.9 percent for FY 2000. The second reason has to do with a 4.4 percent decline in the percentage of veterans independently housed at discharge compared to the previous two years. Analysis indicates that 2.4 percent more veterans moved to other treatment programs than in the previous two years, and 2 percent more veterans were discharged without a known residence.

There may be several factors influencing this measure. Among them are: (a) the increased availability of other supported housing programs funded through VA's Homeless Providers Grant and Per Diem programs. Clinicians may be taking advantage of these additional community-based beds and referring homeless veterans to these programs, rather than trying to help them move to independent living; (b) VA started several new programs in FY 2000. Several new clinicians are just beginning to provide services to homeless veterans and are placing them in contract community-based residential treatment programs that have not previously served homeless veterans. The combination of new VA clinicians and new contract programs may mean that homeless veterans are prematurely placed in contract residential care programs or in contract programs that are not addressing their treatment needs.

Percent of veterans who obtained employment upon discharge from a DCHV Program or a community-based contract residential care program (FY 1997 baseline = 8,502 veterans)	N / A	N / A	54%	55%	51%	57%

Although more detailed analyses have not been conducted to identify factors influencing this measure, it is likely that those factors that may have led to a decline in independent housing may have also led to a decline in the percentage of homeless veterans who were employed at discharge. Specifically, moving homeless veterans to other community-based supported housing programs for continuing care instead of moving them to independent living (where they would have to pay rent and be employed in order to pay rent) may have influenced performance on this measure. New clinicians and new contract residential treatment facilities may also have led to a decline in performance on this measure. A third possibility, not yet verified through further analysis, is that a greater percentage of disabled veterans (not able to return to employment) may have been placed in contract residential treatment in FY 2000 compared to previous years.

Number of homeless veterans treated in the VA health care system	N / A	N / A	82,900	87,900	88,303	92,900

Although the number of homeless veterans treated in the VA health care system in FY 2000 was below expectations and only slightly above the number treated in FY 1999, it represents a dramatic increase over the number treated in FY 1997 (66,000). VHA does not believe the number reflects a decline in program effectiveness. On the contrary, VHA is gratified that a large number of homeless veterans continue to be aware of, and choose to take advantage of, these programs.

Veterans Health Administration Performance Measures

Percent of homeless patients with mental illness who receive a follow-up mental health outpatient visit, admission to a Compensated Work Therapy / Transitional Residence (CWT / TR), or admission to a Psychiatric Residential Rehabilitation Treatment Program (PRRTP) within 30 days of discharge	N / A	N / A	64%	64.5%	62.5%	65%

The percent of homeless veterans with mental illness who received a 30-day follow-up fell just below both the FY 1998 and FY 1999 performance levels as well as the FY 2000 performance target. However, VHA does not view this as representing a decline in overall program effectiveness. Rather, the rate of veterans who receive a 30-day follow-up is essentially the same as for previous years.

Percent of spinal cord injury (SCI) respondents to the National Customer Feedback Center Survey who rate their care as very good or excellent - Inpatient	N / A	55%	55.2%	55%	52%	57%

VA SCI Center care is a unique mixture of acute, sustaining, and long-term care for which comparable data are not available in the private sector. The satisfaction levels for veterans with SCI are significantly lower than the veteran population as a whole. Active efforts to improve their care include, but are not limited to: distribution and implementation of clinical practice guidelines; annual national SCI primary care team training; improvements in the SCI-registry to improve coordination of care; pursuit of Commission on Accreditation of Rehabilitation Facilities accreditation for acute, SCI rehabilitation programs; start of the SCI Quality Enhancement Research Initiative to close gaps in knowledge of SCI issues; and adequate sample sizes which will permit analysis of Veterans Health Service Standards and lead to specific feedback on problem areas at each SCI Center.

The scale for the survey response was poor / fair / good / very good / excellent, but only scores of very good or excellent were considered in the summary score of 52 percent. If respondents who rated their care as good, very good, or excellent are included in the summary, the accomplishment increases to nearly 80 percent. Repeated sampling and trending over time will further address validity and reliability. Nonetheless, in an aging, severely disabled inpatient population such as this, a 52 percent satisfaction level is indicative of a fair amount of success. For FY 2001, VA intends to work toward a goal of 60 percent.

Medical Research

P&F ID Codes: 36-0160-0-1-703; 36-0161-0-1-703; 36-406-0-3-703

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	3,250	2,957	2,758	2,974	3,014	N / A
Research costs ($ in millions)	$592	$648	$725	$779	$800	N / A

Performance Measures

	Goal Achieved					
Percent of funded research projects reviewed by appropriate peers and selected through a merit-based competitive process	99%	99%	99%	99%	99%	99%

Veterans Benefits Administration Performance Measures

Compensation and Pension

P&F ID Codes: 36-0153-0-1-701; 36-0153-2-1-701; 36-0153-4-1-701; 36-0154-0-1-701; 36-0155-0-1-701; 36-0151-0-1-705; 36-0111-0-1-703

Resources

	1996	1997	1998	1999	2000	2000 Plan
FTE	4,364	6,931	6,770	6,841	7,120	N / A
Benefits costs ($ in millions)	$18,532	$19,352	$20,242	$21,112	$22,053	N / A
Administrative costs ($ in millions)	$209	$495	$491	$549	$593	N / A

Performance Measures

	Goal Achieved					
Rating-related actions - average days pending	81	94	119	144	138	150
Fiduciary activities - initial appointment > 45 days	24%	20%	21%	12%	6%	8%

	Goal Not Achieved -- Significant Difference					
National accuracy rate (authorization work)	N / A	N / A	70%	63%	51%	85%

Quality of authorization work has suffered as we moved more experienced staff to rating work. The large number of trainees remains an issue as experienced staff members are moved from authorization to rating work in order to fill new or vacant positions. The high turnover rate impacted significantly in this segment of claims processing.

National accuracy rate (fiduciary work)	N / A	N / A	51%	48%	59%	75%

Although we fell significantly short of our target, we did make improvements so we could achieve real progress from our level of performance during FY 1999. The improvement in this measure is a result of renewed program attention to the measure as well as a strengthening of the training program. In retrospect, the FY 2000 target was set at an unrealistically high level.

Non-rating actions - average days to process	27	23	32	44	50	33
Non-rating actions - average days pending	55	56	74	94	84	59

We failed to achieve our performance goals for these measures because we have not yet realized fully the benefits from Business Performance Reengineering and case management, to include information technology solutions that will support case management. Because of hiring new veterans service representatives, we lost some production time for training. A large portion of the increases in the timeliness figures is attributed to the length of time it takes to process income verification match issues.

Veterans Benefits Administration Performance Measures

The indicators below are the component end-products for the measure on average days to complete rating-related actions. We do not establish separate performance goals for these indicators. For a detailed discussion of rating-related actions timeliness, see the narrative on pages 24-26.

	1996	1997	1998	1999	2000	Claims Completed in 2000
Average days to process rating-related actions	100	94	128	166	173	601,451
Initial disability compensation	144	133	168	205	212	124,910
Initial death compensation / DIC	75	66	89	111	122	25,316
Reopened compensation	107	101	141	182	189	315,261
Initial disability pension	85	77	94	112	115	33,828
Reopened pension	77	67	88	113	111	67,296
Reviews, future exams	45	41	61	104	108	25,158
Reviews, hospital	37	33	52	73	78	9,682

Education

P&F ID Codes: 36-0137-0-1-702; 36-0200-0-1-701; 36-8133-0-7-702; 36-2473-0-0-702; 36-0140-0-3-702; 36-4259-0-3-702 (Off Budget); 36-4260-0-3-702; 36-0151-0-1-705; 36-0111-0-1-703

Resources	1996	1997	1998	1999	2000	2000 Plan
FTE	530	1,051	927	849	781	N / A
Benefits costs ($ in millions)	$924	$914	$891	$1,210	$1,202	N / A
Administrative costs ($ in millions)	$25	$72	$66	$70	$66	N / A

Performance Measures

	Goal Achieved					
Compliance survey completion rate	88.7%	81.8%	79.8%	98.1%	94.5%	88%
Abandoned call rate	N / A	N / A	N / A	N / A	17.1%	18%
Payment accuracy rate	93.9%	92.9%	94%	94.4%	95.8%	95%
Federal Managers' Financial Integrity Act (FMFIA) compliance rate	N / A	75%	75%	75%	75%	75%
Job satisfaction	N / A	N / A	N / A	2.8	3.3	2.9
Administrative cost per trainee	N / A	N / A	$156	$175	$131	$166

	Goal Not Achieved -- Minimal Difference					
Customer satisfaction-high ratings	N / A	76%	76%	78%	78%	79%

The performance goal for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

	Goal Not Achieved -- Significant Difference					
Blocked call rate	N / A	45.0%	60.0%	15.5%	39.1%	23.0%

Although we failed to achieve our annual target, system enhancements put in place through the year resulted in end-of-year performance being significantly better than the cumulative performance for the year.

Veterans Benefits Administration Performance Measures

Vocational Rehabilitation and Employment

P&F ID Codes: 36-0137-0-1-702; 36-0140-0-3-702; 36-4259-0-3-702 (Off Budget); 36-4260-0-3-702; 36-0151-0-1-705; 36-0111-0-1-703

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	722	1,099	919	972	943	N / A
Benefits costs ($ in millions)	$355	$402	$406	$412	$439	N / A
Administrative costs ($ in millions)	$40	$78	$68	$72	$81	N / A

Performance Measures

					Goal Achieved	
Speed of entitlement decisions in average days	N / A	N / A	88	88	78	79
Employment timeliness in average days	N / A	N / A	83	53	42	52
Serious Employment Handicap (SEH) rehabilitation rate	N / A	N / A	N / A	49.2%	62.0%	55.0%

					Goal Not Achieved -- Minimal Difference	
Accuracy of decisions (Entitlement)	N / A	N / A	N / A	86%	89%	94%
Accuracy of decisions (Services)	N / A	N / A	85%	87%	86%	88%
Accuracy of decisions (Fiscal)	N / A	N / A	N / A	94%	94%	95%
Customer satisfaction	N / A	N / A	86%	N / A	76.4%	80%

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Housing

P&F ID Codes: 36-0137-0-1-702; 36-1119-0-1-704; 36-1119-0-2-704; 36-4127-0-3-704 (Off Budget); 36-4129-0-3-704 (Off Budget); 36-4025-0-3-704; 36-0140-0-3-702; 36-4259-0-3-702 (Off Budget); 36-0151-0-1-705; 36-0111-0-1-703

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	1,748	2,254	2,075	2,108	2,058	N / A
Benefits costs ($ in millions)	$1,984	$1,368	$1,676	$1,811	$1,866	N / A
Administrative costs ($ in millions)	$84	$139	$161	$160	$157	N / A

Performance Measures

					Goal Achieved	
Average days to issue certificates of reasonable value	N / A	N / A	N / A	18.8	15	19

					Goal Not Achieved -- Minimal Difference	
Statistical quality index	N / A	N / A	N / A	N / A	93.5%	97.0%

The performance goal for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Veterans Benefits Administration Performance Measures

Administrative cost per loan	$107	$291	$233	$111	N / A	$120
Administrative cost per default	$188	$212	$304	$338	N / A	$340
Return on sale	98.1%	97.2%	99%	100.6%	N / A	98%
Property holding time (months)	N / A	N / A	N / A	6.7	N / A	9.0

FY 2000 data were not available for these measures. Due to a system problem, some Housing program performance information was irretrievably lost.

Insurance

P&F ID Codes: 36-0120-0-1-701; 36-4012-0-3-701; 36-4010-0-3-701; 36-4009-0-3-701; 36-8132-0-7-701; 36-8150-0-7-701; 36-8455-0-8-701; 36-0151-0-1-705; 36-0111-0-1-703

Resources

	1996	1997	1998	1999	2000	2000 Plan
FTE	423	584	563	548	525	N / A
Benefits costs ($ in millions)	$2,817	$2,778	$2,687	$2,559	$2,457	N / A
Administrative costs ($ in millions)	$16	$38	$40	$40	$40	N / A

Performance Measures

	Goal Achieved					
High customer ratings	N / A	90%	95%	96.4%	96%	95%
Low customer ratings	N / A	5%	2%	1.3%	1.7%	2%
Percentage of blocked calls	N / A	44%	17%	6%	4.3%	6%
Average hold time in seconds	35	70	35	20	20.1	21
Percentage of insurance disbursements paid accurately	99%	98%	99%	99.1%	99%	99%
Cost per policy maintained	N / A	$9.96	$10.34	$11.25	$11.34	$11.87
Cost per death award	N / A	$87.55	$88.15	$78.18	$79.45	$85.65
	Goal Not Achieved -- Minimal Difference					
Average days to process insurance disbursements	4.2	4.4	3.2	3.2	3.2	3.0
Employee satisfaction	N / A	N / A	N / A	N / A	3.3	3.5

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

	Goal Not Achieved -- Significant Difference					
Cumulative number of computer-based training modules completed	N / A	N / A	1	1	1	4

After completion of the first module, the insurance program conducted a needs assessment, the outcome of which was to dramatically change the project from developing computer-based training modules to developing "Directed Flow Charts." This is the approach employees prefer. We will complete 13 training initiatives through FY 2005. The program no longer considers this to be a meaningful performance measure and it will be dropped from future plans and reports.

National Cemetery Administration Performance Measures

Burial

P&F ID Code: 36-0155-0-1-701; 36-0129-0-1-705; 36-8129-0-7-705; 36-0183-0-1-705; 36-0110-0-1-703; 36-0111-0-1-703

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	1,287	1,283	1,328	1,357	1,399	N / A
Benefits costs ($ in millions)	$113	$113	$114	$106	$109	N / A
Administrative costs ($ in millions):						
Operating costs	$73	$77	$84	$92	$97	N / A
State cemetery grants	$8	$5	$6	$5	$19	N / A
Capital construction	$15	$19	$79	$21	$43	N / A

Performance Measures

Goal Achieved						
Cumulative number of kiosks installed at national cemeteries	N / A	2	6	14	24	24
Percent of monuments ordered on-line by other federal and state veterans cemeteries using AMAS-R	N / A	N / A	N / A	65%	88%	75%
Percent of Presidential Memorial Certificates that are accurately inscribed	98%	98%	98%	98%	98%	98%
Goal Not Achieved -- Minimal Difference						
Percent of headstones and markers that are undamaged and correctly inscribed	95.5%	95%	94.5%	94.7%	96.5%	96.6%
Percent of individual headstone and marker orders transmitted electronically to contractors	N / A	68%	85%	88%	89%	90%

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Goal Not Achieved -- Significant Difference						
Number of veterans served by a burial option in a state veterans cemetery (veterans served in thousands)	2,510	2,474	2,601	2,596	2,504	2,695

The performance goal for this measure was set at an approximate target level based on projected openings of state veterans cemeteries. Three new state veterans cemeteries--in Massachusetts, Montana, and Wisconsin--did not open in FY 2000 as planned. After a grant has been awarded, VA has little control over the pace of the construction and establishment of a state veterans cemetery. Now expected to open in FY 2001, these three new state veterans cemeteries will provide a burial option to over 130,000 veterans not currently served. We concluded the number of veterans served by a burial option in a state veterans cemetery is not a valid measurement of NCA's performance. As a result, this measure is being changed to the percent of veterans served only by a burial option in a state veterans cemetery. While NCA will continue to collect information on the number of veterans served by a burial option in a state veterans cemetery, we will not include it in future performance plans and reports. In FY 2001, NCA will also measure the percent of veterans served by a burial option in a national cemetery.

Board of Veterans' Appeals Performance Measures

P&F ID Code: 36-0151-0-1-705

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	468	492	483	478	468	N / A
Administrative costs ($ in millions)	$32	$36	$38	$40	$41	N / A

Performance Measures

	Goal Achieved					
BVA response time (in days)	595	334	197	195	220	237
Appeals decided per FTE	72.5	88.1	80.5	78.2	72.7	70.5
Cost per appeals case	$950	$839	$965	$1,062	$1,219	$1,235

	Goal Not Achieved -- Minimal Difference					
Remand rate from the U.S. Court of Appeals for Veterans Claims (CAVC) to BVA	N / A	64.4%	57.7%	65.0%	60.7%	60.0%
Percent of decisions without quality deficiencies	N / A	N / A	88.8%	83.5%	85.8%	88%

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Departmental Management Performance Measures

P&F ID Codes: 36-0151-0-1-705; 36-4539-0-4-705; 36-0110-0-1-703; 36-0111-0-1-703

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	7,088	2,170	2,216	2,483	2,563	N / A
Administrative costs ($ in millions)	$714	$281	$327	$357	$416	N / A

Performance Measures

	Goal Achieved					
Number of national standardized contracts for medical and other related products and services	3	48	99	151	131	120

We are discontinuing the inclusion of this measure in future performance plans and reports because we are now renegotiating and, where possible, consolidating these contracts. Therefore, our reporting in the present format is misleading. While this process continues to provide very significant savings to VA and the Federal Government, the number of contracts will continue to grow at the current rate, and some of the items on the standardized list will cost more than in prior years. These items are still significantly below the market price for the commercial sector and provide the best price available.

Percent increase from FY 1997 baseline in purchases made using electronic data interchange (EDI)	N / A	N / A	16%	48%	86%	50%
Percent of contract disputes electing alternate dispute resolution (ADR)	N / A	9.9%	10.7%	12.0%	13.0%	13.0%

Departmental Management Performance Measures

	Goal Not Achieved -- Significant Difference					
Cumulative number of program evaluations initiated	N / A	N / A	1	4	7	10

During FY 2000, the evaluation of VA's education programs was completed and distributed. Evaluations of the dependency indemnity compensation program, the insurance programs, and cardiac care continued. Evaluations of Leadership VA, prosthetics, non-service-connected pension, and parents' dependency indemnity compensation programs were initiated. The schedule for program evaluations was revised and is included in the FY 2001-2006 Strategic Plan. The revised schedule recognizes that the previous schedule was overly optimistic in terms of the duration of each evaluation and the time required for planning and designing the evaluations.

Office of Inspector General Performance Measures

P&F ID Code: 36-0170-0-1-705

Resources	**1996**	**1997**	**1998**	**1999**	**2000**	**2000 Plan**
FTE	365	339	322	342	354	N / A
Administrative costs ($ in millions)	$32	$32	$33	$38	$45	N / A

Performance Measures

	Goal Achieved					
Indictments, convictions and administrative sanctions	486	395	366	696	938	765
Value of monetary benefits ($ in millions) from:						
IG investigations	$68	$18	$17	$24	$28	$28

	Goal Not Achieved -- Significant Difference					
Reports issued	149	181	171	162	108	161

This goal was not achieved for several reasons. The Office of Healthcare Inspections (OHI) expanded its operations into a regional office concept, and at the same time, became more heavily involved in the Combined Assessment Program (CAP) reviews, and dramatically increased the number of program and oversight evaluations completed. CAP reviews are part of our effort to ensure quality health care service is provided to our Nation's veterans. CAP provides recurring cyclical oversight of VA medical facility operations, focusing on the quality, efficiency, and effectiveness of service provided to veterans, as well as an independent and objective assessment of key operations and programs at VA medical centers. Due to the success of the program, in FY 2001, we are expanding it to include VBA regional offices as well.

In addition, VHA rapidly expanded its points of access, requiring the investment of more OHI resources. Thus, it became a trade-off between the production of health care reports versus providing assistance to the Office of Investigations in about 20 medical-related criminal cases. To some degree, the Office of Contract Reviews also contributed to the shortfall. A re-examination midway through the fiscal year resulted in a modification of its performance measures to reflect a more realistic baseline of anticipated report activity, due to a change in the office's workload from short-term to long-term projects.

Value of monetary benefits ($ in millions) from:						
IG audit and health care inspection reviews	$100	$104	$468	$610	$254	$615
IG contract reviews	$29	$99	$250	$47	$35	$48

A report expecting to have monetary benefits totaling approximately $1 billion was not completed during FY 2000, and the final review carried over into FY 2001. There is a disagreement between VBA and OIG over the methodology and the amount of monetary benefits to be derived from the outstanding report. As a result, we will retain $615 million as our goal for FY 2001. In the Office of Contract Reviews, the goal was not attained because four audits substantially conducted in FY 2000 were still pending completion at the end of the fiscal year. If these audits could have been counted, the goal would have been achieved.

DEFINITIONS

Medical Care

Chronic Disease Care Index (CDCI) — The index consists of 13 medical interventions assessing how well VA follows nationally recognized guidelines for 5 high-volume diagnoses. Within each of the five diagnoses, two to five medical interventions are measured as follows:

Diagnosis	Medical Interventions
Ischemic heart disease	Administration of aspirin Administration of beta blockers Cholesterol management plan
Hypertension	Exercise counseling Nutrition counseling
Chronic obstructive pulmonary disease	Instruction and observation in inhaler use
Diabetes mellitus	Visual foot inspection Examination of pedal pulses Foot sensory examination Retinal eye examination Hemoglobin Alc
Obesity	Nutrition counseling Exercise counseling

Cost per patient — This is the cost to provide health care to a patient during the noted fiscal year. The cost of care per patient is calculated by dividing total obligations by the number of unique patients treated. Reductions in the average cost per unique social security number (see "Unique patients treated" below) are to be understood in "after-inflation" dollars. For example, if the average cost remains the same in 2 successive fiscal years, and the medical inflation is 5 percent, VA would calculate an average cost reduction per patient of 5 percent.

Inpatients/outpatients rating VA health care service as very good or excellent — This measure reflects the results of VA care and service provided to veterans, based on surveys of their experiences during their most recent hospitalization (inpatients) or care received within the previous 2 months (outpatients). Both nationwide and VISN-specific findings are reported annually. The *Inpatient Survey,* targeting a random sample of veterans recently discharged from inpatient care, is a composite of the satisfaction averages from the medicine, neurology, psychiatry, rehabilitation medicine, spinal cord injury, and surgery bed sections. VA sends the *Outpatient Survey* to veterans who had at least one outpatient visit at the General Medicine Clinic, Primary Care Clinic, or Women's Clinic. A standardized questionnaire and consistent methodology nationwide permit the analysis of trends over time, and permit comparisons between VA and private sector benchmarks. Standardized survey research techniques ensure the validity and reliability of the findings.

Medical cost recoveries, Medicare, and other sharing revenues as a percentage of the medical care operating budget — This is a generic description of VA's alternate revenue sources, over and above its yearly Congressional budget appropriations. The income comes from fee-for-service payments or third-party payments for care received by veterans covered by a medical insurance policy.

Number of community-based outpatient clinics (CBOCs) — This term applies to VA-operated, funded, or reimbursed health care facilities, which are geographically distinct and separate from a VA medical center. It does not include hospital-based, mobile, or independent outpatient clinics. Through the establishment of CBOCs, VA has increased the number of access points to facilities providing primary and sub-specialty care, including mental health care services. In particular, VA has encouraged arrangements to establish CBOCs in remote or under-served areas in order to provide comprehensive care closer to veterans' homes.

Outpatients who rate the quality of VA health care service as equivalent to or better than any other health care provider — In many areas, VA benchmarks its performance to other recognized standards of health care quality, e.g., *Healthy People 2000*. In addition, VA solicits information from its veteran patients through the annual *National Ambulatory Care Satisfaction Survey*, to determine how they would compare the quality of VA medical care with that provided elsewhere. Patients are asked to respond to the following statement: "VA medical care is as good as that provided anywhere."

Patients reporting coordination of care problems in the outpatient customer feedback survey — This measure is derived from the annual *National Ambulatory Care Satisfaction Survey*. It reflects a summary score on five questions relating to the coordination of a patient's care during his or her most recent visit to a VA medical facility: (1) Did someone tell you how you would find out the results of your tests? (2) Did someone tell you when you would find out the results of your tests? (3) If you needed another visit with this provider, did the staff do everything they could to make the necessary arrangements? (4) If you were referred to another provider, did the staff do everything they could to make the necessary arrangements? (5) Did you know whom to call if you needed help or had more questions after you left your appointment? The patient's responses to these questions indicate the perception of how well his or her care and treatment were coordinated.

Patients reporting problems on courtesy questions in the annual outpatient customer feedback survey — Veteran patients deserve to be treated with courtesy and respect, and VA places a good deal of emphasis on this veterans' service standard. Courteous service from the employees with whom a patient interacts is an integral factor in determining that patient's overall satisfaction with VA health care. This measure is derived from two questions on the annual *National Ambulatory Care Satisfaction Survey*: (1) How would you rate the courtesy of the person who made your appointment? (2) Overall, how would you rate the courtesy of your provider?

Patients seen within 20 minutes of scheduled appointment at VA health care facilities — Service must be delivered in a timely manner. VA patients with scheduled appointments expect to be seen within a reasonable time of their appointment. This measure reflects the percentage of patients who report being seen in 20 minutes or less. It is derived from the responses to the following question on the annual *National Ambulatory Care Satisfaction Survey*: "How long after the time when your appointment was scheduled to begin did you wait to be seen?"

Patients who know there is one provider or team in charge of their care — Over the last several years, VA has implemented universal primary care for its patients. Primary care may be defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing sustained partnerships with patients, and practicing within the context of family and community. This measure is one indicator of how successful VA has been in this effort. It is based on a single question in the annual *National Ambulatory Care Satisfaction Survey*: "Is there one provider or team in charge of your VA care?" When VA began the conversion to primary care, the answer to this question was used as a proxy for the existence of primary care, i.e., a "yes" answer was interpreted as "Yes, I am in Primary Care." The total "yes" answers were then used to compute the number of patients enrolled in primary care.

Patients who use tobacco products — Smoking remains the single greatest cause of preventable disease in the United States. It is estimated that 34 percent of veterans smoke. The smoking program in VHA's Office of Public Health and Environmental Hazards and the National Center for Health Promotion and Disease Prevention are responsible for policy development relating to smoking by patients, employees, and visitors at VA facilities. Activities revolve around developing and disseminating clinical guidelines for smoking cessation, and implementing a joint VA-DoD National Smoking Cessation Program. Data obtained through a random sample of the records of patients seen at least three times in a year at one of eight ambulatory care clinics are used to assess the effectiveness of the program.

Patients with terminal diagnoses or advanced, progressive, incurable illnesses receiving ongoing care through VA who have a documented individualized plan for palliative care services — Palliative care refers to the comprehensive management of the physical, psychological, social, spiritual, and existential needs of inpatients with advanced, progressive, incurable illnesses. Palliative care affirms life and regards dying as a natural process that is profoundly personal for the individual and family. The goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity, while remaining sensitive to personal, cultural, and religious values.

Prevention Index (PI) — The index consists of eight medical interventions that measure how well VA follows nationally recognized primary prevention and early detection recommendations for eight diseases or health factors that significantly determine health outcomes. Data contained in the prevention index are estimates of the average percentages of patients receiving appropriate medical interventions for these diseases and health factors.

Disease/Health Factor	Medical Intervention
Influenza	Influenza vaccination
Pneumococcal pneumonia	Pneumococcal vaccination
Tobacco consumption	Tobacco use screening
Alcohol abuse	Alcohol use screening
Breast cancer	Mammography
Cervical cancer	Cervical cancer screening
Colorectal cancer	Colorectal cancer screening
Prostate cancer	Prostate cancer screening education

Unique patients treated — The total number of individual patients who use health care services provided by, or funded by, VA in a given one-year period. This figure is obtained through a count of unduplicated social security numbers.

VA-managed Federal Coordinating Centers that complete at least one National Disaster Medical System (NDMS) casualty reception exercise every three years — Since disasters are commonplace in today's world, prompt, coordinated response and relief efforts are necessary to reduce morbidity and mortality. As a large integrated health care system with a presence in every state, VA operates a national emergency management program that includes NDMS Federal Coordinating Centers strategically located throughout the country. Emergency preparedness drills and related activities test the effectiveness of existing training programs and capabilities, and keep skills honed for real-life emergency events. This measure provides the percent of VA-managed NDMS Federal Coordinating Centers that complete at least one casualty reception exercise every three years.

VHA employees receiving necessary level of education time and other learning experience time — The quality of VHA's service depends on a workforce that understands, believes in, and fulfills the organization's mission and goals. As work processes and organizational needs change, there will be a demand for more multi-skilled individuals who will work in new environments, such as teams; rewards will be linked directly to performance measures and organizational goals. Therefore, VHA owes its employees the opportunities to upgrade professional skills and to work in an environment that encourages success. This measure indicates the percent of permanent VHA employees who meet or exceed the minimum number of hours spent in educational activities or other learning experiences.

Special Emphasis Programs

Average number of months in which the veteran received VA mental health services during the six months after the first post-traumatic stress disorder (PTSD) visit — PTSD is an anxiety disorder that can occur following the experience or witnessing of life-threatening events, such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults such as rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can be severe enough and last long enough to significantly impair the person's daily life. Common PTSD stressors in veterans include war zone stress (e.g., combat and exposure to mass casualty situations), the crash of a military aircraft, or sexual assault. VA is committed to providing an integrated, comprehensive, and cost-effective continuum of care for veterans with PTSD, including early identification and intervention; assessment, triage, and referral; acute stabilization and intervention (hospitalization, if necessary); treatment and rehabilitation on an outpatient or residential basis; and other medically indicated outpatient care. This performance measure indicates the average number of months in which PTSD patients with two outpatient visits received follow-up services in the six months following the second outpatient visit. Once a unique patient with two visits is identified, the number of months during the following six-month period in which the patient makes one or more visits is calculated. Each month with one or more visits is counted as one month with a follow-up. The denominator is the number of PTSD patients with at least two outpatient encounters. The numerator is the number of months each unique patient received care for the next six months after two visits.

Cervical cancer screening examination rate among appropriate and consenting women veterans — The proportion of female veterans age 65 and younger (who have not had a hysterectomy) with documentation of a cervical cancer screening in the past 3 years. This is one of the medical interventions measured by the prevention index.

Diabetic patients, at risk for foot amputations, who are referred to a foot care specialist — The goal of the National Diabetes Education Program is to reduce the suffering and death resulting from complications related to diabetes. This is accomplished through programs that increase public and health-professional awareness of the seriousness of diabetes and the importance of proper treatment. Proper care and management of diabetes can prevent or control complications. Early identification and appropriate preventive measures are critical to the preservation of "at-risk" limbs in the diabetic population. VA provides a model of at-risk limb care, known as Preservation-Amputation Care and Treatment (PACT). This program expands the scope of care and treatment by providing preventive measures designed to reduce the incidence of primary and secondary complications due to diabetic foot ulcers and amputations. The PACT program coordinates the efforts of surgeons, rehabilitation physicians, nurses, podiatrists, and therapists with the services of social-work, primary-care-medicine, and prosthetic/ orthotic-personnel. This performance measure addresses the success rate achieved by primary care clinicians in identifying diabetic patients with foot care problems and referring them to a foot care specialist for further evaluation and preventive care.

Health care providers or stakeholders who have received primary care education/training on former prisoners of war (POW) — One goal of the former POW program is to promote compassionate treatment of these veterans by ensuring they are treated by health care providers who are familiar with their special needs. The training provided in former POW issues includes information about presumptive disabilities, their symptoms and treatment, the special emotional and personality qualities of individuals who have been held for some time as prisoners of war, and the need to work closely with VBA in assisting with compensation and pension issues. This performance measure indicates achievement in providing primary care providers and stakeholders with the proper training.

Homeless patients with mental illness who receive a follow-up mental health outpatient visit, admission to a Compensated Work Therapy/Transitional Residence (CWT/TR) or admission to a Psychiatric Residential Rehabilitation Treatment Program (PRRTP) within 30 days of discharge — Operating one of the largest mental health programs in the country, VA provides state-of-the-art diagnosis and treatment to improve the mental and physical functioning of veterans in need of mental health treatment. Care is provided across a broad continuum of inpatient, partial-hospitalization, outpatient, and community facilities. This performance measure tracks the percent of homeless patients with mental health disorders who received follow-up outpatient care related to mental health, admission to a CWT/TR, or admission to a PRRTP within 30 days following discharge from Domiciliary Care for Homeless Veterans (DCHV) or Health Care for Homeless Veterans (HCHV) contract care (see page 124 on the DCHV and HCHV programs).

Mammography examination rate among appropriate and consenting women veterans — The proportion of female veterans age 50-69 who have documentation in their medical records of receiving a mammography examination in the past two years. This is one of the medical interventions measured by the prevention index.

Medical facilities that have at least one clinician trained in primary care for Gulf War veterans — Between August 1990 and March 1991, the United States deployed 697,000 troops to the Persian Gulf to liberate Kuwait from Iraqi occupation. Since the Gulf War, several thousand veterans have complained of illnesses that have not been readily explained. The most commonly reported unexplained complaints have been chronic fatigue, skin rash, headache, arthralgias, myalgias, difficulty concentrating, forgetfulness, and irritability. These symptoms have not been localized to any one-organ system, and there has been no consistent physical sign or laboratory abnormality that indicates a single specific disease. Because of these unexplained illnesses, the Departments of Veterans Affairs, Defense, and Health and Human Services have organized comprehensive clinical and research efforts to provide care for veterans and to evaluate their medical problems. This performance measure tracks the progress in VHA's effort to ensure all VA medical facilities have at least one clinician who is trained in primary care for Gulf War veterans and who will be able to respond to the needs of that population.

Number of homeless veterans treated in the VA health care system — The mission of the Homeless Veterans Treatment and Assistance Program is to address the causes and effects of homelessness among veterans. VA accomplishes this in two ways: providing direct services, such as outreach, case management, residential treatment, therapeutic work opportunities, and assistance with permanent housing for homeless veterans and veterans at risk for homelessness; and coordinating the provision of care with Federal, state, and local agencies, community non-profit organizations, and private entities. VA is the only Federal agency that offers substantial hands-on assistance directly to homeless persons. This performance measure is an indicator of VHA's efforts to identify veterans diagnosed as homeless during any mental health encounter and to treat them within the VA health care system.

Patients queried on the National Blind Rehabilitation Customer Satisfaction Survey who are satisfied or completely satisfied — VA has been committed to providing comprehensive rehabilitation services to America's blinded veterans since the late 1940s and has been an international leader in the rehabilitation of the blind. The Blind Rehabilitation Service improves the quality of life for blind veterans by assisting them to develop the skills and capabilities needed to attain personal independence and emotional stability. The annual *National Blind Rehabilitation Patient Satisfaction Survey* is the patient's personal evaluation of satisfaction with the services or care received in the inpatient setting. This measure is derived from the responses to the following question on the survey: "How would you rate your overall satisfaction with the blind rehabilitation program?" Since FY 1997, 98 percent of blind veterans responding to the survey have indicated they were either "satisfied" or "completely satisfied" with the inpatient blind rehabilitation program.

Patients seen in specialized substance abuse treatment settings who have an initial Addiction Severity Index (ASI) and six month follow-up — The ASI is a semi-structured interview designed to address seven potential problem areas in substance-abuse patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. By providing an overview of problems related to substance abuse, the ASI can be used effectively to explore problems within any adult group of individuals who report substance abuse as their major problem. The ASI provides two scores: severity ratings, which are subjective ratings of the client's need for treatment and are derived by the interviewer; and composite scores, which are measures of problem severity during the prior 30 days and are calculated by a computerized scoring program. The ASI has been used

extensively for treatment planning and outcome evaluation. VA administers an initial ASI on admission of a patient to a specialized addiction treatment program and a six-month follow-up ASI on current or past patients to determine their current functioning. Exceptions are patients lost to follow-up after attempts to locate them or patients who refuse to complete an initial or follow-up ASI. The central database is then used to compare the functioning of patients in specialized programs at baseline and the six-month follow-up. The goal is to increase the percentage of patients who show improvement at the six-month ASI over the initial ASI.

Proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings — This measure is the percentage of SCI inpatient veterans who are discharged to non-institutional community living locations from a VA SCI bed section. Excluded from the count are patients with irregular discharges, patients transferred in from institutional care, and patients who have died. Non-institutional community living locations do not include a different hospital, nursing home care unit, state home, domiciliary, or penal institution.

Rate of prophylaxis for human immunodeficiency virus (HIV)-related, opportunistic infections — Because of their compromised immune systems, HIV-infected patients have an increased susceptibility to opportunistic infections. Since AIDS was first recognized nearly 20 years ago, remarkable progress has been made in improving the quality and duration of survival for HIV-infected persons. During the first decade of the epidemic, this improvement occurred because of better recognition of opportunistic disease processes, better therapy for acute and chronic complications, and the introduction of chemoprophylaxis against Pneumocystis carinii pneumonia (PCP), toxoplasmosis, Mycobacterium avium complex disease, and bacterial infections. In recent years, the clinical improvements of patients receiving highly active anti-retroviral therapy (HAART) have allowed discontinuation of previously required opportunistic infection prophylaxis. Due to the success of HAART in improving immune function, the rate of prophylaxis declined from 65 percent in FY 1999 to 61 percent in FY 2000. The VA National HIV Registry tracks HIV-infected patients through various stages of the disease, reports on the inpatient and outpatient medical care provided to veterans for whom care is indicated (in accordance with national guidelines), records diagnoses for opportunistic infections (including PCP), and extracts outpatient pharmacy data. The pharmacy data are used for comparing the rates of prophylaxis against PCP.

Spinal cord injury respondents to the National Performance Data Feedback Center who rate their care as "very good" or "excellent" — The Spinal Cord Injury and Disorders (SCI&D) program assists veterans with SCI&D to develop the capacities needed to maintain independence, health, and well-being. To accomplish this, the SCI&D program provides rehabilitation, preventive care, sustaining care, and extended care across a continuum. This measure indicates VA's ability to maintain a viable spinal cord injury system providing health care that will receive positive patient evaluations.

Traumatic brain injury patients discharged to a community setting — The Traumatic Brain Injury (TBI) Network of Care provides case-managed, comprehensive, specialized TBI rehabilitation, spanning the period from the acute surgical treatment unit until permanent living arrangements can be made. Arrangements are made at the highest independent living level and are confirmed through follow-up. This measure indicates our level of success in increasing the percentage of patients discharged to the community following inpatient rehabilitation.

Veterans currently enrolled in the National Post-Traumatic Stress Disorder (PTSD) Outcomes Monitoring System who were successfully followed-up by the fourth month after discharge — Patients enrolled in the National PTSD Outcomes Monitoring System are those registered with VHA's Mental Health and Behavioral Sciences Strategic Health Care Group and admitted to the following specialized intensive PTSD programs: Evaluation Brief Treatment PTSD unit, Specialized Inpatient PTSD program, PTSD Residential program, or a PTSD Day Hospital program. Patients with successful follow-ups are those who have completed a follow-up assessment form, as required for the outcome-monitoring program. This measure scores the percentage of all patients discharged from a registered specialized PTSD program who have completed a four-month follow-up form.

Veterans using Vet Centers who report being satisfied with services and saying they would recommend the Vet Center to other veterans — Since 1979, VA has provided counseling services to assist veterans in readjusting to civilian life through a nationwide system of 206 community-based counseling facilities known as Vet Centers. The Vet Centers were the first VA service program to treat PTSD systematically in returning war veterans. Vet Centers now provide, in a non-hospital community setting, a variety of social services, extensive community outreach and referral activities, psychological assessment, psychological counseling for war-related experiences (including PTSD) and sexual trauma, and family counseling when needed. Initially restricted to Vietnam veterans, current law has extended eligibility for Vet Center services to any veteran who has served in the military in a theater of combat operations or in any area where armed hostility was occurring at the time of the veteran's service. This performance measure tracks the percentage of veterans who respond on the *Vet Center Veteran Satisfaction Survey* that they are satisfied with services and would recommend the Vet Center to other veterans.

Veterans who obtained employment upon discharge from a Domiciliary Care for Homeless Veterans (DCHV) program or a community-based contract residential care program — VA administers two special programs for homeless veterans: the Domiciliary Care for Homeless Veterans (DCHV) program and the Health Care for Homeless Veterans (HCHV) program. These programs provide outreach, psychosocial assessments, referrals, residential treatments, and follow-up case management to homeless veterans. The denominator for the homeless/independent living and homeless/ employment measures includes all veterans discharged from DCHV programs or HCHV community-based residential treatment programs. The homeless/independent living measure tracks the percentage of these veterans who are discharged directly to independent living in the community. Independent living is defined as residence in one's own apartment, rooms, or house. The homeless/employment measure tracks the percentage of discharged veterans who obtain full-time employment, part-time employment, or therapeutic work opportunities in Veterans Industries at discharge.

Veterans who acquired independent living arrangements at discharge from a Domiciliary Care for Homeless Veterans (DCHV) program or a community-based contract residential care program — *See the previous definition.*

Medical Education

Residents trained in primary care (Category I) — Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. It consists of intake, initial assessment, health promotion, disease prevention, emergency services, management of acute and chronic conditions, medical referrals (for specialty, rehabilitation, and other levels of care), follow-up, overall care management, and patient and caregiver education. For several years, VA has been working toward redirecting educational resources to primary care, realigning the academic training program, and updating the curriculum to reflect a greater emphasis on primary care. This measure demonstrates, in part, the extent to which VA's education mission has been reengineered to support the overall goal of providing universal primary care to veterans.

Medical Research

Funded research projects in Designated Research Areas (DRA) relevant to VA's health care mission — While all VA research and development is relevant to veterans and their health, VHA's Office of Research and Development has identified certain areas as primary research targets because of their prevalence in the veteran patient population. These DRAs are aging, chronic disease, mental illness, substance abuse, sensory loss, trauma-related impairment, health systems, special populations, and military occupational and environmental exposures. This measure tracks the percent of the total number of research projects whose subject matter places them in one or more of the DRAs.

Funded research projects reviewed by appropriate peers and selected through a merit-based competitive process — VHA's Office of Research and Development uses peer review as the basis for all research funding decisions. Peer review consists of a rigorous evaluation by a multidisciplinary group of experts, from inside and outside VA, to ensure the scientific and technical merit of individual research projects and the integrity of VA's research programs. Virtually all research projects undergo the peer review process for scientific merit before being funded. This measure tracks the percentage of the total number of projects funded that have undergone peer review.

Compensation and Pension (C&P)

Abandoned call rate — Nationwide, the percentage of call attempts for which the caller gets through, but hangs up before talking to a VA representative.

Average days to process rating-related actions — Elapsed time, in days, from receipt of a claim in the regional office to closure of the case by issuing a decision by a regional office. Rating-related actions include the following types of claims: original compensation, original disability pension, original dependency and indemnity compensation (DIC), reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization.

Average days to process non-rating actions — Elapsed time, in days, from receipt of a claim in the regional office to closure of the case by issuing a decision by a regional office. Non-rating actions

include the following types of claims: original death pension, dependency issues, income issues, income verification matches, income verification reports, burial and plot allowances, claims for accrued benefits, and special eligibility determinations.

Blocked call rate — Nationwide, the percentage of call attempts for which callers receive a busy signal because all circuits were in use.

Fiduciary activities — Nationwide, the percentage of fiduciary initial appointments that require more than 45 days to complete.

National accuracy rate (authorization work) — Nationwide, the percentage of original death pension claims, dependency issues, income issues, income verification matches, income verification reports, burial and plot allowances, claims for accrued benefits, and special eligibility determinations completed and determined to be technically accurate. The accuracy rate for the Nation is a compilation of the C&P Service review results for the nine Service Delivery Networks (SDNs).

National accuracy rate for core rating work — Nationwide, the percentage of original compensation, disability pension, death pension, and DIC claims; reopened compensation and pension claims; and appellate actions completed and determined to be technically accurate. The accuracy rate for the Nation is a compilation of the C&P Service review results for the nine SDNs weighted to reflect their relative share of national workload.

National accuracy rate (fiduciary work) — Nationwide, the percentage of field examinations and account audits completed and determined to be technically accurate. The accuracy rate for the Nation is a compilation of the C&P Service review results for the nine SDNs.

Non-rating actions - average days pending — Elapsed time, in days, from date of receipt of a claim (for which work has not been completed) in the regional office to current date. Non-rating actions include the following types of claims: original death pension, dependency issues, income issues, income verification matches, income verification reports, burial and plot allowances, claims for accrued benefits, and special eligibility determinations.

Overall satisfaction — This is an index of answers from the annual customer satisfaction survey. The survey assesses the level of satisfaction veterans had with the way their claim was handled by VA.

Rating-related actions - average days pending — Elapsed time, in days, from date of receipt of a claim (for which work has not been completed) in the regional office to current date. Rating actions include the following types of claims: original compensation, original disability pension, DIC, reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization.

Education

Abandoned call rate — Nationwide, the percentage of call attempts for which the caller gets through, but hangs up before talking to a VA representative.

Administrative cost per trainee — The average annual cost, including direct labor and overhead, to serve an education beneficiary.

Average days to complete education claims — Elapsed time, in days, from receipt of a claim in the regional office to closure of the case by issuing a decision.

Blocked call rate — Nationwide, the percentage of call attempts for which callers receive a busy signal because all circuits were in use.

Compliance survey completion rate — The percentage of compliance surveys completed, compared with the number of surveys scheduled at the beginning of the fiscal year.

Customer satisfaction — Nationally, the percentage of respondents to the education customer satisfaction survey who rated their interactions with VA as "very satisfied" or "somewhat satisfied."

Job satisfaction — The overall level of job satisfaction, on a 5-point scale, expressed by education employees.

Montgomery GI Bill usage rate — The percent of eligible veterans who have ever used their earned benefits.

Payment accuracy rate — Measures how well decisions reflect payment at the proper rate for the correct period of time.

Vocational Rehabilitation and Employment (VR&E)

Accuracy of decisions (entitlement) — Percent of entitlement determinations completed accurately. Accuracy is determined through case reviews.

Accuracy of decisions (fiscal) — Percent of vendor fiscal transactions and subsistence award transactions that are accurate and consistent with laws and regulations. The measure, calculated by determining the number of completed cases reviewed that were correct compared to the total number of cases reviewed, is expressed as a ratio.

Accuracy of decisions (services) — Percent of cases completed accurately of veterans who receive Chapter 31 (disabled veterans receiving vocational rehabilitation services) services and/or educational/ vocational counseling benefits under several other benefit chapters. Accuracy of service delivery is expressed as a percent of the highest possible score (100) on cases reviewed.

Customer satisfaction — Percent of veterans who answered "very satisfied" or "somewhat satisfied" when asked about their level of overall satisfaction with VR&E services.

Employment timeliness in average days — The average number of days taken from the date the veteran begins Employment Services (job ready) to the date the veteran enters suitable employment.

Rehabilitation rate — The percentage of veterans who acquuire and maintain suitable employment and leave the program, compared to the total number leaving the program. For veterans with disabilities that make employment infeasible, VR&E seeks to assist them to become independent in their daily living.

Serious Employment Handicap (SEH) rehabilitation rate — Proportion of all veterans with an SEH who are rehabilitated, compared to all veterans with an SEH who exit a program of services (discontinued or rehabilitated) during the fiscal year. These veterans are also included in the rehabilitation rate. The SEH rehabilitation rate provides additional credit for success in rehabilitating veterans with serious employment handicaps. VR&E Service is targeting veterans with SEH for increased attention and services.

Speed of entitlement decisions — Average number of days from the time the application is received until the veteran is notified of the entitlement decision.

Housing

Administrative cost per default — The average administrative costs of all defaults processed.

Administrative cost per loan — Administrative unit cost for each guaranty issued, including direct labor, indirect labor, and non-payroll costs.

Average days to issue certificates of reasonable value — The average number of days for VA to issue value determinations on properties to be purchased with a guaranteed loan.

Foreclosure avoidance through servicing (FATS) ratio — Measures the effectiveness of VA supplemental servicing of defaulted guaranteed loans. The ratio measures the extent to which foreclosures would have been greater had VA not pursued alternatives to foreclosure.

Property holding time (months) — The average number of months from date of custody of a property to the date of sale of a property acquired due to defaults on VA-guaranteed loans.

Return on sale — The national average on the return on investment (percentage) on properties sold that were acquired due to defaults on a VA-guaranteed loan. It is the amount received for the property (selling price) divided by the acquisition cost and all subsequent expenditures for improvements, operating, management, and sales expenses.

Statistical quality index — A quality index that reflects the number of correct actions found in Statistical Quality Control reviews, measured as a percentage of total actions reviewed.

Insurance

Average days to process insurance disbursements — The weighted composite average processing days for all disbursements, including death claims and applications for policy loans and cash surrenders.

Average hold time in seconds — The average length of time (in seconds) that a caller using the toll-free service number waits before being connected to an insurance representative.

Cost per death award — The average cost of processing a death claim, including appropriate support costs.

Cost per policy maintained — The average cost of maintaining an insurance policy, including all appropriate support costs.

Cumulative number of computer-based training modules completed — The number of insurance training modules computerized.

Employee satisfaction — The Insurance Service uses the national *One VA* survey for the purpose of measuring employee satisfaction. The survey, consisting of 100 questions, uses a 5-point scale to measure satisfaction. We include the top three categories as a favorable measure.

High customer ratings — The percent of insurance customers who rate different aspects of insurance services in the highest two categories, based on a 5-point scale, using data from the insurance customer survey.

Low customer ratings — The percent of insurance customers who rate different aspects of insurance services in the lowest two categories, based on a 5-point scale, using data from the insurance customer survey.

Percent of insurance disbursements paid accurately — The weighted composite accuracy rate for all disbursements, including death claims, policy loans, and cash surrenders.

Percentage of blocked calls — The percentage of call attempts for which callers receive a busy signal because all circuits were in use for the insurance toll-free service number.

Burial

Cumulative number of kiosks installed at national cemeteries — The total number of kiosks installed at national cemeteries to provide automated gravesite locator information. These kiosks also provide information regarding NCA services, such as eligibility requirements, Presidential Memorial Certificates, floral regulations, and other information about the cemetery.

Headstones and markers that are undamaged and correctly inscribed — This percentage represents the number of headstones and markers that are undamaged and correctly inscribed, divided by the number of headstones and markers ordered.

Individual headstone and marker orders transmitted electronically to contractors — The percent of individual headstone and marker orders that were transmitted to contractors via communication software or Internet e-mail.

Monuments ordered on-line by other federal and state veterans cemeteries using AMAS-R — The percentage represents the number of headstones and markers ordered through NCA's Automated

Monument Application System-Redesign (AMAS-R) by other federal (e.g., Arlington National Cemetery) and state veterans cemeteries, divided by the total number of headstones and markers ordered by other federal and state veterans cemeteries.

Presidential Memorial Certificates that are accurately inscribed — A Presidential Memorial Certificate (PMC) conveys to the family of the veteran the gratitude of the Nation for the veteran's service. To convey this gratitude, each certificate must be accurately inscribed. This measure represents the number of PMCs initially sent to the families of deceased veterans that are accurately inscribed, divided by the number of PMCs issued.

Respondents who rate cemetery appearance as excellent — NCA periodically obtains feedback from the families of individuals who are interred in national cemeteries, and from other visitors, to judge how the public perceives the appearance of the cemeteries. The measure for cemetery appearance is the percentage of respondents who rate the appearance of the cemetery as "excellent." Respondents are asked to rate the appearance of cemetery grounds, headstones and markers, gravesites, and facilities. Cemetery appearance is considered the average of excellent scores in each of the four areas rated.

Respondents who rate the quality of service provided by the national cemeteries as excellent — NCA periodically obtains feedback from the families of individuals who are interred in national cemeteries, and from other visitors, to judge how the public perceives the service provided. The measure for quality of service is the percentage of respondents who rate the quality of interaction with cemetery staff as "excellent."

Veteran population served by the existence of a burial option within a reasonable distance of place of residence — Burial option includes national cemeteries or state veterans cemeteries with space for first interments, whether full-casket or cremain, or both, either in-ground or in columbaria. Reasonable distance means, in most cases, 75 miles; however, for certain sites where historical data exist to demonstrate substantial usage from a greater distance, reasonable distance is defined as that greater distance.

Veterans served by a burial option in a state veterans cemetery — The number of veterans with reasonable access to a state veterans cemetery with space for first interments, whether full-casket or cremain or both, either in-ground or in columbaria. Reasonable access means, in most cases, within 75 miles of the veteran's place of residence.

Board of Veterans' Appeals (BVA)

Appeals decided per FTE — A basic measure of efficiency determined by dividing the number of appeals decided by the total BVA full-time equivalent staff.

Appeals resolution time (in days) — The average length of time the Department takes to process an appeal, from the date a claimant files a Notice of Disagreement until a case is resolved, including resolution at a regional office or by a final decision by the Board.

BVA response time (in days) — A future-oriented timeliness indicator that, based upon BVA's appellate processing rate of the immediately preceding one-year time frame, projects the time BVA will take to decide a new appeal added to its docket.

Cost per appeals case — A unit decision cost derived by dividing BVA's total obligational authority by the number of decisions.

Decisions containing quality deficiencies — This goal is based on a random sampling of approximately 5 percent of Board decisions. Decisions are checked for deficiencies in the following categories: identification of issues, findings of fact, conclusions of law, reasons and bases (or rationale) for preliminary orders, due process, and format.

Remand rate from CAVC to BVA — Percent of decisions entered by the United States Court of Appeals for Veterans Claims (CAVC) that are remanded (returned) to the Board of Veterans' Appeals.

Departmental Management

Contract disputes electing ADR — The percent of contract dispute matters electing to use Alternate Dispute Resolution (ADR) techniques. ADR techniques refer generally to several formal and informal processes for resolving disputes that do not entail courtroom litigation.

Franchise Fund — VA's fund is comprised of six Enterprise Centers that competitively sell common administrative services and products throughout the Federal Government. The Centers' operations are funded solely on a fee-for-service basis. Full cost recovery ensures they are self-sustaining.

Increase in purchases made using EDI from FY 1997 baseline — The percent increase in the number of line items ordered through Electronic Data Interchange (EDI) by fiscal year.

Number of national standardized contracts for medical and other related products and services — National standardized contracts for medical and other related products and services support the VA policy to standardize, to the maximum extent possible, the types of supplies and equipment purchased, consistent with clinical and practitioner needs. These national standardized contracts are for families of items that facilitate best-value product pricing through volume purchasing, and facilitate the delivery of high-quality health care. The number of these contracts is an indicator of our success in the ongoing standardization process.

Program evaluation — An assessment, through objective measurement and systematic analysis, of the manner and extent to which Federal programs achieve intended outcomes.

Office of Inspector General

Indictments, convictions, and administrative sanctions — The results of criminal and administrative investigations conducted in response to allegations or proactive initiatives.

Reports issued — Audit, contract review, and health care inspection documents that reflect independent and objective assessments of key operations and programs at VA facilities nationwide. These reports include recommendations for corrective action, cost savings, and/or programmatic improvement of the activities under review.

Value of monetary benefits from IG audits — A quantification of funds that could be used more efficiently if management took actions to complete recommendations pertaining to deobligating funds, costs not incurred by implementing recommended improvements, and other savings identified in audit reports.

Value of monetary benefits from IG contract reviews — The sum of the questioned and unsupported costs, identified in pre-award contract reviews, that the IG recommends be disallowed in negotiations unless additional evidence supporting the costs is provided.

Value of monetary benefits from IG investigations — Includes court fines, penalties, restitution, civil judgments, and investigative recoveries and savings.