Department of Veterans Affairs

Office of Inspector General

AUDIT OF VETERANS INTEGRATED SERVICE NETWORK (VISN 10) ORGANIZATION, PLANNING, AND IMPLEMENTATION OF KEY STRATEGIC GOALS AND OBJECTIVES

Integration of the VISN 10 facility management structure is proceeding in accordance with the Under Secretary for Health's overall reorganization plan. Weaknesses in VHA's patient enrollment process, workload reporting systems, and resulting future resource allocations may adversely affect some of these efforts.

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Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
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Memorandum to the Director, Veterans Healthcare Network of Ohio (10N10)

Audit of Veterans Integrated Service Network (VISN 10) Organization, Planning, and Implementation of Key Strategic Goals and Objectives

1. The purpose of the audit was to assess the Veterans Healthcare Network of Ohio's implementation of the Veterans Health Administration's (VHA) overall reorganization plan, and to examine details of the implementation of three of VHA's most significant strategic goals and objectives. These strategic goals include: (1) decreasing the costs per patient treated, (2) increasing revenues from non-appropriated sources, and (3) increasing the number of veterans who have access to VA healthcare services.

2. The Veterans Healthcare Network of Ohio was formally established in 1996 by the Under Secretary for Health (USH) as part of a nationwide reorganization of VHA's field management structure. The Ohio Network (also known organizationally as VISN 10), includes 5 major medical facilities, and a growing number of smaller community based clinics. VISN 10 has an annual operating budget of over $550 million and employs approximately 6,500 employees. The Network provides a comprehensive range of healthcare services in its assigned geographic area (the vast majority of Ohio and portions of northern Kentucky and southeastern Indiana), which includes a veteran population of approximately 1.1 million.

3. The VISN 10 management team was effectively implementing the USH's reorganization plan. Network-wide controls had been established over the medical centers by establishing and restructuring a broad range of councils, task forces, and committees focused on Network integration issues. A "Service Line" management structure was implemented as an alternative to facility integrations. Under this structure, a total of six service lines, each headed by a physician or a Ph.D., will have budget and policy control over their designated clinical areas. Facility directors will become "site managers" with a "core" budget to cover administrative and building maintenance costs. Site managers will then negotiate with service line directors for the clinical component of their budget. Network strategies were

developed addressing the accomplishment of VHA's overall mission goals and strategic targets. The Network's efforts to reduce the costs per patient treated have been substantial. The primary focus of these efforts was the shifting of care from an inpatient to outpatient setting. Good results were achieved in reducing inpatient bed capacity and acute bed days of care per patient treated. Ambulatory care resources were increased substantially through the opening of community clinics throughout the state of Ohio. In addition, we found significant emphasis on individual cost savings initiatives focusing on consolidations of administrative and ancillary support activities and on the acquisition of new technologies to reduce clinical costs. The underutilization of some facilities was being addressed through mission realignments and the search for alternative uses of existing physical plant assets. Efforts to increase funding from sources other than Federal appropriations have included the hiring of a Network Revenue Coordinator who is responsible for increasing third party revenues, and the designation of a Network Revenue Team to develop and implement short and long range operational efficiencies as well as revenue enhancement.

4. Efforts to increase veteran access to VA healthcare are proving effective. However, Network management needs to ensure that weaknesses in VHA's overall patient enrollment, reporting systems, and resource allocation do not adversely affect these efforts. VHA's patient enrollment process did not include some eligible veterans who had applied for care at the Network's facilities; and by not including all countable VISN workload, the Network was at risk of loosing the opportunity for as much as $35.2 million in future annual funding.

5. The report contains recommendations to strengthen VISN 10's patient enrollment process and reporting of patient workload data used in the distribution of resources. The Network Director concurred with the audit recommendations and provided appropriate implementation actions. The Network Director has already initiated actions to strengthen the Network's data collection systems. These actions include establishment of a Network Corporate Data Management Board and conduct of various audits and staff training in current coding practices. The Network Director is also participating on a VHA Task Force to identify data elements that will be used to monitor the enrollment process nationwide. In addition to these actions, the Allocation Resource Center (ARC) has also taken action to correct national data system information that was discovered to be flawed. This situation contributed to the exclusion of fundable VISN 10 workload from Veterans Equitable Resource Allocation (VERA) system calculations that we identified during the audit. While the Network Director did not comment on the monetary benefits presented in the report, we believe that our statistical sample

results fairly presents the potential funding impact to the Network based on the countable patient workload that we had identified was excluded from VERA calculations. Given the significance to the Department of assuring accurate and complete data input for the new patient enrollment process and annual Network VERA budget allocations, we plan to complete additional work in these areas in future VISN audits. We consider the report issues resolved and will follow up on planned actions until they are completed.

For the Assistant Inspector General for Auditing

(Original signed by:)
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INTRODUCTION

In March 1995, the Under Secretary for Health (USH) set forth a field reorganization plan, *Vision for Change*, for the Veterans Health Administration (VHA). The plan was intended to: (1) increase access to care, (2) emphasize primary care, (3) decentralize decision making, and (4) integrate delivery assets to provide an interdependent, interlocking system of care. The structural vehicle for accomplishing these goals was the Veterans Integrated Service Network (VISN). Under this strategy, "the basic budgetary and planning unit of the VA healthcare delivery system shifts from individual medical centers to integrated service networks for populations of veterans living within defined geographical areas. The hospital remains an important, but less central component of a larger, more coordinated community based network of care." Emphasis is placed on providing a continuum of care by integrating ambulatory, acute, and extended inpatient services. The geographic boundaries of the twenty two VISNs were established nationwide in October 1995 based on "…patient referral patterns, aggregate numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders."

Eligibility Reform: The following year (1996) Congress enacted the Veterans Healthcare Eligibility Reform Act. This law included, among other requirements, the following provisions: (1) elimination of previous differences between inpatient and outpatient eligibility rules, (2) authority for VHA to provide preventive and primary care services, and (3) a requirement for VHA to implement a patient enrollment system to manage access according to a priority listing provided in the law.

Strategic Plans: In April 1997, VHA published its national strategic plan covering Fiscal Years (FY) 1997 through 2002. These goals were incorporated into the VA Strategic Plan, which was approved by the Office of Management and Budget (OMB) and submitted to Congress in September 1997 based on the requirements of the Government Performance and Results Act (GPRA). This plan articulates VA's mission and reflects priorities that the Department believes must be addressed. For VHA, the plan describes 27 general goals, 56 supporting objectives, 100 strategies, and 235 separate performance goals and timeframes. VHA has grouped these into "Strategic Targets" referred to as "10 for 2002". (*A listing of the strategic goals is presented in Appendix III on pages 35 to 39.*)

VISN 10 Implementation Efforts: Our audit found that VISN 10 is effectively implementing the USH's reorganization plan and has developed Network strategies to accomplish VHA's overall mission goals and strategic targets. We also found that the Network's efforts to reduce the costs for patients treated have been substantial with a primary focus of shifting care from an inpatient to an outpatient setting. The VISN has also taken initiatives to increase revenues from several non-appropriated funding sources. Also, the VISN's efforts to increase the number of new patients has been successful. (*A summary of VISN 10's initiatives to reorganize, reduce costs, enhance revenue, and increase the number of new patients is presented in Appendix II on pages 15 to 33.*)

RESULTS AND RECOMMENDATIONS

1. VHA's Patient Enrollment Process Did Not Include Some Eligible Veterans in VISN 10

VISN enrollment data was not accurately included in the national patient enrollment database. Approximately 6,582 (25 percent) of the new patients seen at the VISN for the first time during the period of our audit (the first half of FY 1998) were erroneously excluded from the initial enrollment process. The underlying reason for veterans being excluded from the enrollment process was that facilities did not clearly understand how the enrollment process was accomplished and incorrectly assumed that the Health Eligibility Center (HEC) would automatically enroll new veteran patients. As a result of the exclusion of significant numbers of new patients from the enrollment process, (1) VISN operations will be adversely affected throughout the year when many veterans, believing they have been enrolled discover that they will need to re-apply for care, (2) the VISN will not be able to accurately estimate its future workload – a basic purpose of the enrollment legislation, and (3) decisions about which priority groups can be enrolled will be based on inaccurate/incomplete information.

When presented with these findings, VISN management indicated that VHA was aware of this problem and, as a result, has tasked a national work group to develop a process that will allow medical centers to validate the patient enrollment database. While we do not know what form this process will take, the VISN needs to assure that veteran enrollments are accomplished by facility personnel so they can be transmitted to the HEC's enrollment database.

Veterans Treated For the First Time at VISN 10 Facilities Were Erroneously Excluded From the Enrollment Process: VHA began implementing the patient enrollment process required by P.L. 104-262 by first developing an interim system of annual enrollment in preparation for full implementation by October 1, 1998. This system required: (1) the development and installation of local and national software, (2) a formal process to acquire eligibility information from veterans, and (3) the creation of an information system to be used to evaluate the impact of the legislation. VHA's already existing HEC was chosen to administer the enrollment database and act as central authority in determining which veterans would be enrolled and in which priority group.

To expedite the process, veterans who had been treated at a VHA facility since January 1, 1996 would not need to re-apply but would instead have an enrollment

application processed automatically. This would include all patients with visits through the period January 20 – 30, 1998 (the dates the HEC performed its extract from VHA's nationwide patient database). Subsequent to this date, facilities would enroll new patients at the time of their initial visit/registration. During the FY 1998 test period for enrollment, HEC created the initial enrollment database by a national data extract from all VHA facilities of those patients with a visit or future visit scheduled from January 1996 to late January 1998. These veterans were to have their eligibility verified and be automatically enrolled by HEC without having to apply for enrollment. Not all facilities could be downloaded on the same day and once the extract was completed new patients needed to be added to the enrollment database. Consequently on the local level, Network facilities patched new enrollment software onto their Veterans Information Systems and Technology Architecture (VISTA) to facilitate the direct electronic transmission of new patients to HEC's enrollment database.

To determine whether the enrollment process was being implemented effectively, we focused on veterans who were entered into the VISN 10 system (VISTA) for the first time from October 1997 through early March 1998 (the date of our extract from VISN 10's patient databases). Specifically, we extracted the names and Social Security Numbers (SSN) of almost 12,000 patients entered for the first time during the 5 months covered by our audit. We then selected a statistical sample of 366 of these patients and sent their names and SSN's to the HEC and asked if they were included in the nationwide enrollment database. The HEC replied that 272 (74 percent) of these were included in the enrollment database in preparation of being formally enrolled for care in one of the 7 priority groups.

On return of the data from the HEC we validated the appropriateness of those patients who were excluded from the enrollment database. We found that 4 (1 percent) of the patients were not eligible for VA healthcare and were properly excluded. However, we also found that 54 (15 percent) of the patients who were excluded from the enrollment database should have been included under existing legislative and policy requirements. An additional 36 (10 percent) could have been enrolled but were excluded. These veterans received mandated care and were not required to be enrolled, however VA strongly encourages enrolling these veterans. Projecting these results to the VISN 10 population, we estimate that 6,852 (25 percent) veterans who should have (or could have) been enrolled for VA healthcare for FY 1999 beginning October 1, 1998 will be excluded from the process. (*A summary of the statistical sample results is presented in Appendix VI on pages 59 to 62.*)

The exclusion of these veterans from the enrollment database did not follow any detectable pattern that would suggest one group of veterans is more likely to be excluded from enrollment. For example, of the 41 veterans in our sample who did not receive medical care, 25 (61 percent) were included in the enrollment databases while 16 (39 percent) were excluded. Based on conversations we had with HEC and facility staff, we believe that the underlying reason for veterans being erroneously excluded from the enrollment database was simple confusion. Some facility personnel incorrectly assumed that veterans would automatically be enrolled if they had been treated since January 1996. However, this automatic process ended when the HEC conducted its patient database extract in early 1998 subsequent to which enrollments had to be accomplished by facility personnel.

Recommendation 1

We recommend that the VISN 10 Director assure that veteran enrollments are accomplished by facility personnel so they can be transmitted to the HEC's enrollment database.

VISN 10 Director Comments

The Network Director concurred with the audit recommendation and provided acceptable implementation actions.

Implementation Plan

The Network Director stated that "A VISN 10 Corporate Data Management Board has been established to assure the accuracy and adequacy of network data collections systems. Network oversight of the enrollment processes will also occur at the Executive Leadership Council once routine reports become available from the national databases. This is currently planned for February."

(See Appendix VIII on pages 65-66 for the full text of the VISN 10 Director's comments.)

Office of Inspector General Comments

The Network Director's implementation actions are acceptable and responsive to the recommendation. Given the significance to the Department of assuring accurate and complete data input for the new patient enrollment process, we plan to complete additional work in this area in future VISN audits. We consider the

report issue resolved and will follow up on planned actions until they are completed.

The Network Director's comments also cite five factors that are presented as mitigating the potential effects of the missed enrollments on the Network's overall budget allocation under the Veterans Equitable Resource Allocation (VERA) system. Although the implementation actions for the recommendation are acceptable, we believe some additional comments addressing these factors are warranted in order to avoid the incorrect conclusion that there is no connection between the patient enrollment process and the budget allocation process.

Factor 1. "There is no direct relationship between enrollment and VERA allocation".

> **OIG Comment:** In theory, this is an accurate statement. However; in practice, over 80 percent of the new VISN 10 enrollments were accompanied by a least one visit for medical care - which in turn is directly related to the VERA allocation.

Factor 2. "Operationally, there will be a rolling enrollment process at the Network level so there should be no lasting impact to initially missed enrollees".

> **OIG Comment:** While no patient will be denied care because their initial enrollment was inadvertently lost to VA's enrollment record system, the impact could be significant (to both the VA and the veteran) if the credibility of the enrollment process is questioned.

Factor 3. "Number of enrollees has no definite relationship to number of users" and,
Factor 4. "With plans to enroll all veterans (including Category C) and newly expanded clinical benefits package (e.g., infertility, maternity, and emergency care), forecasting of FY99 workload is not yet possible due to lack of system experience".

> **OIG Comment:** One of the basic purposes of the enrollment legislation was to allow VHA to more effectively plan for, and manage access to, its health care services. As VHA gains experience with the frequency and the types of services used by enrolled veterans, there will at some point be a clearly understood relationship between the number of enrollees and the number of users.

Factor 5. System-wide VERA implementation within an overall flat global budget minimizes individual impact on the budget.

> **OIG Comment:** The statement is accurate from a VHA-wide perspective only. Congress approves an overall VHA budget which is only then divided among Networks by VERA (based on each Network's number of unique patients). As a result, under a flat budget, the greater the number of unique patients treated by VHA, the greater the reduction in funding for each patient. However, each Network competes directly with all other Networks for a larger *percentage* of the overall budget (flat or otherwise) and thus an individual patient's impact on each Network's budget is significant (ranging upwards of $36,000 per patient/per year).

2. VERA Funding Did Not Include All Countable VISN 10 Patient Workload

VISN 10 needs to establish a method to validate the funding allocations generated by the VERA system. The audit found that the VERA funding allocation system did not capture the Network's entire "new patient" workload during the first half of FY 1998. As a result, we estimate that over $35.2 million in (uncapped) funding could have been lost to the Network's medical programs in FY 2000. We believe that the VERA system failure to capture all of the fundable patient workload may be the result of changes made earlier in the year to the patient databases from which the model draws its input and that this may be an anomaly peculiar to this year. Nevertheless, because of the significant effect VERA has on funding levels for Network medical programs, and the probability that errors from different causes will continue to be made, we believe that the Network needs to take corrective and preventive action. Specifically we believe that the Network should follow up with the Allocation Resource Center (ARC) to determine why fundable patient workload was excluded from VERA calculations and ensure the ongoing integrity of patient workload and funding systems. This will help assure that the VISN's annual budget allocation will be properly calculated.

Background: VERA was created to correct funding imbalances among VA medical facilities that had developed over the years. These funding imbalances were the result of budgeting for each individual medical center based on its historical funding and adjusting for inflation and program starts. As a result of facilities not being required to justify their programs once they were activated, facilities with relatively larger funding bases received larger shares of the total dollars available – in spite of decreasing workloads and changing technologies.

In order to correct these historical funding inequities and to begin moving each Network's average cost per patient towards the national average, VHA developed the VERA system which distributes VA's $17 billion annual appropriation among the 22 VISN's initially using two patient groups. However, during the course of the audit, a third patient group was added to fund one-time users who had care/treatment in an outpatient setting only. The amount of funding provided for each patient within each group is dependent on how many patients VA treats since the total funding pool is fixed. For FY 1997 each patient within the Basic Care group was funded at about $2,600 while each patient within the Special Care group was funded at about $36,000. For the recently created third patient group the annual funding for FY 1999 is $65 for each unique patient. The calculations for

each FY use the patient workload data from 2 years prior. For example, the FY 2000 budget distribution will use FY 1998 patient workload.

The VERA model also provides incentives which support VHA's overall strategic goals including: (1) encouraging Networks to treat the greatest number of veterans, (2) encouraging Networks to treat the highest priority veterans, (3) recognizing special high cost illnesses and injuries, and (4) providing for an understandable and predictable budget process. However, in order for VERA to work correctly, the underlying patient workload data, which is first collected by each medical facility and then transmitted and processed at a national VHA data processing facility, must be accurate and complete.

The VERA System Did Not Include All of VISN 10's Countable Patient Workload That Could Have Resulted in Lost Funding For Network Operations: In order to determine whether VISN 10's new patients would be properly accounted for in the VERA funding model, we provided the names and SSNs of the 366 patients included in our sample to the ARC staff, who in turn matched these with their data to determine which patients would be included in the VERA funding model for the FY 2000 budget year.

In total, 36 (10 percent) of the new patients in our sample were captured by the VERA data system and would therefore be used to calculate the FY 2000 appropriation allocation for the VISN's activities. Our review identified 1 (2.8 percent) of these patients who could potentially be funded in error. In addition, we found that 116 (31.7 percent) of the new patients in our sample should also be included in the funding calculations for VISN 10. These consisted of 27 veterans who received mandatory care and 89 Category A veterans who received substantive care. The remaining 214 veterans/patients did not receive fundable care or received no care at all and were therefore properly excluded from the funding calculations.

Our audit results show that the potential effect of VERA's omission of countable workload on VISN 10's funding could be significant. Based on the above findings and projecting the statistical sample results to the total population of new patients for FY 1998, we estimate that in FY 2000 $35.2 million in funding for Network operations could be potentially lost. However, depending on the funding caps that VHA may choose to impose in FY 2000 to limit the amount of funds moved among Networks, the actual amount of the impact could be lower. (*A summary of the statistical sample results is presented in Appendix VI on pages 59 to 62.*)

Because of the large number of fundable patients who were omitted from VERA, we provided the complete listing of the patient names and SSN's to the Network Director for validation during the course of the audit. In the review results that were provided, the Network Director did not challenge the accuracy of the sample cases. The Director also stated support for the need for the VISN to take action to assure the VERA funding model includes all countable patient workload and properly calculates the VISN's annual budget allocation. The Director also noted that VHA had established a National Data Validation Committee to focus on the reliability and validity of VERA output.

Subsequent to the issuance of the draft report, we were advised by the ARC that it had taken action to correct national data system information that was discovered to be flawed. We were advised that this situation contributed to the exclusion of fundable VISN 10 workload from VERA system calculations that we had identified during the audit. Given the significance to the Department of assuring accurate and complete data input for annual Network VERA budget calculations, we plan to complete additional work in this area in future VISN audits.

Recommendation 2

We recommend that the VISN 10 Director coordinate with the ARC to determine why the fundable patients identified by the audit were omitted from VERA and assure that the VISN's FY 2000 budget allocation is properly calculated.

VISN 10 Director Comments

The Network Director concurred with the audit recommendation and provided acceptable implementation actions.

Implementation Plan

The Network Director's comments discussed various actions that the Network is taking to address the audit findings and recommendation. The Network Director stated that "The Network worked with the Allocation Resource Center (ARC) to validate the numbers provided in the Draft Audit Report. The ARC has provided some updated information which has captured a significant number of the omitted patients. In addition, the Network has taken steps to improve internal data collection systems. These steps include third party collection audits, medical record coding audits, training of all coders and physicians in current coding practices, the development of Network-wide standardized encounter forms, the

recruitment of a Corporate Database Manager, and the ongoing feedback of internally generated information to facilities." The Network Director also discussed various actions that are being taken at the national level to enhance the data collection process and monitor enrollment.

(See Appendix VIII on pages 65-66 for the full text of the VISN 10 Director's comments.)

Office of Inspector General Comments

The Network Director's implementation actions are acceptable and responsive to the recommendation.

In addition to the Network Director's implementation actions, the ARC has taken action to correct national data system information that was discovered to be flawed. We were advised that this situation contributed to the exclusion of fundable VISN 10 workload from VERA system calculations that we had identified during the audit. While the Network Director did not comment on the monetary benefits presented in the report, we believe that our statistical sample results fairly presents the potential funding impact to the Network based on the countable patient workload that we identified was excluded from VERA calculations. Given the significance to the Department of assuring accurate and complete data input for annual Network VERA budget calculations, we plan to complete additional work in this area in future VISN audits. We consider the report issue resolved and will follow up on planned actions until they are completed.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The purpose of the audit was to assess the Veterans Healthcare Network of Ohio's implementation of the Veterans Health Administration (VHA) field reorganization plans, and to examine details of its implementation of VHA's three most significant strategic goals and objectives:

(1). Decreasing the cost per patient treated.
(2). Increasing revenues from non-appropriated sources.
(3). Increasing the number of veterans who have access to VA healthcare services.

Scope and Methodology

The Veterans Healthcare Network of Ohio was selected for review after discussion with the Chief Network Officer who agreed that, with the exception of the Network's relatively compact and clearly defined geographic boundaries, it was fairly representative of the other 21 regional Veterans Integrated Service Networks (VISN).

In preparation for the audit, we identified relevant reports, plans, legislation, regulations, directives, and policies addressing VHA's strategic goals. We also spoke with management and operating staff at both the Central Office and Network levels, and we conducted searches of those parts of VA's intranet devoted to performance and financial data. (*A complete bibliography of the reference sources used is in Appendix IV on pages 41 to 43.*)

The fieldwork phase of the audit focused on a review of the medical and administrative records of a sample of patients registered for the first time by VISN 10 during Fiscal Year (FY) 1998. (*A summary of the statistical sample results is presented in Appendix VI on pages 59 to 62.*) We collected information on the nature of services provided to these patients and followed them through VHA's reporting systems to determine their effect on resource allocations, performance measurement goals, and the enrollment process.

Additional audit work focused on: (1) acquiring VISN-wide financial and workload information relevant to cost reduction efforts, including efforts to shift

the delivery of clinical services away from inpatient towards outpatient care, and (2) acquiring VISN-wide third party billing information, including the results of past audits conducted by the OIG.

The audit was conducted in accordance with generally accepted government auditing standards.

SUMMARY OF VISN 10's REORGANIZATION, COST REDUCTIONS, REVENUE ENHANCEMENT INITIATIVES, AND INCREASE IN NEW PATIENTS

A. VISN 10's Management Team Has Been Effective in Implementing VHA's Field Reorganization Plan.

Introduction: In March 1995, the Under Secretary for Health (USH) submitted a plan to Congress reorganizing VHA's field management structure. The plan was required under 38 USC §510(b) since it eliminated the then four regional field management offices and reassigned those personnel and functions. The purpose of the reorganization was to improve the integration of resources and service delivery by increasing the autonomy, flexibility, and accountability of field management. Specifically, the plan details the replacement of 4 regions, 33 networks, and 159 independent medical centers with 22 Veterans Integrated Service Networks (VISN) that report directly to the Office of the USH.

Each of the "new" VISN's consists of a geographic area encompassing the existing population of veteran beneficiaries. The VISN's geographic boundaries were established after a review of patient referral patterns and the types of facilities needed to provide primary, secondary, and tertiary care to the veteran population.

Conceptually, the VISN is intended to become the basic budgeting and planning unit of the veterans healthcare system with the emphasis focusing on integrating ambulatory services with acute and long term inpatient services. Specifically, each of the 22 VISN Directors' has been given authority and responsibility for the following:

(1). Ensuring that a full range of services is provided, to include specialized services and programs for disabled veterans.
(2). Developing and implementing VISN budgets.
(3). Area-wide (population-based) planning.
(4). Consolidating and/or realigning institutional functions.
(5). Maximizing effectiveness of human resources available to the VISN.
(6). Moving patients within and outside the VISN to ensure receipt of appropriate and timely care.
(7). Contracting with non-VA providers for medical and non-medical services, as needed.

(8). Maintaining cooperative relationships with other VA field entities, such as Veterans Benefits Administration (VBA) regional offices and national cemeteries.

Conclusion: VISN 10's management team is effectively implementing the Under Secretary's reorganization plan. The following sections briefly describe the various areas we addressed during the audit and the review results.

Council and Committee Structure: The VISN Director's implementation of Network-wide control over the individual medical centers and outpatient clinics was initiated by establishing and restructuring councils, task forces, and committees focused on Network integration issues. Our review of the current Network-level council and committee structure showed that a broad range of committees have been established since the March 1996 startup of the VISN 10 organization. These include a Management Advisory Committee (which, as recommended in the USH's reorganization plan, includes representatives from veterans service organizations (VSO), labor unions, state and county officials, and non-VHA officials). In addition, an Academic Leadership Council (whose functions, although largely overlapped by an existing statewide Council of Deans, are being developed as integration progresses), and an Executive Leadership Council have been established to encourage a pooling of resources and guide overall planning efforts. These 3 and the more than 50 additional Network level committees, subcommittees, task forces, and councils address a broad range of issues facing the VISN management team and represent a formalized structure assuring input from internal and external stakeholders.

Service Line Management: In addition to the Network-wide and integration-focused committee structure, VISN 10 management has begun implementing a "Service Line" management structure. VISN management considers this type of organizational structure to be a better alternative to facility integrations and will more effectively encourage Network-wide integration. This type of management structure is becoming a characteristic of most other VISNs as well. For example, service line implementation is the subject of an ongoing study by Health Services Research & Development's Management Decision & Research Center which has reported 19 of the 22 VISNs have indicated an intent to implement some form of this type of management structure.

For VISN 10, a total of six service lines are planned: (1) mental health, (2) rehabilitation care, (3) clinical support, (4) extended care, (5) primary care, and (6) medical/surgical specialty. All of the service line directors are to be physicians and will have budget and policy control over their designated clinical areas. Clinical and support staffs from each of the medical centers and outpatient clinics will be aligned to one of the service lines, with the role of facility directors changing to that of a medical site manager. Service line directors will oversee clinical service delivery throughout the Network by means of controlling and directing funds at the facility level. Medical site managers will be given a core budget to cover administrative and building maintenance costs and will then negotiate with the service line directors for the clinical (i.e., service delivery) component of their budget.

The full implementation of VISN 10's service line management structure is expected to take several years. VISN management expects that this will then be followed by slow changes in the overall culture moving away from a focus on individual clinical disciplines (and the resulting episodic care of patients) toward muti-disciplinary teams organized around the needs of individual patients.

Strategic Plans: VHA's strategic framework outlines its 5 overall mission goals and 10 strategic targets for which the 22 VISNs are responsible for implementing. VISN 10's strategic plans emphasize its service line management structure, clinical councils, Network-wide initiatives, and facility programs as the primary vehicles for implementing the means to achieve these goals and objectives.

> Improving Access to Healthcare: In order to accomplish one of the more visible and fundamental of these goals (i.e., increasing the number of veterans who use VHAs healthcare services and to improve access for current users), VISN management has developed a range of strategies. Examples include: (1) the opening (and planned future openings) of approximately 20 community based outpatient clinics (CBOC) throughout VISN 10's geographic area; (2) the extension of existing clinic hours to include evenings and weekends; (3) outreach services (state and county fairs); and (4) extending mental health services to veterans soon to be released from the custody of state corrections officials.

Reducing Costs: A second strategic goal being pursued by the VISN is to decrease its per patient costs. To do this, the VISN will need to redistribute resources from inpatient to outpatient programs by reducing bed days of care, inpatient beds, lengths of stay, etc. and then follow this with a concurrent increase in outpatient capacity.

VISN management's recognition of a need to realign existing inpatient and outpatient resources was demonstrated in their efforts to address the Chillicothe VA Medical Center's underutilized facilities. A recent VISN long-term mission review at the facility identified the need to further reduce the number of medicine beds and to review intermediate care service needs. VISN management recognizes that a long-term solution may be to transfer the facility (or significant parts of it) to the state government that has expressed an interest in establishing a state veterans home in the same geographic area.

Focusing on Primary Care: The VISN has taken a number of actions to enhance its existing Primary Care Program including: (1) establishing a Primary Care Service Line, (2) enrolling all patients with primary care teams, (3) reviewing residency allocations and making shifts from specialty to primary care slots, (4) standardizing primary care patient panel sizes across the Network, (5) establishing a standardized Provider Team composition, (6) recruiting additional physician extenders, (7) expanding primary care clinic hours, and (8) increasing Spinal Cord Injury (SCI) primary care services.

Developing and Implementing Evidence-Based Clinical Guidelines: VISN 10's primary means of addressing quality of care and accountability issues is through the use of clinical guidelines, 15 of which were implemented in FY 1997 with more to be implemented as nationally accepted standards are developed and adapted for local conditions.

In addition to clinical guidelines, performance measures addressing quality of care indicators have been developed nationally and are being emphasized by VISN management. These measures, while not as comprehensive as clinical practice guidelines, nevertheless address the extent to which clinical staff should follow nationally recognized medical interventions. For example, the chronic disease index consists of 14 medical interventions within each of 5 diagnoses. Also, for

chronic obstructive pulmonary disease one of the medical interventions which is measured is documentation in the patient's record of the observation of the use of an inhaler for patients placed on inhalers.

Developing and Improving Customer Standards, Patient Education Programs, and Stakeholder Involvement and Support: Efforts to increase the number of veterans who use VA health services is closely linked to the level of confidence that veterans have in the timeliness and quality of VA services. VHA's and VISN 10's market penetration is low for all categories of veterans (with VISN 10 being lower than average). Studies have shown that veterans have several specific concerns which need to be addressed: (1) poor coordination of care, (2) appointment delays, (3) waiting times, (4) involvement in decisions, (5) communication skills of providers, and (6) lack of courtesy. VISN 10's response has been to work on improving customer standards beginning with conducting customer surveys and planning for the implementation of a customer service program.

Other components of the effort to improve customer satisfaction include: (1) the development of patient education programs in order to improve the patients understanding of his/her healthcare, (2) the inclusion in a new "providers report card" information about customer satisfaction, (3) newsletters specifically directed towards patients, and (4) collaborating with VBA to ensure veterans have the sense that all VA services are coordinated and focused.

Promoting Research Related to Veterans Healthcare and Focusing Clinical Education on Patient Needs: One of VHA's strategic goals is to increase to 99 percent the proportion of research projects that are demonstrably related to the healthcare of veterans. To accomplish this goal, the Network began with a review of each facility's affiliation relationships in order to develop Network-wide areas where research efforts could be concentrated. Plans also include the further development of research corporations that are expected to contribute to the development of new sources for research funding.

Efforts to implement VHA's strategic goals for clinical education include plans to improve communication and customer service skills for some providers through continuing education programs. Plans also

include the development of a Network-wide assessment tool for residency and fellowship programs in order to evaluate the programs from an integrated delivery system perspective.

Establishing Career Development Services and Improving the Working Environment: Recognizing that the successful achievement of its strategic goals and objectives depends on its employees, VHA has also incorporated the goal of being an organization that employees choose to work for. VISN 10's efforts to achieve this goal includes: (1) the establishment of Network-wide career development services, (2) providing specialized training opportunities, (3) identifying and correcting safety hazards, and (4) specific initiatives to improve employee job satisfaction.

Achievement of Performance Measures: VHA's national strategic plan for FYs 1997 through 2002, *Journey of Change*, describes system-wide strategic targets that "identify and quantify the results VHA desires to achieve at the national level." The targets, referred to as "Ten for 2002," are as follows:

(1). Decrease the system-wide average cost (expenditure) per patient by 30 percent.
(2). Increase the number of users of the veterans healthcare system by 20 percent.
(3). Increase the percent of the operating budget obtained from non-appropriated sources to 10 percent of the total.
(4). Exceed by 10 percent the proportion of patients of other large healthcare providers who achieve maximal functional potential.
(5). Increase to 90 percent the proportion of patients reporting VA healthcare as very good or excellent.
(6). Increase to 90 percent the proportion of patients who rate the quality of VHA healthcare as equivalent to or better than what they would receive from others.
(7). Increase to 99 percent the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of the Department of Veterans Affairs.
(8). When asked, 95 percent of physician house staff and other trainees would rate their VA educational experience as good or superior to their other academic training.

(9). Increase to 2 percent, or 40 hours per year, the amount of an employee's paid time that is spent in continuing education to promote and support quality improvement or customer service.

(10). Increase to 100 percent the number of employees who, when queried, are able to appropriately describe how their work helps meet the mission of the "new VHA".

VHA has instituted a performance measurement system to monitor each VISN's progress toward the strategic targets. One of the purposes of this system is to hold VISN Directors accountable, through a specific performance plan, for results achieved. The plan for each fiscal year is developed through discussions between the National Performance Management Workgroup and the USH. The Workgroup is comprised of two VISN Directors, two clinical managers, two VA Medical Center (VAMC) Directors, two VAMC Chiefs of Staff, and two VHA Central Office (VACO) officials. The discussions also consider input on specific topics and background analyses provided by various committees, task forces, and VACO officials. *(A summary of the performance plan and a description of the performance measurement system is presented in Appendix V on pages 45 to 57.)*

Each VISN Director's annual performance evaluation is based on a combination of self-reported information, reviews of patient medical records, surveys of patients, and information from automated VHA databases. The 1998 Network Directors' performance plan consists of four parts. Part C of the plan contains "work-plan measures" related to healthcare that are intended by VHA to provide accountability and to require matching best practices to achieve "Exceptional" performance levels. *(A description of the performance plan and work-plan measures is presented in Appendix V on pages 45 to 57.)* VHA publishes a "Network Performance Report" for each fiscal quarter summarizing each VISN's achievements relating to these measures and comparing the VISN's achievements to the performance plan's standards for "Fully Successful" and "Exceptional" performance.

The table on the following page summarizes VISN 10's performance on the work-plan measures for FY 1997 and through the third quarter of FY 1998 which ranged from exceptional to less than fully successful:

APPENDIX II

VISN 10 HEALTHCARE PERFORMANCE

Measures	1997	1998 (3rd quarter)
Healthcare Value: Price/Cost:		
Bed days of care	Exceptional.	Exceptional.
Total operating beds	Exceptional.	Fully successful
Percent procedures performed in ambulatory setting	Less than Fully Successful for total of all targeted procedures, but improvement was "statistically significant"; VHA did not report percentages for individual procedures.	Less than Fully Successful for three of 11 targeted procedures; Fully Successful for five procedures; three procedures had not been done often enough to be measured.
Healthcare Value: Access:		
Category A users	Exceptional.	Exceptional.
Care management	Not reported by VHA.	Less than Fully Successful.
Follow-up after hospitalization for mental illness	Not reported by VHA.	Fully Successful.
Healthcare Value: Quality		
Primary care enrollment	Less than Fully Successful, but improvement was "statistically significant".	Less than Fully Successful.
Chronic Disease Care Index	Fully Successful	Less than Fully Successful
Prevention Index	Less than Fully Successful	Less than Fully Successful
Practice Guidelines	Exceptional	Evaluation to be based on 4th quarter data
Palliative Care Index	Less than Fully Successful	Less than Fully Successful
Healthcare Value: Satisfaction		
Customer service standards	Less than Fully Successful	Less than Fully Successful
Healthcare Value: Functional Status		
Addiction Severity Index	Less than Fully Successful	Less than Fully Successful
Research Measure	Exceptional	Evaluation to be based on expenditures for all of FY 1998
Employer of Choice		
Continuing education	Not reported by VHA	Less than Fully Successful
Accountability		
Decision Support System implementation	Implementation began in FY 1997	N/A
Patient safety	Not reported by VHA	N/A

Network Initiatives: VISN 10 has initiated several actions and strategies aimed at meeting the overall goals and objectives that VHA has adopted. Although many of these are being tried at other VISNs (e.g., service line management, CBOCs, etc.) several may be unique to this Network and may be applicable to other VISNs with cultural, demographical and/or economic similarities.

Access/Patient Population Growth: (Mental health, telephone triage, and conversion of facilities to state home use.) Network initiatives to improve access and increase the number of veterans treated include a specific focus on veterans suffering from chronic, serious mental health conditions. Demographic studies show that VISN 10's penetration into the potential market of veterans service connected for a mental disorder was several percentage points below the national average (31.5 percent versus 36.8 percent). Based on the belief that this low penetration is directly related to the concentrations of veterans in the state where there has been no ready access to VHA services, VISN management has developed plans to expand access to include incarcerated veterans about to be released into the community and veterans diagnosed with Post Traumatic Stress Syndrome (PTSD) for which the Network has the lowest penetration rate of any of the 22 Networks.

Additional Network initiatives specific to improving access include the extension of clinic hours and the expansion of telephone triage services through contracting with two other VISN's (2 and 17) to provide services for veterans in those Networks. At the beginning of FY 1998 the Network was averaging over 200 triage calls each week.

Organizational Realignments/Reengineering: Network-wide initiatives to reorganize clinical and support activities to achieve cost and operational efficiencies include:

(1). Purchase and installation of advanced food preparation equipment.
(2). Consolidating laundry operations.
(3). Centralizing business, contracting, education, fee services, and MCCF activities.
(4). Exploring the possibility of having a single body responsible for credentialing and/or privileging providers across the Network.
(5). Centralizing HIV viral load testing, non-urgent laboratory testing, and realigning dental laboratory functions.

(6). Developing more consistent staffing patterns across the Network for extended care activities.

Patient and Stakeholder Communications: Initiatives to improve communications with patients and employees and other stakeholders include the development and publication of employee and patient newsletters, quarterly "town hall" and focus group meetings, and the inclusion of VSO's, state and county officials, and non-VHA Department officials as part of the Network's formal committee and council structure.

Clinical and Quality Assurance Processes: VHA's mission goals and strategic objectives addressing healthcare value and excellence in service are linked to the supporting goals of ensuring/improving the quality of healthcare services. Included in these supporting goals are crosscutting "themes" of technical quality and service satisfaction. As mentioned earlier, the VISNs primary means of addressing quality of care and accountability issues is through the use of clinical guidelines that are specific to the medical conditions of individual patients. However, quality assurance efforts are also focused on the overall processes involved in the provision of healthcare and the Network-wide coordination of patient care. These efforts include: (1) Network-wide accreditation by Joint Commission for the Accreditation of Healthcare Organizations or National Committee for Quality Assurance, (2) utilization review, (3) provider profiling, and (4) risk management. Also, in recognition that the final arbiter of quality is the veteran patient, efforts to increase customer satisfaction include: (1) incorporating customer service standards into employee performance standards, (2) implementing a customer service program based on Baldridge Performance Improvement Criteria, (3) developing patient education programs, implementing provider report cards, and (4) conducting meetings and publishing newsletters for all stakeholders.

B. Efforts to Reduce Costs Per Patient Have Been Substantial.

Introduction: In March 1996, the USH issued *Prescription for Change: Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*. This document defines five corporate mission goals for VHA that provide unity of purpose throughout the organization and define VHA's strategy in operational terms. The five corporate mission goals are the focal point for aligning the activities of the organization.

One of these goals is to provide excellence in healthcare value and consists of specific objectives including: reducing operating costs, providing improved

services through better integration of VHA inpatient and outpatient resources and through increased functioning as a virtual organization, and decreasing the unit cost of goods and services by purchasing them under master agreements that lower cost but maintain quality.

A key component to reducing operating costs is to transition VA's healthcare system from a hospital, bed-based system to an ambulatory care-based system. VHA's overall action plan includes:

(1). Increasing outpatient capacity to accommodate the workload shifted from inpatient to outpatient settings and to obviate the need for as much inpatient care as possible (including the creations of CBOCs).

(2). Expanding treatment site alternatives so that patient care can be provided in the most cost-effective setting that is clinically appropriate (including increasing ambulatory surgeries and procedures, temporary lodging programs, and supporting expansion of the state veteran home program).

(3). Implementing multidisciplinary "service line" clinical care services in recognition of the "transdimensional" nature of healthcare today. A service line, also know as a product line, is a strategy to consolidate delivery systems, budgeting and accountability within broad groupings or functions rather than by traditional departments to treat patients in the most appropriate setting.

In order to provide improved services through better integration of inpatient and outpatient resources, the *Prescription for Change* calls for the development of strategic partnerships with other government healthcare providers and the private sector. It also calls for the restructuring of management and groupings of facilities to reduce administrative costs and increase the proportion of resources devoted to direct patient care.

The purpose of shifting healthcare resources and patient treatment modalities from inpatient care to outpatient care is to reduce the average cost or expenditure per patient by 30 percent by FY 2002. Interim performance is measured by decreases in the number of bed days of care, increases in the percent of healthcare funds expended on outpatient care, and the ratio of outpatient visits to inpatient admissions.

Additional strategies to reduce costs include: (1) developing shared and integrated services with the Department of Defense (DoD) to improve service and the use of resources; (2) implementing a computerized patient medical record system and a Clinical Information Resource Network to support primary care nationally; (3) implementing an enrollment system to streamline the registration process and support managed care, and (4) expanding telemedicine systems.

Conclusion: Based on our review of VISN 10's budget and performance reports, and interviews with Network and facility managers and staff, we concluded that VISN 10's efforts to reduce its costs have been substantial. The number of inpatient hospital bed has been reduced by over 25 percent since FY 1996, (acute) bed days of care (BDOC) per (VISN-wide) patient have been reduced by 50 percent since FY 1996, and efforts are underway to find alternative uses for underutilized facilities.

Refocusing Services Towards Outpatient Care: In order to monitor the system-wide strategic target of decreasing average cost per patient by 30 percent, VHA uses an annual performance measurement system to measure each VISN's progress toward the cost reduction target. For each indicator reported by the system, two levels of performance, labeled "fully successful" and "exceptional," have been established. Two of the indicators that track a VISN's success in minimizing hospital use and reducing average cost per patient are the number of "operating beds" and the number of acute BDOC per 1,000 unique patients.

> **The Number of VISN 10 Hospital Beds Has Been Decreased:** In its budget forecast, VISN 10 is planning for a "straight-line" funding level for FY's 1998 through 2002. These plans assume an inflation rate of three percent during the period, resulting in an effective spending reduction of 10 to 20 percent (or as much as $86 million). This has provided a strong incentive for the Network to achieve the goal of reducing per patient costs by 30 percent. The Network's FY 1998 Strategic Plan outlines its ongoing reengineering efforts and organizational realignments and a shift in focus from hospital to a more cost efficient outpatient delivery system. These initiatives are intended to allow for quality care while contributing to meeting the VHA overall cost reduction goals.
>
> The effectiveness of the Network's efforts to meet its bed reduction goals are evidenced in its performance reports. For example, efforts in FY 1997 and through the second quarter of FY 1998 to reduce the number of

operating beds of all types meet the criteria for "exceptional" under the VHA performance measurement system as shown below:

REDUCTION IN VISN 10 OPERATING BEDS, FYS 1996-1998

VISN 10		VHA Goals		Total VISN Beds by Type		
FY	**Total Beds**	**Fully Successful**	**Exceptional**	**Hospital**	**NHCU**	**Dom.**
1996	**2,594**	*	*	1,374	753	467
1997	**2,019**	**2,438**	**2,129**	966	696	357
1998	**1,905**	**2,019**	**2,129**	882	696	327
Percent Change FY96-98	**-26.6**	— —	— —	-35.8	-7.6	-30.0

* The *1996 Veterans Health Administration Performance Report* did not report this indicator.

Acute Bed Days of Care Per 1,000 Unique Patients Has Been Reduced: Although in FY 1996, VISN 10 did not meet the "Fully Successful" criteria of a 20 percent reduction in the number of acute bed days per patient, its 18 percent improvement was considered "statistically significant." In FY 1997, the Network's performance improved substantially and exceeded the criteria for an "Exceptional" rating. Projected performance for FY 1998, based on data through the second quarter, also approaches the "Exceptional" level. The following table summarizes VISN 10's performance in this measurement:

VISN 10 ACUTE BED DAYS OF CARE PER 1,000 UNIQUE PATIENTS, FYS 1996-1998

	VISN 10	VHA Goals	
FY	**BDOC/ 1000**	**Fully Successful**	**Exceptional**
1996	2,563	*	*
1997	1,776	2,091	1,986
1998	1,257	1,782	1,241

* VHA goals for FY 1996 were stated as a percentage decrease from FY 1995 to FY 1996. A 20 percent decrease was considered "Fully Successful" and a 30 percent decrease "Exceptional."

Implementing Specific Cost Savings Initiatives: In keeping with the USH's policy and VA's Strategic Plan, VISN 10 has consolidated some activities and is in the process of consolidating others.

(1). In FY 1997, the Decision Support System was centralized at VAMC Dayton with a reported annual saving of $450,000.
(2). VAMC Dayton currently provides laundry services for VAMC Cincinnati and will eventually provide services for VAMC Chillicothe. Laundry consolidation will save an expected $3 million annually when completed.
(3). VAMC Dayton's "cook-chill" food service equipment will be used to prepare meals for VAMCs Chillicothe and Cleveland, saving a further estimated $3 million over 5 years.
(4). Non-urgent laboratory testing is planned to be centralized at VAMCs Cincinnati and Cleveland resulting in an expected savings of 17.5 Full Time Employee Equivalents and $1 million this year, with a goal of 20 percent total savings when full implementation is achieved in FY 1999.
(5). Plans to centralize Network contracting activities into a Contract Service Center in FY 1999, as well as increased use of large-scale purchases, elimination of duplicate contracts, and standardization of products will save an additional $2 million annually.

In addition to consolidations, VISN 10 plans to reduce costs by acquiring new technology.

(1). VAMC Cleveland can now do viral load testing for VISN 10 patients at a cost of $82 per test where before the fee-basis cost of this test for HIV patients was $100.

(2). Automatic Fabrication of Mobility Aids (AFMA) is a computer aided design/manufacturing system that replaces plaster molding and modeling technology in fabricating fittings for lower limb prostheses. In FY 1997, VISN 10 projected $1 million savings at VAMC Cincinnati from AFMA. In FY 1998, AFMA will be in place at all facilities.

(3). Brachytherapy, a treatment option of prostate cancer is being offered at VAMC Cincinnati in order to bring this procedure in house. Significant savings will result from reducing the contracted cost of brachytherapy from $9,500 per patient to an estimated in-house cost of $5,500.

(4). Concurrent use of video conference cabling for intra-Network long distance telephone calls is estimated to save as much as $750,000 in telephone costs.

(5). Plans also include the elimination of most Assistant (Service) Chief positions through retirements and early-outs, and a Network-wide review to eliminate supervisory positions will help meet supervisory ratios established by the National Performance Review.

Addressing Potential Alternative Uses For Underutilized Facilities: Nationwide, VHA's physical plant is projected to remain essentially unchanged. Recent Congressional testimony by the USH indicates that VHA does not have plans to close any facility. In fact, with the addition of several hundred CBOCs nationwide, the overall numbers of VHA medical facilities will grow significantly during the next several years. Since VISN 10 has seen significant efficiencies (e.g., reductions in BDOC, and increases in the proportion of surgeries done on an outpatient basis) it has become clear to Network management that a challenge exists in finding alternative uses for some of its facilities which are becoming more underutilized as efficiency improves. The Network has begun the process of finding alternative uses for its growing list of unused and unneeded buildings. For example, the VISN's Strategic Plan for FY 1998 notes that three VAMC campuses have excess building capacity. The Network is exploring opportunities to offer these buildings to other governmental agencies or local communities. The most notable effort in this area is its offer of excess buildings at VAMC Chillicothe to the State of Ohio as the possible site for a state veterans home.

C. The VISN Has Taken Specific Steps to Increase Revenues From Several Non-Appropriated Funding Sources.

Introduction: Another VHA goal established by the USH has been to increase the percentage of its operating budget that is obtained from non-VA appropriated sources to 10 percent of the total budget by 2002. The most significant source of non-appropriated funds for VHA has been third party insurance collections, currently referred to as the Medical Care Collections Fund (MCCF) and formerly referred to as Medical Care Cost Recovery.

The current MCCF law allows VA to keep reimbursements from third-party insurers whereas previously VA was required to turn funds over to the Department of the Treasury. As part of the current law, MCCF funds are distributed to each VISN based on the ratio of each region's collection to total collections during the fiscal year. However, during the last 3 years, these collections have steadily

declined from a high of $580.7 million in FY 1995 to $519.7 million in FY 1997. To counter this trend and to offset costs of providing care to veterans who are eligible for Medicare, VA has sought additional third party reimbursement direct from Medicare. Known technically as "Medicare Subvention", proposed legislation will require an agreement between VA and the Health Care Financing Administration (HCFA) in which VA would provide medical care to more elderly veterans and bill their care to HCFA. House and Senate Bills (HR 3828 and S2054) are currently pending Congressional action.

Conclusion: The Network has taken specific steps to increase revenues from several non-appropriated funding sources. With a new Revenue Coordinator and Network Revenue Team, VISN 10 is actively pursing and considering potential sources of alternative revenue in addition to MCCF payments. Network efforts range from offering government agencies and communities excess building capacity to various types of contracted services for mental health and substance abuse services, food and laundry services, medical examinations, and continuing education. Furthermore as a result of various evaluations, reviews, and a recent OIG audit, recommended improvements to increase third party insurance billing and collections are in process. However, in spite of these efforts, VHA and Network management are aware that the VISN's Strategic Funding Goals will not be met without legislation allowing Medicare to pay for some veterans care.

Actions Taken to Increase Revenues: VISN 10 is actively pursuing or considering various potential sources of alternative revenue including offering excess building capacity at three VAMC campuses to government agencies and communities. Additionally, the Network is pursuing or considering providing the following services under contract basis:

(1). Vocational rehabilitation services to VBA.
(2). Excess advanced food preparation (cook-chill) and/or excess laundry capacity to Wright Patterson Air Force Base (WPAFB) hospital, Ohio state prison system, and other government agencies.
(3). Mental health services including inpatient treatment to WPAFB.
(4). Subcontractor medical care to contractor for Tricare DOD beneficiaries.
(5). All healthcare services for active duty Navy and Marine Corps personnel in VISN 10's catchment area.
(6). Medical examinations for active duty reservists.
(7). Community-based mental health and substance abuse services if successful in competition for federal funds.
(8). Continuing education to community healthcare providers.

(9). Employee assistance programs at major Ohio employers.
(10). Toll free telephone healthcare advice service (Tele-Nurse) to other VISNs and non-healthcare providers.

Relative to increased MCCF revenues, according to a July 10, 1998 OIG audit report (8R1-G01-118) VHA can enhance MCCF recoveries by over $83 million by requiring VISN Directors to more actively manage MCCF program activities. Additionally, the report concluded that facilities should be required to use management tools developed by the MCCF Program Office, set up and monitor staff performance standards, and more aggressively pursue collection of delinquent accounts receivable. The USH generally concurred with the findings and recommendations of this report and pointed out that as a result of a various audits, internal reviews and evaluations, required improvements to billing and collections for MCCF revenues would be taken.

In addition, in response to an earlier briefing on our audit survey results, the Network Director outlined two steps taken to increase revenues since completion of our review: (1) the hiring of a VISN Revenue Coordinator who's focal point is to increase third party revenues and identify areas of standardization, and (2) the designation of a Network Revenue Team charged with developing and implementing short and long range operational efficiencies as well as revenue enhancement.

D. The VISN's Efforts to Increase the Number of New Patients Has Been Successful.

Introduction: Concurrent with the development and implementation of the patient enrollment system discussed in the results and recommendations section of the report, VHA has also had a policy of increasing the number of users of VA healthcare services. This policy is described in the Department's current Strategic Plan that was published in September 1997. In its FY 1997 Annual Performance Report, VHA reported that over 80,000 new Category A veterans (i.e., entitled to medical care from VA without cost because they have service-connected disabilities or limited income) used VA health services. As a group, the 22 VISNs ranged from a net loss of over 1,000 patients (-1 percent) to a maximum gain of over 21,000 (+12 percent).

To assist VISNs initiate and sustain this growth, numerous studies have been conducted to collect the demographic and other data needed to answer several critical questions. These include: (1) where eligible veterans live, and (2) why

these veterans choose (or do not choose) VA as their healthcare provider. Market and demographic data collected thus far have shown that the majority of eligible veterans do not use VA health services. This has encouraged VISN's (including VISN 10) to develop strategies to capture a greater share of this potential market. For example, in 1996 VISN 10 had a total veteran population of almost 1.1 million (including over 330,000 "Category A" veterans); however, fewer than 87,000 Category A patients used its health services during that year.

Internal planning documents indicate that VISN 10 management believes that this low penetration can be directly related to large veteran concentrations where there has been no ready access to VHA services. As a result, VISN 10's strategy is to increase the number of new patients served and improve access to current patients by increasing the number of CBOCs – from an initial 2 CBOC's opened in FY 1997 to a total of approximately 20 over the next 4–5 years.

VISN 10 Has Significantly Increased the Number of New Patients The initial success of the VISN's efforts is evidenced by the fact that in FY 97, VISN 10 accounted for over 10 percent of VHA's reported overall increase in new Category A patients (8,900 of the 80,000 increase). This represented a 6.7 percent increase in VISN 10's Category A patients who used its healthcare services and substantially exceeded its performance goals for fully successful by over 500 percent and exceptional by over 250 percent.

Given the potential impact of these additional patients on future VISN workload and resources, we selected a statistical sample of 366 patients who were seen for the first time during the period between October 1, 1997 and March 5, 1998 (from a total population of 11,786 patients) to determine the nature of medical services provided. We examined each patients medical and administrative files as well as data contained in the computerized records. Our working definition of substantive care was judgmental but we believe, reasonable. For example, any inpatient care was defined as substantive, as was any care or treatment that addressed a specific healthcare complaint (even if the complaint was not diagnosed as a specific condition). An additional working criteria was if the services would be billable.

We found that 132 (36.1 percent) of the patients in our sample received substantive care either on their initial visit or subsequent visits and 234 (63.9 percent) did not receive substantive care. In 66 (18 percent) of these cases, we could not identify that any medical care was provided and in 138 (37.7 percent) the services were related to Health Fairs which, for the most part, are limited to blood pressure and cholesterol screening and counseling on what types of care VA could offer. (*A*

summary of the statistical sample results is presented in Appendix VI on pages 59 to 62.)

Initially, we were concerned that these cases were being used to influence funding allocations under the VERA system which funds Networks based on a flat rate formula of $2,596 for each unique patient regardless of the services provided (the exception being high cost patients such as those with spinal cord injuries who are funded at $35,707/year). However, during the course of the audit, we learned that this unintended effect of the VERA system was recognized by VHA and addressed by implementing a separate funding rate for patients who are seen only once in an outpatient setting. The funding change will take effect for the FY 1999 budget year, and will fund patients who are seen only once in an outpatient setting at $65/year (versus the previous $2,596/year).

When we were informed of the addition of a third patient funding group for the VERA system, we examined our sample of 366 patient case files to determine the effect this change would have. We found that, of the 234 (63.9 percent) who did not receive substantive care, essentially all would be covered by the new policy. In otherwords, the patients who did not receive substantive care will now be more appropriately funded at $65 versus $2,596. We also noted that 24 of the 132 patients in our sample whom we determined had received substantive care were single outpatient visits who would be funded at the $65 rate. This suggests to us that the funding policy change is appropriate.

VA HEALTHCARE STRATEGIC GOALS AND RELATED PERFORMANCE GOALS

(Note: VA and VHA strategic goals are the same except in cases as noted where VHA's strategic goals are expressed as performance goals in the overall VA strategic plan)

Strategic Target	Performance Goals
Decrease system-wide costs per patient by 30 percent.	Decrease bed days of care from 2,025 per 1,000 unique users in FY 1998 to 1,500 days by FY 2003.
	Increase the percent of healthcare funds expended on outpatient from 53 percent in FY 1998 to 60 percent by FY 2003.
	Increase the ratio of outpatient visits to inpatient admissions from 38:1 in FY 1998 to 50:1 by FY 2003.
Increase the number of unique users of the veterans healthcare system by 20 percent.	Increase the number of patients enrolled in the healthcare system by 4 percent per year beginning in FY 1998.
	Increase the number of patients enrolled in the healthcare system by 20 percent by FY 2002.
Increase the percentage of the medical operating budget obtained from non-appropriated sources to 10 percent.	Pursue alternative revenue streams including Medical Care Cost Recovery and Medicare reimbursement by FY 2002.
Exceed by 10 percent the proportion of patients of other healthcare providers who achieve maximum functional potential.	Implement primary care by increasing the percentage of patients who know there is one provider or team in charge of their care from 85 percent in FY 1998 to 96 percent in FY 2003.
	Implement selected clinical guidelines for common disease entities and increase the number of patients with high volume common disease entities treated using clinical guidelines from 40 percent in FY 1998 to 90 percent in FY 2003.
	Increase the scores on the Chronic Disease Index (CDI) from 85 percent in FY 1998 to 98 percent by FY 2003 *(note: the CDI is a measure of how well clinical guidelines are followed for the selected common disease entities*).

Strategic Target	**Performance Goals**
	Increase the scores on the Prevention Index (PI) from 85 percent in FY 1998 to 98 percent by FY 2003 (*note: the PI is a measure of how well nationally recognized approaches are followed for primary prevention and early detection of diseases with major social consequences*).
Increase to 99 percent (100 percent per DVA plan) the proportion of VA medical research projects that are demonstrably related to the healthcare of veterans or other Department missions.	Create a system for administrative review before (letter of intent) or after (secondary review) scientific peer review to select projects relevant to VA's healthcare mission by FY 1998.
	Achieve the goals of 90 percent by FY 1999 and 99 percent by FY 2003 the percent of funded research projects relevant to VA's healthcare mission.
	Establish and implement at least one new partnering opportunity with VSO's, Federal agencies, private foundations, or industry by FY 1998.
	Design and implement a career development program for all of research and development by FY 2000 (*Medical Research, Health Services Research, and Rehabilitation Research*).
	Integrate career development programs into designated research areas by FY 2000.
Realign the academic training program and update the curriculum with greater emphasis on primary care to better meet the needs of VHA, its patients, students, and academic partners (*note: this is a Departmental goal rather than a VHA specific goal – VHA's "strategic target" is expressed as achieving 95 percent of trainees rating their VA training experience as good - which in the overall VA-wide Strategic Plan is expressed as a "Performance Goal" and is shown in the next column*).	Increase the proportion of residents trained in primary care from 38.6 percent in FY 1996 to 48 percent in FY 2000.
	Reallocate 750 specialty resident positions to primary care and eliminate 250 specialty residency training positions by FY 2000.

Strategic Target	**Performance Goals**
	Review affiliations with medical school partners, establish strategic plans and milestones for these affiliations, and execute new master affiliation and school of medicine affiliation agreements in FY 1998.
	Execute new master and educational program affiliation agreements for all other non-medical school partners by FY 2000.
	Achieve full implementation of the planned improvements developed by the review of its academic affiliations by FY 2003.
	Increase to 95 percent the number of medical school residents and other trainees who rate their VA healthcare educational experience as good or superior to their other academic training by FY 2002 (*note: this is expressed as a performance measure in the VA-wide Strategic Plan but as a "Strategic Target" in VHA's strategic plan*).
Increase customer satisfaction of veterans, their dependents and beneficiaries, and stakeholders who interact with VA employees to the highest possible levels (*note: this is a Departmental goal rather than a VHA specific goal – VHA's related "strategic targets" are expressed as: (a). achieving 90 percent of customers rating VA service as "very good" or "excellent", and (b). achieving 90 percent of the customers rating the quality of healthcare as equivalent or better than what they would receive elsewhere – both of which are expressed in the overall VA_wide strategic plan as "Performance Goals" and are shown in the next column*).	Identify core data requirements that apply to VA programs and appropriate collection methods in FY 1998.
	Conduct annual surveys to gauge veterans overall satisfaction with VA services beginning in FY 1999.
	Develop and implement a compliment and complaint system to improve customer relations and integrate suggestions and concerns into the strategic management process by FY 2000.

Strategic Target	**Performance Goals**
	Enhance and publicize the Department's Scissors Award Program as an incentive for recognizing improvements in customer service in FY 1998.
	Increase the percent of customers rating VA service as "very good" or "excellent" to 95 percent by FY 2003 (*note: this is expressed as a performance measure in the VA-wide Strategic Plan but as a "Strategic Target" in VHA's strategic plan*).
	Increase to 90 percent the proportion of patients who rate the quality of VA healthcare as equivalent to, or better than, what they would receive from any other healthcare provider by FY 2003 (*note: this is expressed as a performance measure in the VA-wide Strategic Plan but as a "Strategic Target" in VHA's strategic plan*).
Provide employees the opportunity to develop or enhance requisite skills and program knowledge (*note: this is a Departmental goal rather than a VHA specific goal – VHA's "strategic target" is expressed as increasing employee education for Quality Improvement or customer service to 40 hours per year for each employee – which in the overall VA-wide Strategic Plan is expressed as a "Performance Goal" and is shown in the next column*).	Increase education time and other learning experience time to a minimum of 2 percent of total work time or 40 hour per year for each employee by FY 2002 (*note: this is expressed as a performance measure in the VA-wide Strategic Plan but as a "Strategic Target" in VHA's strategic plan*).
Recognize and reward individual and group achievement consistent with VA's restructured performance measurement system (*note: this is a Departmental goal rather than a VHA specific goal – VHA's "strategic target" is expressed most closely as achieving 100 percent of employees being able to relate their work to the "New VHA" mission - which in the overall VA-wide Strategic Plan is expressed as "Performance Goals" and are shown in the next column*).	Review and revise policies and directions on rewards and recognition to conform to the revised performance management policy by FY 1998 (*note: this is expressed as a performance measure in the VA-wide Strategic Plan but as a "Strategic Target" in VHA's strategic plan*).
	Develop a "One VA" orientation program that promotes awareness of VA's mission, vision, values, and strategic direction by FY 1998.

Strategic Target	**Performance Goals**
	Develop an ongoing system for reinforcing and updating employee knowledge about VA's strategic direction by FY 1999.
	Provide leadership development to all employees to enhance the achievement of VA strategic business goals by FY 2002.

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APPENDIX IV

NETWORK PERFORMANCE DATA

I. VHA Network Director's Performance Measures

The Network Directors' performance plan has four parts. Part A describes "eight core competencies that govern the behavior of successful executives:

- ◆ Interpersonal Effectiveness
- ◆ Customer Service
- ◆ Systems Thinking
- ◆ Flexibility/Adaptability
- ◆ Creative Thinking
- ◆ Organizational Stewardship
- ◆ Personal Mastery
- ◆ Technical Competency

Part B of the performance plan "describes the ten dimensions of VHA's comprehensive framework for quality healthcare:

- ◆ Personnel
- ◆ Clinical Care Activities
- ◆ Performance Indicators
- ◆ Internal Review and Improvement
- ◆ External review and Oversight
- ◆ Technology Management
- ◆ Patient-Reported Outcomes
- ◆ Education
- ◆ Research
- ◆ Change Management

Part C contains objectively quantifiable "work-plan measures." VHA tracks these measures, based on "Ten for 2002" goals, using data from various automated information systems and through various independent external reviews and surveys. These measures and evaluation methods are described later in this Appendix.

Part D of the plan "addresses areas of organizational emphasis including fair workforce treatment (including EEO concerns), occupational safety, and national contributions of Network Directors."

VHA has grouped the work-plan measures in Part C of the performance plan into the following general categories:

- ◆ Healthcare value: Cost
- ◆ Healthcare value: Access
- ◆ Healthcare value: Quality
- ◆ Healthcare value: Patient Reported Outcomes
- ◆ Healthcare value: Functional Status
- ◆ Research
- ◆ Employer of Choice
- ◆ Accountability: Areas of Organizational Effectiveness

II. Workplan Measures

Within each category, at least one performance indicator is reported, using data from various automated databases. The following table describes the indicators tracked, the level of performance required under the performance plan to be considered "fully successful" and "exceptional" for FYs 1997 and 1998, and VISN 10's actual performance:

	FY 1997			FY 1998 (through third quarter)		
Measure	**Fully Successful**	**Exceptional**	**VISN 10 Performance**	**Fully Successful**	**Exceptional**	**VISN 10 Performance**
Healthcare Value: Cost						
Acute Bed Days of Care per 1,000 Unique Patients: VHA uses this indicator as a measure of the efficiency of the healthcare delivery system.	2,091	1,986	1,776	1,782	1,241	1,191 *(VHA estimated third quarter values using a weighted denominator based on end of year projections of SSNs.)*

Acute Bed Days of Care are those days generated by VA patients treated by acute care treating specialties at VA or non-VA contract hospitals. The acute treating specialties are:

Allergy	Cardiology	Pulmonary TB	Pulmonary non-TB	Dermatology
Endocrinology	Gastroenterology	Hematology/Oncology	Neurology	Epilepsy Center
Medical ICU	Metabolic	General (acute) Medical	Gerontology	Cardiac Step Down
Telemetry	Stroke GEM	Acute Medicine	GEM neurology	Surgery (General)
Gynecology	Neurosurgery	Ophthalmology	Orthopedic	Ear, Nose and Throat
Plastic Surgery	Proctology	Thoracic Surgery	Urology Oral Surgery	Podiatry
Peripheral Vascular	Surgical ICU	Acute Psychiatry	Evaluation/Brief Treatment PTSD	High Intensity General Psychiatry-Inpatient
Alcohol Dependency-High Intensity			Drug Dependency-High Intensity	Substance Abuse-High Intensity

Unique Patients are those who used VA healthcare services, as indicated by a count of unduplicated SSNs. At the Station Level, a patient is counted as a Unique Patient at each facility where he/she is treated. Thus, a patient treated at two facilities will be counted as a Unique Patient at each of the two facilities. At the VISN level, Unique Patients are not duplicated across facilities within the VISN. A patient treated at two facilities in the same VISN is counted as a Unique Patient only one time in that VISN's count.

Measure	FY 1997			FY 1998 (through third quarter)		
	Fully Successful	Exceptional	VISN 10 Performance	Fully Successful	Exceptional	VISN 10 Performance
Total Operating Beds: The number of beds that are required to support the planned patient load and are available for the 24-hour daily care of bed occupants. Operating beds comprise hospital (acute and intermediate medicine, psychiatry, and surgery), nursing home care unit, and domiciliary beds. Actual, not average, bed counts are used to measure VISN performance.	2,438	2,129	2,019	2,019	*OIG could not determine the "Exceptional" level from the available information.*	1,885

Measure	FY 1997 Fully Successful	FY 1997 Exceptional	FY 1997 VISN 10 Performance	FY 1998 (through third quarter) Fully Successful	FY 1998 (through third quarter) Exceptional	FY 1998 (through third quarter) VISN 10 Performance
Ambulatory Procedures: VHA's goal is to increase the percentage of appropriate surgical and invasive diagnostic procedures performed in an ambulatory setting instead of an inpatient setting. The targeted procedures are: Arthroscopy Breast biopsy and other diagnostic procedures of the breast Colonoscopy Cystoscopy Eyelids—other therapeutic procedures Laparoscopy Diagnostic bronchoscopy and biopsy of bronchus Upper GI endoscopy Cardiac catheterization and coronary arteriography—diagnostic Hernia repair, inguinal and femoral Lens and cataract procedures	*VHA's* 1997 Network Performance Report *did not report the percentage of each targeted procedure done on an ambulatory basis. The "Fully Successful" level for all targeted procedures was 65 percent. The "Exceptional" level was 75 percent or greater.*		62% *Although VISN 10's performance was less than "Fully Successful," the* 1997 Network Performance Report *stated that VISN 10's "improvement is statistically significant."*	Arthroscopy 89% Breast biopsy 88% Colonoscopy 88% Cystoscopy 90% Eyelid procedures 90% Laparoscopy 79% Bronchoscopy 38% Endoscopy 67% Catheterization 26% Hernia repair 77% Cataract procedures 85%	95% 95% 93% 95% 95% 95% 51% 79% 53% 90% 95%	89% ***** 89% 91% 89% ***** 35% 64% 34% ***** 89%
The "Fully Successful" level for FYs 1997 and 1998 for each procedure is the VHA average for the prior FY. The "Exceptional" level requires matching the VISN with the best outpatient performance for the prior FY, or 95 percent, whichever is lower.						***** *Fewer than 30 breast biopsies and laparoscopies have been done. The percentage of ambulatory hernia repairs was not stated.*

Measure	FY 1997			FY 1998 (through third quarter)		
	Fully Successful	Exceptional	VISN 10 Performance	Fully Successful	Exceptional	VISN 10 Performance
Healthcare Value: Access						
Category A Users: One of VHA's "10 for 2002" strategic goals is to increase the number of users of the VA healthcare system by 20 percent from FYs 1997-2002. To track progress toward this goal, VHA measures the increase in "market penetration" of Category A veteran users. These veterans are entitled to medical care from VA without cost because they have service-connected disabilities or limited income.	1,653 new Category A veteran users.	3,306 new Category A veteran users.	8,865 new Category A veteran users.	4,065 new Category A veteran users.	8,677 new Category A veteran users.	10,439 projected new Category A veteran users in FY 1998, based on actual number of Category A veteran users through third quarter of FY.

VA's Office of Policy and Forecasting has estimated the Category A veteran population in each VISN for 1997 through 2002. Based on these estimates (which anticipate a declining population in most VISNs), VHA believes that increasing market penetration by 1.24 percent annually in each VISN beginning in 1998 will achieve the goal of increasing users by 20 percent by 2002.

	FY 1997			FY 1998 (through third quarter)		
Measure	**Fully Successful**	**Exceptional**	**VISN 10 Performance**	**Fully Successful**	**Exceptional**	**VISN 10 Performance**
Care Management is described by VHA as "a process for increasing the likelihood that a patient receives easily accessible, coordinated, continuous, high quality healthcare. Care management is that aspect of primary care that coordinates care across all settings, including the home. VA care management is patient-centered rather than disease-specific; coordination of care for all diseases and all episodes of illness is carried out by the care manager assigned to a particular patient. VA care managers especially focus on the patient in the context of family and community by integrating an assessment of living conditions, family dynamics, and cultural background into the patient's plan of care." VHA measures improvement in care management by tracking problems in coordination of care reported by patients on the "FY98 Interim Ambulatory Care Survey."	VHA did not report scores for this measure in its *1997 Network Performance Agreement Report*.			Improve (decrease) VISN score on overall coordination of care customer service standard in the FY 1998 ambulatory care survey by 5 percent.	Improve (decrease) VISN score by 10 percent.	3 percent decrease (second quarter data).
Follow-up after hospitalization for mental illness: VHA's goal is to provide outpatient mental health care within 30 days of discharge to patients discharged with a principal diagnosis of a mental health disorder. VHA tracks this indicator using data from various automated systems.	VHA did not report scores for this measure in its *1997 Network Performance Agreement Report*.			70 percent of patients discharged March through August 1998 receive follow-up.	85 percent of patients discharged March through August 1998 receive follow-up.	70 percent.

Measure	FY 1997			FY 1998 (through third quarter)		
	Fully Successful	Exceptional	VISN 10 Performance	Fully Successful	Exceptional	VISN 10 Performance
Healthcare Value: Quality						
Primary care enrollment/continuity: VHA describes primary care as "the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. All VHA facilities are now required to implement primary care programs. Consistent with this priority, Networks are establishing primary care as the central focus of patient treatment." VHA tracks the success of this initiative through patient responses to the question "Is there one provider or team in charge of your care?" on the 1998 ambulatory care customer survey.	85 percent of patients answer "Yes" to the survey question on the 1997 Ambulatory Care Survey.	90 percent of patients answer "Yes" to the survey question on the 1997 Ambulatory Care Survey.	72 percent answered "Yes" on 1997 survey. *Although VISN 10's favorable responses were less that 85 percent, VHA noted that the VISN's improvement over FY 1996 was "statistically significant.*	80 percent of patients answer "Yes" to the survey question.	90 percent of patients answer "Yes" to the survey question.	76 percent answered "Yes" on mid-year survey in February 1998.
Chronic disease care index (CDCI): The CDCI consists of 14 medical interventions that assess how well VHA follows nationally recognized guidelines for five high volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and obesity. For each diagnosis, several medical interventions are measured. The CDCI is calculated from a random sample of medical records of patients discharged with one of the targeted diagnoses.	Network score on CDCI is doubled in fourth quarter of FY 1997 from 1996 baseline.	CDCI is 95 percent in fourth quarter of FY 1997.	75 percent *Score improved by at least 100 percent.*	CDCI is 90 percent in snapshot taken fourth quarter of FY 1998.	CDCI is 95 percent in snapshot taken fourth quarter of FY 1998.	77 percent in third quarter.

	FY 1997			FY 1998 (through third quarter)		
Measure	**Fully Successful**	**Exceptional**	**VISN 10 Performance**	**Fully Successful**	**Exceptional**	**VISN 10 Performance**
Prevention index (PI): The PI consists of 9 medical interventions that measure how well VHA follows nationally recognized primary prevention and early detection recommendations for eight diseases with major social consequences. The eight diseases are: influenza and pneumococcal diseases; tobacco consumption; alcohol abuse; and cancer of the breast, cervix, colon, and prostate. One or two medical interventions are measured for each disease. The CDCI is calculated from a random sample of medical records of patients diagnosed with one of the targeted diseases.	Network score on PI is doubled in fourth quarter of FY 1997 from 1996 baseline.	PI is 95 percent in fourth quarter of FY 1997.	61 percent *Score did not improve by at least 100 percent.*	PI is 85 percent in snapshot taken fourth quarter of FY 1998.	PI is 90 percent in snapshot taken fourth quarter of FY 1998.	73 percent in third quarter.
VHA-wide clinical practice guidelines: All VISNs must implement specific nationally developed clinical practice guidelines in the following areas: • Treatment of ischemic heart disease, diabetes mellitus, and major depressive disorder. • Pharmacological management of hypertension. • Smoking cessation. For FY 1997, VISN compliance was self-reported with follow-up audits. In FY 1998, compliance will be tested through reviews of randomly selected patient records.	VISN must implement 12 nationally developed clinical practice guidelines, two of which are for "special emphasis" populations, by September 30, 1997.	In addition to the two "special emphasis" guidelines, the 12 new guidelines implemented cover 12 of the VISN's 20 common disease entities.	VISN met the "Exceptional" standard.	By September 30, 1998, implement targeted guidelines and show a standard error improvement of greater than one in snapshot taken fourth quarter FY 1998 compared to snapshot taken fourth quarter FY 1997.	Show a standard error improvement of greater than two, or implementation in 80 percent of the specific population, whichever is greater.	*Snapshot for fourth quarter FY 1998 not taken yet.*

	FY 1997			FY 1998 (through third quarter)		
Measure	**Fully Successful**	**Exceptional**	**VISN 10 Performance**	**Fully Successful**	**Exceptional**	**VISN 10 Performance**
Palliative care index: VHA describes palliative care as "the comprehensive management of the physical, psychological, social, spiritual and existential needs of patients with incurable, progressive illnesses.… The goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs and practices." The index is calculated through random monthly chart reviews of patients with terminal diagnoses or advanced, progressive, incurable illness who are receiving ongoing care through VHA. The charts are reviewed for documentation of the patient's admission to a palliative care program or documentation of an individualized plan for comprehensive, coordinated, palliative care services.	95 percent achievement in fourth quarter FY 1997.	99 percent achievement in fourth quarter FY 1997.	47 percent.	Palliative care index is 95 percent in snapshot taken fourth quarter FY 1998.	Effective palliative symptom management that includes documented assessment of symptoms (100 percent), interventions for identified symptoms (90 percent), and evaluation of effectiveness of interventions (80 percent). Snapshot will be taken in fourth quarter of FY 1998.	67 percent *(First quarter FY 1998 data).*

Measure	FY 1997			FY 1998 (through third quarter)		
	Fully Successful	Exceptional	VISN 10 Performance	Fully Successful	Exceptional	VISN 10 Performance
Healthcare Value: Patient Reported Outcomes						
Customer service satisfaction: Two of VA's "Ten for 2002" goals are to increase to 90 percent the proportion of patients rating VA healthcare as very good or excellent and as equivalent to or better than what they would receive from others. VHA tracks progress toward this goal by comparing the results of its ambulatory care customer feedback survey with the results of the same surveys at non-VA academic medical facilities.	Average VISN performance equals non-VA performance of 15 percent (one problem reported per six questions answered).	Average number of problems reported per patient is 10 percent (one problem reported per ten questions answered).	23 percent average.	Average VISN performance equals non-VA performance of 14 percent (one problem reported per seven questions answered).	Match non-VA performance on each customer service standard in the survey.	24 percent average (second quarter FY 1998 interim survey).
Healthcare Value: Functional Status						
Addiction severity index (ASI): VHA describes the ASI as one of the most widely used assessment tools in the field of substance abuse and treatment. It was developed to assess the multiple problems often seen in alcohol and drug dependent persons. It is… one of the most appropriate tools available for functional assessments among abusive and dependent populations. One of VHA's "Ten for 2002" goals is to administer the ASI to all substance abuse patients.	90 percent of substance abuse patients have at least one ASI on record.	99 percent of substance abuse patients have at least one ASI on record.	69 percent.	90 percent of substance abuse patients have an ASI on record; 90 percent of patients available for follow-up who were seen in September 1997 receive follow-up ASI.	95 percent of substance abuse patients have an ASI on record; 95 percent of patients available for follow-up who were seen in September 1997 receive follow-up ASI.	ASI on record: 67 percent. Follow-up ASI: 65 percent.

Measure	FY 1997			FY 1998 (through third quarter)		
	Fully Successful	Exceptional	VISN 10 Performance	Fully Successful	Exceptional	VISN 10 Performance
Research						
Total peer-reviewed research funding: One of VHA's "Ten for 2002" goals is to increase to 99 percent the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of VA. VA tracks progress toward this goal through research expenditures for VA funded, VA non-profit, and university research expenditures for VA principal investigators. "Peer reviewed" refers to research subjected to national review for scientific merit. Examples are VA funded research, grants from government agencies (NIH, DoD, DoE) and national societies (American Cancer Society, American Heart Association). Industrial (pharmaceutical companies) clinical trials contracts are not subject to national review for scientific merit and are not counted.	2.5 percent increase (prorated for six months of FY 1997).	5 percent increase (prorated for six months of FY 1997).	5 percent increase.	5 percent increase in FY 1998.	7.5 percent increase in FY 1998.	*Data not available until after the close of the FY*

Measure	FY 1997			FY 1998 (through third quarter)		
	Fully Successful	Exceptional	VISN 10 Performance	Fully Successful	Exceptional	VISN 10 Performance
Employer of Choice						
Continuing education: One of VHA's "Ten for 2002" goals is to increase to 2 percent, or 40 hours per year, the amount of an employee's paid time that is spent in continuing education to promote and support quality improvement or customer service. Each VISN must provide training in activities associated with Total Quality Improvement. Training done as a requirement of employment (e.g., safety training, sexual harassment) does not count toward the continuing education requirement. Training related to clinical patient care or specifics of medical treatment or disease processes also does not count.	VHA did not report this measure for FY 1997.			50 percent of permanent employees receive 20 hours of continuing education.	70 percent of permanent employees receive 20 hours of continuing education.	39 percent.

Measure	FY 1997 Fully Successful	FY 1997 Exceptional	FY 1997 VISN 10 Performance	FY 1998 (through third quarter) Fully Successful	FY 1998 (through third quarter) Exceptional	FY 1998 (through third quarter) VISN 10 Performance
Accountability: Areas of Organizational Effectiveness *Decision Support System (DSS) implementation*: VHA describes DSS as "a management information system that integrates cost, quality and clinical information into a patient-centered data base. It is used to improve strategic and operational decision making.… It enables accurate determination of the results of performance measurements.… DSS is a tool to analyze information on patterns of care and patient outcomes, which is linked to resource consumption and the costs associated with that care. This provides the potential to manage in ways not previously possible in VHA."	DSS training began in FY 1997.			*1998 Network Directors' Performance Measures* and *1998 3rd Quarter Network Performance Report* do not clearly state the criteria for "Fully Successful" and "Exceptional" performance.		
Patient safety: VHA's goal is to decrease adverse events related to patient safety. VISN accomplishments in this area are self-reported, with site visits to verify this information.	VHA did not report this measure for FY 1997.			Redesign the service delivery system for one critical process of care at all applicable VISN facilities; redesign two service delivery systems identified from adverse events.	Meet fully successful criteria and implement 3 additional VISN system redesigns identified from the lessons learned database or another appropriate source.	Three redesigns identified.

SUMMARY OF STATISTICAL SAMPLE RESULTS

SAMPLING PLAN

Audit Universe

To examine the nature of services provided to new patients, and to follow these new patients through the patient enrollment and resource allocation databases, we reviewed a statistically random sample of the medical and administrative records of patients seen for the first time at VISN 10 facilities. The total population of new patients from which the sample was drawn was 11,786. The population criteria was based on unique SSNs for whom the patient record creation date was subsequent to September 30, 1997 and ending on the date the records were pulled on March 5, 1998.

Sample Design

From the total "new patient" population we drew two separate statistical samples. This was necessary because of the logistics involved in visiting all facilities within the VISN's geographic area. The first sample was drawn from a population combining the four medical centers (and their satellite facilities) located in the central and southern regions of the VISN's geographic area. The second was drawn from the single large urban facility (and its satellites) located in the northern region of the VISN. The purpose of the file review was to address three objectives:

- To determine the nature of services being provided to "new patients" and whether these services constituted "substantive" care.

- To determine how the Resource Allocation Model counted these "new patients" and the potential effect on resource distributions.

- To determine how "new patients" were being recorded in the Health Eligibility Center's (HEC) Patient Enrollment database.

The random samples were drawn from the two groupings of the patient population based on an attribute sampling design with a 2 percent error rate and a 95 percent confidence level. The sample consisted of a total of 366 records. The following chart shows the breakdown of the total records in the population by facility and the corresponding sample sizes:

VISN 10 Facilities	**Population** (new patients)	**Sample Size**
Chillicothe	1,596	51
Cincinnati	1,129	42
Dayton	1,440	51
Columbus	996	38
Cleveland	6,625	184
TOTALS	11,786	366

SAMPLE RESULTS

To obtain an understanding of the patient population, we gathered detailed information about each of the 366 veterans in our sample, including eligibility and priority categories if information was available. We found that 117 veterans (32 percent) were verified as Category A (15 were service-connected and 102 were low income.) Another 59 (16.1 percent) were verified as Category C. Of the remaining 190 veterans (51.9 percent), 21 had been Category A but needed a means test to update their eligibility, 29 were not service-connected or on pension and required a means test to determine eligibility, 134 were not verified, and 6 had insufficient information available to determine eligibility.

According to the HEC, 17 veterans (4.6 percent) were priorities 1 to 4 (service-connected or on pension), while 206 veterans (56.3 percent) were Category 5 (i.e, non-service connected (NSC), or 0 percent service connected (SC) with low-income). In addition, 4 veterans (1.1 percent) were Category 6 (WWI, exposure to Agent Orange, etc.), 46 (12.6 percent) were category 7 (NSC or 0 percent SC with income exceeding VA's threshold) and 93 (25.4 percent) had no record.

Our review also determined that 30 patients (8.2 percent) had Compensation and Pension or other mandated examinations, 66 (18 percent) required no medical services, 138 (37.7 percent) attended health fairs and 132 (36.1 percent) required substantive, continuing care. The sample results found that 234 (63.9 percent) did not receive substantive care. We also found that 116 (31.7 percent) of the 366 veterans in our sample were not included in Veterans Equitable Resource Allocation (VERA) model which could result in VISN 10's loss of funding in the FY 2000 budget year.

Based on our review, we determined that 90 patients (25 percent) in our sample were eligible to be enrolled but were not recorded in HEC's enrollment database. Of this 90, 54 veterans (15 percent) had requested or received care and were

required to be included in the enrollment database. The remaining 36 (10 percent) received mandated care and were not required to be enrolled, however VA strongly encourages enrolling these veterans.

PROJECTION TO POPULATION

Based on the results of our review, we estimate that in FY 1998 VISN 10's number of new patients will be 27,408 (11,786/5.16 months x 12 months). Because the expected error rate in our sample was lower than routinely used in our audits (2 percent versus 5 percent), and because the final funding levels for patient workload will not be known until after the end of the current FY, we have not provided projections within the upper and lower limits of the expected error rate (i.e., +/- 2 percent.) As a result, our sample result projections are based on conservative mid-point estimates.

NATURE OF SERVICES PROVIDED

Based on our analysis, we project the nature of the medical services provided to VISN 10's new patients as follows:

Requires substantive, continuing care (27,408 x 36.1 percent)	9,894
Requires C&P or other mandated exams only (27,408 x 8.2 percent)	2,248
Requires health fair/initial visit only (27,408 x 37.7 percent)	10,333
Requires no medical service (27,408 x 18 percent)	4,933
TOTAL	27,408

Based on our review, we project that 9,894 (36.1 percent) of 27,408 new patient/veterans in FY 1998 will required substantive resources for continuing care, 2,248 (8.2 percent) will required resources for a short duration to accomplish mandated exams, 10,333 (37.7 percent) will require minimum resources to provide primarily health fair services only, and 4,933 (18 percent) will require no medical services.

RESOURCE ALLOCATION MODEL

Since 116 (31.7 percent) of the 366 veterans in our sample were excluded from the VERA model calculations and are potentially unfunded, we project that 8,688 veterans (27,408 x 31.7 percent) are potentially unfunded. For FY 1998, there were 120,560 veterans, consisting of 115,276 (95.6 percent) Basic-care and 5,284

(4.4 percent) Special-care. Therefore, the number of veterans potentially unfunded in each category of care is:

Type of Care	No. of Veterans	Percentage	TOTAL
Basic	8,688	95.6%	8,306
Special	8,688	4.4%	382
TOTAL			8,688

Based on the FY 1997 VERA funding levels for Basic-care veterans ($2,596) and Special-care veterans ($35,707), we project that VISN 10 could lose $35.2 million in future FY 2000 funding. (The VISN FY 2000 funding levels will be calculated by VA based on the FY 1998 workload which our sample results are based on.)

Type of Care	No. of Veterans	Funding Rate	TOTAL
Basic Care	8,306	$2,596	$21,562,376
Special Care	382	$35,707	13,640,074
TOTAL	8,688		$35,202,450

HEALTH ELIGIBILITY CENTER

We project that during FY 1998, 6,852 (27,408 x 25 percent) of VISN 10's veterans were eligible to be enrolled but were not included in HEC's enrollment database. Of this total 4,111 veterans will have requested or received care and would be required to be included in HEC's enrollment database. An additional 2,741 veterans will have received mandated care and should be encouraged to enroll.

MONETARY BENEFITS
IN ACCORDANCE WITH IG ACT AMENDMENTS

Report Title: Audit of Veterans Integrated Service Network (VISN 10) Organization, Planning, and Implementation of Key Strategic Goals and Objectives

Project Number: 8D2-048

Recommendation Number	Category/Explanation of Dollar Impact	Better Use of Funds	Questioned Costs
2	Better Use of Funds. Annual budget allocation that the Network could potentially lose if countable workload is omitted in the VERA funding model calculations.	$35,202,450	
Total		$35,202,450	

VISN 10 DIRECTOR COMMENTS

Department of Veterans Affairs

Memorandum

Date: December 29, 1998

From: Network director, VA Healthcare System of Ohio (10N10)

Subj: **Draft Report of Audit of Veterans Integrated Service Network (VISN 10) Organization, Planning, and Implementation of Key Strategic Goals and Objectives**

To: Assistant Inspector General for Auditing (52)

1. This memo summarizes and finalizes VISN 10's response to this audit.

Recommendation 1: Concur.

A VISN 10 Corporate Data Management Board has been established to assure the accuracy and adequacy of network data collections systems. Network oversight of the enrollment processes will also occur at the Executive Leadership Council once routine reports become available from the national data bases. This is currently planned for February. However, the budget impact of not capturing an enrollment application is impacted by the following factors:

- There is no direct relationship between enrollment and VERA allocation
- Operationally, there will be a rolling enrollment process at the Network level so there should be no lasting impact to initially missed enrollees
- Number of enrollees has no definite relationship to number of users
- With plans to enroll all veterans (including Category C) and newly expanded clinical benefits package (e.g., infertility, maternity, and emergency care), forecasting of FY99 workload is not yet possible due to lack of system experience
- System-wide VERA implementation within an overall flat global budget minimizes individual impact on the budget

Recommendation 2: Concur.

The Network worked with the Allocation Resource Center (ARC) to validate the numbers provided in the Draft Audit Report. The ARC has provided some updated information which has captured a significant number of the omitted patients. In addition, the Network has taken steps to improve internal data collection systems. These steps include third party collection audits, medical record coding audits, training of all coders and physicians in current coding practices, the development of Network-wide standardized encounter forms, the recruitement of a Corporate Database Manager, and the ongoing feedback of internally generated information to facilities. At a national level, the Network Director is participating on a new Task Force to identify data elements that VHA will use on an ongoing basis to monitor enrollment. Those

elements, as currently envisioned, will require the ongoing collaboration of the ARC, the Austin Automation Center, and the HEC. First reports are expected in February. Additionally, both the Network Chief Medical Officer and the Network Planner are serving on the VHA Data Quality Summit Planning Committee and served on faculty for the December Data Quality Summit that was held in Washington, DC.

2. If you have any further questions, you may contact Ms. Peg Dochterman, Network Planner, at 513-697-2615.

(Original signed by:)
Laura J. Miller

Cc: Chief Network Officer (10N)

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This report will be available in the near future on the VA Office of Audit web site at **http://www.va.gov/oig/reports/mainlist.htm** List of Available Reports. This report will remain on the OIG web site for two fiscal years after it is issued.