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United States General Accounting Office
Washington, DC 20548

Health, Education, and
Human Services Division

B-285520

June 30, 2000

The Honorable Fred Thompson, Chairman
The Honorable Joseph I. Lieberman, Ranking Member
Committee on Governmental Affairs
United States Senate

Subject: Observations on the Department of Veterans Affairs' Fiscal Year 1999 Performance Report and Fiscal Year 2001 Performance Plan

As you requested, we have reviewed the 24 Chief Financial Officers Act agencies' fiscal year 1999 performance reports and fiscal year 2001 performance plans required by the Government Performance and Results Act of 1993 (GPRA). In essence, under GPRA, annual performance plans are to establish performance goals and measures covering a given fiscal year and provide the direct linkage between an agency's longer term goals and day-to-day activities. Annual performance reports are to subsequently report on the degree to which those performance goals were met.

This letter contains two enclosures responding to your request concerning key program outcomes and major management challenges at the Department of Veterans Affairs (VA). Enclosure I provides our observations on VA's fiscal year 1999 performance and fiscal year 2001 planned performance for the key outcomes that you identified as important mission areas for the agency. These key outcomes are (1) veterans are provided high-quality health care at a reasonable cost to the government, (2) veterans' benefit claims are processed timely and accurately, (3) disabled veterans acquire and maintain suitable employment, and (4) reduced availability and/or use of illegal drugs. Enclosure II lists the major management challenges facing the Department that we and VA's Inspector General (IG) identified, how VA's fiscal year 1999 performance report discussed the progress the Department made in resolving these challenges, and the applicable goals and measures in the fiscal year 2001 performance plan.

Results in Brief

Overall, VA's fiscal year 1999 performance showed progress in providing quality health care at a reasonable cost. The performance goals were objective, measurable, quantifiable, and generally results-oriented. Although VA did not meet all of its fiscal year 1999 performance goals, it met one of its most important goals—to reduce the

average health care cost per patient by 13 percent since fiscal year 1997; actual performance reported was a 16-percent reduction. VA slightly missed another key goal—to improve quality as measured by the Chronic Disease Care Index. The goal was to achieve a score on this index of 91 percent; actual performance was 89 percent. For many of VA's unmet goals, fiscal year 1999 performance exceeded fiscal year 1998 performance. For example, in fiscal year 1999, VA increased to 519 the number of community-based outpatient clinics, slightly missing its goal of 532. However, the number of clinics increased by 43 percent from fiscal year 1998. Generally, VA's performance report provided reasons why goals were not met. The report also provided means and strategies for achieving future key goals—the goals VA considers most important.

VA's health care performance goals and measures for fiscal years 2000 and 2001 have been revised to reflect actual fiscal year 1999 performance, and to reflect VA's latest evaluation of how to best measure its success. VA revised the quantitative goals for some of its performance measures, based on fiscal year 1999 performance. For example, VA had performance goals that 78 percent of spinal cord injury patients rate their inpatient and outpatient care as good or excellent, but actual fiscal year 1999 performance was 55 percent. When VA established the 78-percent goal, benchmarking data were unavailable. Based on performance for fiscal years 1998 and 1999 remaining consistent at 55 percent, VA lowered these goals in FY 2000 to 57 percent. VA dropped some performance goals in fiscal year 2000, and added others. These changes were made because (1) some fiscal year 1999 goals were unrealistic, (2) VA decided that it had too many goals and measures and attempted to focus on fewer and more outcome-oriented goals and measures, and (3) VA met some goals early. Also, VA revised the set of key performance goals and measures for its health care program. For example, VA designated three key goals and measures for the timeliness of medical appointments—including two for which it has yet to develop quantifiable goals because it has not yet developed baseline data.

VA failed to meet its fiscal year 1999 performance goals related to the timely and accurate processing of veterans' benefit claims. These goals covered the accuracy and timeliness of VA decisions on claims for compensation and pension benefits, and the timeliness of resolution of veterans' appeals of claims decisions. VA failed to meet most of these goals by substantial margins. VA set a fiscal year 1999 goal to complete decisions on compensation and pension claims in an average of 99 days; actual performance was 166 days. Another goal was to resolve initial decisions appealed to VA's Board of Veterans Appeals within an average of 590 days; actual performance was 745 days. The performance goals were objective, measurable, and quantifiable. VA revised its performance goals for fiscal years 2000 and 2001 to make them more realistic: the fiscal year 2001 goal for claims processing timeliness is 142 days; the goal for appeals resolution timeliness is 650 days. VA's performance report explained why it failed to meet its key accuracy and timeliness goals and provided means and strategies for meeting its future goals. Like last year, VA has still not developed results-oriented goals for the compensation and pension programs, although it is in the process of developing such goals. In addition, the Veterans Benefits Administration (VBA) does not provide a true picture of the individual

performance of each of these two programs because it externally reports combined compensation and pension data.

In May 2000, we testified before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, that VA's problems with large claims backlogs and long waits for decisions have not improved, despite years of study.[1] Many of these problems stem from the growing complexity of claims processing, due to (1) increasing numbers of service-connected disabilities per veteran and (2) increasing procedural and documentation requirements. Although VA has a number of initiatives to streamline its claims processing performance and improve accuracy, it is unclear how much improvement will be gained. Among VA's key initiatives are (1) the Systematic Technical Accuracy Review (STAR), designed to provide data on accuracy, which in turn would help to identify staff training needs, and (2) the Training and Performance Support System (TPSS), designed to provide the needed training.

In fiscal year 1999, VA achieved both performance goals related to helping disabled veterans acquire and maintain suitable employment. In particular, 53 percent of veterans who exited the vocational rehabilitation program obtained and maintained suitable employment—technically exceeding the performance goal of 45 percent. These performance goals were objective, measurable, quantifiable, and generally results-oriented. We have noted, however, that while this rehabilitation rate generally shows VA's progress in moving the vocational rehabilitation program's focus toward helping veterans find employment, it does not fully measure program results because it (1) focuses on veterans who left the program, rather than on all veterans eligible for the program and (2) does not consider how long it took veterans to complete the program.

Based on fiscal year 1999 performance, VA established higher strategic and performance goals for the vocational rehabilitation program. In its fiscal year 2001 performance plan, VA reported that it raised the strategic rehabilitation rate goal to 70 percent, with performance goals of 60 percent in fiscal year 2000 and 65 percent in fiscal year 2001. In response to criticisms of the vocational rehabilitation program by us and other stakeholders, VA has several initiatives under way to continue to improve program performance. As part of its effort to better focus the program on its outcome—employment—VA is working to improve staff training, in cooperation with the Department of Labor. This training is intended to improve the staff's ability to assist veterans in obtaining and maintaining employment—for example, by helping veterans improve their interviewing skills. Also, VA plans to improve veterans' access to the program—for example, by providing staff with the tools to do their jobs away from VA offices and closer to the veterans they are assisting.

VA does not have any performance goals and measures directly related to reducing the availability and use of illegal drugs. However, VA slightly exceeded its one performance goal indirectly related to this outcome. In fiscal year 1999, 56 percent of

[1] Veterans Benefits Administration: Problems and Challenges Facing Disability Claims Processing (GAO/T-HEHS/AIMD-00-146, May 18, 2000).

the patients with primary addictive disorders showed improvement in their addiction severity index (ASI) composite scores at 6 months after their initial ASI assessment. This goal is not considered by VA to be a "key" performance goal, one that is critical to the success of the Department. For this reason, VA provides limited details in its performance report and performance plans on data verification and future plans and strategies as they relate to this goal. Notwithstanding this, for fiscal years 1999 and 2000, VA used a measure to assess its progress toward achieving this outcome that was results-oriented, objective, and quantifiable. However, in its fiscal year 2001 performance plan, VA changed its goal to one that was more process-oriented. Rather than assess the percentage of patients who show improvement in their ASI composite scores, the revised goal will assess the percentage of patients who receive a 6-month follow-up ASI assessment.

In addition to this performance goal, VA is taking actions to address the inadequate internal controls over its lower scheduled addictive drugs.[2] In a 1991 report, we recommended that VA pharmacies address internal weaknesses related to storing, dispensing, and monitoring lower scheduled drugs.[3] According to VA's Federal Manager's Financial Integrity Act report, in fiscal year 1999, VA continued to make progress toward correcting this material weakness. VA expects to have this material weakness corrected by September 2000.

VA's fiscal year 1999 performance report and fiscal year 2001 performance plan indicated some progress in addressing major management challenges we and VA's IG identified. For example, VA has made some progress in improving veterans' access to health care services. On the other hand, VA has not made significant progress in addressing such challenges as restructuring its health care infrastructure or improving the timeliness and accuracy of compensation and pension claims processing.

VA, in its fiscal year 1999 performance report and fiscal year 2001 performance plan, identified at least one goal, measure, or strategy to address 9 of its 11 major management challenges. The exceptions were the challenges related to (1) assessing the effect of managed care initiatives and (2) deficient VA debt prevention and collection practices:

- For two challenges, VA had at least one directly applicable goal and measure—addressing the lack of information on whether veterans have access to needed health care services and difficulties in managing nonhealth benefits programs.
- For another challenge—addressing VA's health care infrastructure's failure to meet current and future health care needs—VA did not have a directly applicable goal and measure, but it had an indirectly applicable goal and measure.
- For the other six challenges, VA had no directly or indirectly applicable goals and measures but provided strategies to address these challenges. These challenges are related to the need to (1) more effectively manage information systems, (2)

[2]Lower scheduled drugs generally have accepted medical use for treatment in the United States and have a potential for limited and moderate physical or psychological dependence.
[3]VA Health Care: Inadequate Controls Over Addictive Drugs (GAO/HRD-91-101, June 6, 1991).

address the potential for medical errors, (3) improve compensation and pension medical examinations, (4) more effectively manage VA's Federal Employees' Compensation Act (FECA) program, (5) improve identification of inappropriate benefit payments, and (6) address erroneous data in VA's automated data collection systems.

Objectives, Scope, and Methodology

Our objectives concerning selected key outcomes for VA were to (1) identify and assess the quality of the performance goals and measures directly related to a key outcome, (2) assess VA's actual performance in fiscal year 1999 for each outcome, and (3) assess VA's planned performance for fiscal year 2001 for each outcome. Our objectives concerning major management challenges were to (1) assess how well VA's fiscal year 1999 performance report discussed the progress it had made in resolving the major management challenges that we and the Department's IG had previously identified and (2) identify whether VA's fiscal year 2001 performance plan had goals and measures applicable to the major management challenges.

As agreed, in order to meet the Committee's tight reporting time frames, our observations were generally based on the requirements of GPRA, guidance to agencies from the Office of Management and Budget for developing performance plans and reports (OMB Circular A-11, part 2), previous reports and evaluations by us and others, our knowledge of VA's operations and programs, and our observations on VA's other GPRA-related efforts. We did not independently verify the information contained in VA's performance report or plan. We conducted our review from April through May 2000 in accordance with generally accepted government auditing standards.

Agency Comments and Our Evaluation

We discussed this letter with VA officials on June 13, 2000, and received written comments from VA's Assistant Secretary for Planning and Analysis on June 16, 2000. VA generally agreed with our findings and was pleased with our acknowledgment of its efforts to explain why it did not meet some of its fiscal year 1999 performance goals. Also, VA appreciated our discussion of its efforts to improve computer security and commented that it plans to more fully integrate its information technology goals and measures into its formal GPRA documents. Based on VA's comments, we revised this letter to clarify (1) changes made to fiscal year 2000 and fiscal year 2001 goals based on fiscal year 1999 actual performance and (2) the fiscal year 2001 performance plan's presentation of budgetary information. In addition, we incorporated VA's technical comments where appropriate.

VA disagreed with our statement that by combining compensation and pension data, VBA will not be able to provide a true picture of the individual performance of the compensation and pension programs. VA stated that, while its external reports combined compensation and pension timeliness and accuracy data, it maintains more detailed information internally on the individual performance of each program. We continue to believe that VA's external reports should include separate claims

processing goals and measures for the compensation and pension programs because problems in one of the programs can be masked by data from the other and will not be surfaced in the reports.

VA does not believe that its substance abuse treatment program should be included under the "reduced availability and/or use of illegal drugs" key outcome. Rather, it believes that only its efforts to physically protect controlled substances from access by unauthorized persons should be addressed. We included both the drug addiction treatment and physical protection program because each of them should contribute to the key outcome.

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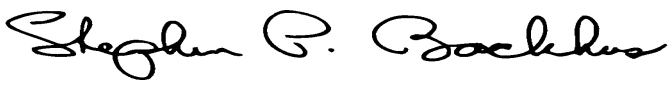
As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Honorable Togo West, Secretary of Veterans Affairs; appropriate congressional committees; and other interested parties. Copies will also be available through our web site, "www.gao.gov." If you or your staff have any questions, please call me at (202) 512-7101. Key contributors to this letter were Shelia Drake, Greg Whitney, Maria Vargas, Linda Diggs, Sandy Davis, Helen Lew, Alana Stanfield, Robert Kershaw, Mike Resser, and Bonnie McEwan.



Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Enclosures—2

OBSERVATIONS ON THE DEPARTMENT OF VETERANS AFFAIRS' FISCAL YEAR 1999 ACTUAL PERFORMANCE AND FISCAL YEAR 2001 PLANNED PERFORMANCE RELATED TO KEY OUTCOMES

This enclosure contains our observations on VA's FY 1999 actual performance and FY 2001 planned performance related to the following selected key outcomes: (1) veterans are provided high-quality health care at a reasonable cost to the government, (2) veterans' benefit claims are processed timely and accurately, (3) disabled veterans acquire and maintain suitable employment, and (4) reduced availability and/or use of illegal drugs.

Key Agency Outcome: Veterans Are Provided High-Quality Health Care at a Reasonable Cost to the Government

Table I-1 shows VA's 29 performance goals and measures that relate to the key agency outcome of ensuring veterans are provided high-quality health care at a reasonable cost to the government and whether or not these goals were met in FY 1999, as reported in VA's FY 1999 performance report.

Table I-1: Goals and Measures to Ensure Veterans Are Provided High-Quality Health Care at a Reasonable Cost to the Government and Their FY 1999 Status, as Reported by VA

Goal/measure	FY 1999 status
Key performance goals	
Reduce by 13% the FY 1997 average cost per patient.	Goal met (16%)
Increase to 4.3% the percentage of the medical care operating budget derived from alternative revenue streams.	Goal not met (3.8%)
Increase to 91% the Chronic Disease Care Index.	Goal not met (89%)
Increase to 87% the Prevention Index.	Goal not met (81%)
Increase to 79% the percentage of customers rating VA inpatient health care service as very good or excellent.	Goal not met (65%)
Increase to 79% the percentage of customers rating VA outpatient health care service as very good or excellent.	Goal not met (65%)
Increase to 532 the number of community-based outpatient clinics.	Goal not met (519)
Related performance goals	
Increase to 96% the Palliative Care Index.	Goal met (96%)
Increase to 87% the percentage of patients who know there is one provider or team in charge of their care.	Goal not met (76%)
Increase to 75% the percentage of patients discharged for mental health disorders who receive outpatient care related to mental health within 30 days of discharge.	Goal met (81%)
Increase to 87% the percentage of patients who rate the quality of VA health care as equivalent to or better than any other health care providers.	Goal not met (84%)
Reduce to 1,330 the number of bed days of care per 1,000 unique patients.	Goal met (1,136 bed days)

Goal/measure	FY 1999 status
Increase to 68% the percentage of patients seen within 20 minutes of scheduled appointments.	Goal met (68%)
Increase to 44% the percentage of residents trained in primary care.	Goal met (46%)
Reallocate 375 specialty resident positions to primary care.	Goal not met (358 positions)
Eliminate 125 specialty resident positions.	Goal met (127 positions)
Increase to 27% the percentage of long-term care patients who are being cared for in a clinically appropriate setting.	Goal met (29.4%)
Increase to 86% the percentage of diabetic patients identified as at risk for foot amputations who will be referred to a foot care specialist.	Goal met (86%)
Increase to 78% the percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their inpatient care as very good or excellent.	Goal not met (55%)
Increase to 78% the percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their outpatient care as very good or excellent.	Goal not met (55%)
Maintain at 89% the mammography examination rate.	Goal met (91%)
Increase to 93.5% the Pap smear examination rate.	Goal met (94%)
Increase to 128, the number of patients in the traumatic brain injury protocol.	Goal met (174 patients)
Increase to 64% first admission traumatic brain injury patients who will be discharged to a community setting.	Goal met (65.8%)
Increase to 60% the percentage of medical centers with at least one clinician who has received primary care education training on health care of former prisoners of war.	Goal met (66%)
1% of seriously mentally ill patients will show improvement in Global Assessment of Functioning Index.	Goal met (3.4%)
Maintain at 97.7% the percentage of patients reflected on the National Blind Rehabilitation Customer Satisfaction Survey who are fully or highly satisfied.	Goal met (98%)
Maintain at 2% the percentage of prosthetic orders not placed within 5 work days.	Goal met (1.3%)
Limit to 27% the percentage of patients reporting coordination of care problems.	Goal not met (29%)

GAO Observations on VA's FY 1999 Goals and Measures to Ensure Veterans Are Provided High-Quality Health Care at a Reasonable Cost to the Government

In FY 1999, VA met one of the seven key performance goals and most of its other goals related to this outcome. The performance measures are objective, measurable, quantifiable, and generally outcome-oriented; overall, they adequately indicate progress toward the performance goals.

The performance report clearly presented which goals were and were not achieved. In most instances, performance improved over FY 1998, and the differences between VA's goals and actual performance were not significant. For example, the Chronic Disease Care Index increased to 89% rather than the planned 91%. VA fell significantly short of

meeting a few goals. For example, VA had goals to increase to 78% the percentage of spinal cord injury patients who rate their inpatient and outpatient care as very good or excellent, but VA's FY 1998 and FY 1999 performance was only 55%.

VA's performance report reflected some changes in its FY 1999 health care performance goals and measures after the issuance of its FY 1999 performance plan in February 1998. VA's final FY 1999 performance goals were included in the FY 2000 performance plan—for example, (1) the ratio of outpatient visits to inpatient admissions, (2) the percentage of VA medical centers with one or more Department of Defense (DOD) managed care (TRICARE) contracts, and (3) the percentage of health care funds expended on outpatient care. VA did not state in its FY 1999 performance report that it had changed these goals and measures after issuing the FY 1999 performance plan. VA officials explained that these changes were made to the FY 1999 performance goals because (1) the Veterans Health Administration (VHA) included more goals than necessary in the FY 1999 performance plan; (2) some goals duplicated each other; for example, the ratio of outpatient visits to inpatient admissions and the percentage of health care funds expended on outpatient care duplicated the number of bed days of care per 1,000 unique patients; and (3) VHA decided to focus on the most significant goals and make all their goals results-oriented; for example, three medical care collections fund-related goals were dropped because they were not considered to be significant.

VA's FY 1999 performance report reflects limited assurance that its performance information is credible; however, VA has improved in this area. VA's IG has found erroneous data in many computerized systems including those involved in the medical care program. For example, the IG found that VA's data overestimated the number of unique patients by 5.7% in FY 1997. VHA agreed to implement the IG's recommendations to (1) establish edit checks on data input into the National Patient Care Database and (2) establish edit checks to identify inaccurate Social Security numbers.

The FY 2001 performance plan lists some actions VA has taken to begin to address data weaknesses. For example, VA's Health Care Decision Support System Steering Committee recently completed a test of four national measures of data quality. Based on the outcome of these tests, recommendations regarding standardization and data quality will be forwarded to VA's National Leadership Board for action.

Unmet FY 1999 Performance Goals and Measures for This Key Outcome

VA's performance fell short of its targets for 12 goals:

- The percentage of the medical care operating budget derived from alternative revenue streams was 3.8% (goal: 4.3%).
- The Chronic Disease Care Index was 89% (goal: 91%).
- The Prevention Index was 81% (goal: 87%).
- The percentage of customers rating VA inpatient health care service as very good or excellent was 65% (goal: 79%).

- The percentage of customers rating VA outpatient health care service as very good or excellent was 65% (goal: 79%).
- The number of community-based outpatient clinics was 519 (goal: 532).
- The percentage of patients who rate the quality of VA health care as equivalent to or better than any other health care providers was 84% (goal: 87%).
- The number of reallocated specialty resident positions to primary care was 358 (goal: 375 positions).
- The percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their inpatient care as very good or excellent was 55% (goal: 78%).
- The percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their outpatient care as very good or excellent was 55% (goal: 78%).
- The percentage of patients who know there is one provider or team in charge of their care was 76% (goal: 87%).
- The percentage of patients reporting coordination of care problems was 29% (goal: 27%).

VA adequately explained the extent to which it failed to achieve these goals, categorizing the extent to which goals were not met as significant or minimal. For example, while VA did not meet the goals for the Chronic Disease Care Index and Prevention Index, the deviation was slight and had minimal effect on overall program effectiveness. Also, while VA failed to meet its goal for increasing the number of community-based outpatient clinics by a small margin, FY 1999 performance represented a 43% increase over FY 1998.

VA generally provided clear reasons for its unmet FY 1999 performance goals. For example, VA explained that it failed to meet (1) the alternative revenue streams funding goal because the Congress has not given VA authority to collect from Medicare for care provided to Medicare-eligible veterans and (2) the goal for percentage of patients rating VA health care as very good or excellent for both inpatient and outpatient care because the goal was set unrealistically high and had to be adjusted to be better aligned with historical results. Where VA missed a goal by a small margin, VA noted this in its performance report and noted that there was minimal effect on program performance. VA also provided means and strategies for achieving future key goals.

VA's FY 2000 Performance Goals and Measures to Ensure Veterans Are Provided High-Quality Health Care at a Reasonable Cost to the Government

Goals and Measures Added

- Percentage of patients able to schedule a specialty care appointment within 30 days (no numerical target).
- Percentage of patients able to schedule a primary care appointment within 30 days (no numerical target).
- Increase to 70% the rate of prophylaxis for HIV-related opportunistic infections.

- Increase to 95% the percentage of medical facilities that have at least one clinician trained in primary care for Gulf War veterans.
- Increase to 65% the percentage of homeless patients with mental illness who receive a follow-up mental health outpatient visit, Compensated Work Therapy/Transitional Residence, or admission to a Psychiatric Residential Rehabilitation Treatment Program within 30 days of discharge.
- Increase to 94% the proportion of discharges from spinal cord injury bed sections to noninstitutional settings.
- Increase to 52% the percentage of veterans currently enrolled in the national post-traumatic stress disorder outcome-monitoring system who will be successfully followed-up by the fourth month after discharge.
- Veterans will receive VA mental health services for 4.36 months during their first 6 months after their first post-traumatic stress disorder visit.

Goals and Measures Dropped

VA dropped several goals and measures related to this outcome, including the following:

- The number of bed days of care per 1,000 unique patients.
- The percentage of patients discharged for mental health disorders who receive outpatient care related to mental health within 30 days of discharge.
- The number of specialty resident positions shifted to primary care.
- The number of specialty resident positions eliminated.
- The percentage of long-term care patients who are being cared for in a clinically appropriate setting.
- The percentage of seriously mentally ill patients who will show improvement in the Global Assessment of Functioning Index.
- The percentage change in medical care collections from the previous year.

Goals and Measures Changed

- Reduce by 16% (from 13%) the FY 1997 average cost per patient.
- Maintain at 4% (from “increase to 4.3%”) the percentage of the medical care operating budget derived from alternative revenue streams.
- Maintain at 89% (from “increase to 91%”) the Chronic Disease Care Index.
- Increase to 89% (from 87%) the Prevention Index.
- Increase to 67% (from 79%) the percentage of customers rating VA inpatient health care service as very good or excellent.
- Increase to 67% (from 79%) the percentage of customers rating VA outpatient health care service as very good or excellent.
- Increase to 47% (from 44%) the percentage of residents trained in primary care.
- Increase to 622 (from 532) the number of community-based outpatient clinics (also, a key performance goal in FY 1999, now a related performance goal).
- Increase to 97% (from 96%) the Palliative Care Index.
- Increase to 80% (from 75%) the percentage of patients who know there is one provider or team in charge of their care.

- Increase to 89% (from 87%) the percentage of outpatients (from "patients") who rate the quality of VA health care as equivalent to or better than any other health care providers.
- Increase to 75% (from 68%) the percentage of patients seen within 20 minutes of scheduled appointments.
- Increase to 88% (from 86%) the percentage of diabetic patients identified as at risk for foot amputations who will be referred to a foot care specialist.
- Increase to 57% (from "increase to 78%") the percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their inpatient care as very good or excellent.
- Increase to 57% (from "increase to 78%") the percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their outpatient care as very good or excellent.
- Increase to 92% (from 89%) the mammography examination rate.
- Maintain at 94% (from 93.5%) the Pap smear examination rate.
- Increase to 66% (from 65%) the percentage of first admissions traumatic brain injury patients who will be discharged to a community setting.
- Increase to 80% (from 60%) the percentage of medical centers that will have at least one clinician trained in problems, diseases, and experiences prevalent in former prisoners of war.
- Maintain at 98% (from 97.7%) the percentage of patients reflected on the National Blind Rehabilitation Customer Satisfaction Survey who are satisfied or completely satisfied.
- Reduce to 15% the percentage of patients reporting coordination of care problems in the outpatient customer feedback survey (from "limit to 27% the percentage of patients reporting coordination of care problems").

GAO Observations on the FY 2000 Performance Plan for This Key Outcome

VA revised some of its FY 2000 goals to make them consistent with actual FY 1999 performance. These revised goals appear in VA's FY 2001 performance plan. For example, VA lowered its goals for spinal cord injury patients who rated their care as very good or excellent—for both inpatient and outpatient care. VA's FY 1999 goals were 78% for each measure, but its actual FY 1999 performance was 55%. VA lowered the FY 2000 goals to 57%. In its FY 1999 performance report, VA stated that, due to a lack of benchmarking experience, the FY 1999 goals were unrealistic.

VA did not state in its report the reasons why some goals were dropped. However, according to a VA official, the reasons were the following:

- Some goals were unrealistic. For example, VHA set unrealistic goals for customer satisfaction for those with spinal cord injuries because it lacked the benchmarking experience needed to set realistic goals.
- VHA had included too many performance goals in the FY 1999 performance plan. For FY 2000, VHA attempted to focus on fewer, but more outcome-oriented performance goals and measures. For example, VA had four FY 1999 goals for its Medical Care

Collections Fund; in FY 2000, this was reduced to one goal—the percentage of health care funding from alternative revenue streams.
- Some goals were met or exceeded. For example, VA exceeded its FY 1999 goal to reduce the bed days of care by almost 200 days and VA determined that it would be unrealistic to further reduce this measure.

In addition, VA significantly changed one performance measure—the percentage of veterans reporting coordination of care problems. According to VA, this measure was refocused from reflecting a variety of coordination of care issues to one issue—transfer of care for patients among health care providers. This narrower focus resulted in a smaller percentage of patients reporting coordination of care problems than under the previous measure.

VA's FY 1999 performance report and FY 2000 and FY 2001 performance plans describe means and strategies to improve the quality and cost-effectiveness of VA health care. These means and strategies include (1) shifting care from inpatient to outpatient settings; (2) obtaining additional funding from nonappropriated sources, such as third-party insurers; and (3) implementation of nationally recognized guidelines for ensuring health care quality.

VA's FY 2001 Performance Goals and Measures to Ensure Veterans Are Provided High-Quality Health Care at a Reasonable Cost to the Government

Goals and Measures Changed

- Increase to 95% (from 89%) the Chronic Disease Care Index.
- Increase to 90% (from 89%) the Prevention Index.
- Increase to 68% (from 67%) the percentage of customers rating VA inpatient health care service as very good or excellent.
- Increase to 68% (from 47%) the percentage of customers rating VA outpatient health care service as very good or excellent.
- Increase to 48% (from 47%) the percentage of residents trained in primary care (elevated to key performance goal).
- Percentage of patients able to schedule primary care appointments within 30 days (no numerical target).
- Percentage of patients able to schedule specialist appointments within 30 days (no numerical target).
- Increase to 79% (from 75%) the percentage of patients with scheduled appointments at VA health care facilities seen within 20 minutes.
- Increase to 635 (from 622) the number of community-based outpatient clinics.
- Increase to 98% (from 97%) the Palliative Care Index.
- Increase to 85% (from 80%) the percentage of patients who know there is one provider or team in charge of their care.
- Increase to 89.5% (from 89%) the percentage of outpatients who rate the quality of VA health care as equivalent to or better than any other health care providers.

- Increase to 90% (from 88%) the percentage of diabetic patients identified as at risk for foot amputations who will be referred to a foot care specialist.
- Increase to 58% (from 57%) the percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their inpatient care as very good or excellent.
- Increase to 58% (from 57%) the percentage of spinal cord injury respondents to the National Customer Feedback Center Survey who rate their outpatient care as very good or excellent.
- Increase to 93% (from 92%) the mammography examination rate.
- Increase to 95% (from 94%) the Pap smear examination rate.
- Increase to 67% (from 66%) the percentage of first admissions of traumatic brain injury patients who will be discharged to a community setting.
- Increase to 100% (from 80%) the percentage of medical centers with at least one clinician trained in problems, diseases, and experiences prevalent in former prisoners of war.
- Reduce to 14% (from 15%) the percentage of patients reporting coordination of care problems in the outpatient customer feedback survey.
- Increase to 75% (from 70%) the rate of prophylaxis for HIV-related opportunistic infections.
- Increase to 100% (from 95%) the percentage of medical facilities who have at least one clinician trained in primary care for Gulf War veterans.
- Increase to 66.5% (from 65%) the percentage of homeless patients with mental illness who receive a follow-up mental health outpatient visit, Compensated Work Therapy/Transitional Residence, or admission to a Psychiatric Residential Rehabilitation Treatment Program within 30 days of discharge.
- Increase to 95% (from 94%) the proportion of discharges from spinal cord injury bed sections to noninstitutional settings.
- Increase to 53% (from 52%) the percentage of veterans currently enrolled in the national post-traumatic stress disorder outcome-monitoring system who will be successfully followed-up by the fourth month after their first post-traumatic stress disorder visit.
- Increase to 4.4 months (from 4.36 months) the number of months veterans receive VA mental health services during their first 6 months after their first post-traumatic stress disorder visit.

These FY 2001 goals are preliminary. VA will publish its final FY 2001 goals in its FY 2002 performance plan.

GAO Observations on the FY 2001 Performance Plan for This Key Outcome

In general, VA's FY 2001 performance plan shows how it expects to improve the quality and cost-effectiveness of its health care. Generally, the plan presents a set of goals and measures that will allow assessment of VA's actual FY 2001 progress toward achieving the strategic goals for this outcome. For almost all performance measures, the FY 2001 goals reflect expected improvement over expected FY 2000 performance. Two exceptions are (1) average cost per patient and (2) percentage of health care funding

from alternative revenue streams. One measure is expected to remain the same as in FY 2000, and the other is expected to drop by 1%. VA plans to reevaluate whether it will continue to use average cost per patient as one of its key goals and measures. Also, VA expects the percentage of funds from alternative revenues to drop by 1% in part because VA has not obtained the authority to collect from Medicare.

The FY 2001 performance plan includes a revised list of key performance goals and measures. VA noted that it modified its performance goals and measures as necessary to reflect its latest evaluation as to how to best measure its success. VA elevated to key goal and measure status (1) the percentage of residents trained in primary care and (2) the percentage of patients with scheduled appointments at VA health care facilities seen within 20 minutes. Also, VA added two new key goals and measures: (1) percentage of patients able to schedule primary care appointments within 30 days and (2) percentage of patients able to schedule specialist appointments within 30 days. VA has not yet developed quantifiable goals for the latter two key performance measures because it has not yet developed baseline data.

As with the final FY 2000 performance goals, VA's FY 2001 plan reflects actual FY 1999 performance.

VA's discussion of the means and strategies for achieving FY 2001 performance goals for this outcome is similar to the discussion in the FY 2000 performance plan. An exception is the discussion of the alternative revenue streams goal and measure. The FY 2001 performance plan notes that VHA (1) has implemented its reasonable charges system for billing third-party insurers, (2) will implement patient preregistration to ensure accurate insurance information, and (3) will pursue opportunities to contract out all or part of the medical care collections process.

VA has improved its discussion of the budgetary resources needed to implement initiatives to improve the quality and cost-effectiveness of its health care. The FY 2001 performance plan includes a table showing the estimated FY 2001 budget obligations for the medical care, medical education, and medical research programs to support each of VA's new strategic goals, as presented in the plan. VA estimated obligations of approximately $11.4 billion to "restore disabled veterans," $77 million to "assure a smooth transition," $10.4 billion to "honor and serve veterans," $1.1 billion to "support national goals," and $72 million to "provide world-class service." Also, VA indicates that it is still working to restructure its budget accounts to link performance goals with program activities.

VA's FY 2001 performance plan includes a discussion of VHA's efforts to improve the validity, reliability, and integrity of the data it uses to assess its performance. VHA held a Data Quality Summit in December 1998 and established five task forces to address data quality issues. This effort has resulted in recommendations to improve ambulatory care data quality, such as improvement of documentation for coding outpatient care.

VA's FY 2001 performance plan identified numerous information technology strategies for improving VA's health care system. For example, VHA is implementing telemedicine

systems to increase patient access and the efficiency of health care delivery. However, the plan does not include specific goals and measures for these strategies.

Key Agency Outcome: Veterans' Benefits Claims Are Processed Timely and Accurately

Table I-2 shows VA's four performance goals and measures that relate to the key agency outcome of ensuring veterans' benefits claims are processed timely and accurately and whether or not these goals were met in FY 1999, as reported in VA's FY 1999 performance report.

Table I-2: Goals and Measures to Ensure Veterans' Benefits Claims Are Processed Timely and Accurately and Their FY 1999 Status, as Reported by VA

Goal/measure	FY 1999 status
Key performance goals	
Increase to 75% the national accuracy rate for core rating work.	Goal not met (68%)
Decrease to 99 days the average time from receipt of claim to VA's decision for disability rating-related claims.	Goal not met (166 days)
Decrease to 590 days the average time required to resolve appeals of VA compensation and pension claims decisions to the Board of Veterans Appeals.	Goal not met (745 days)
Related performance goal	
Decrease to 91 days the average time that rating-related compensation and pension actions will be pending.	Goal not met (144 days)

GAO Observations on VA's 1999 Goals and Measures to Ensure Veterans' Benefits Claims Are Processed Timely and Accurately

VA did not meet any of the FY 1999 performance goals and measures related to this outcome. VA adequately explains the extent to which it failed to achieve the three key performance goals. For example, it noted that it failed to meet the rating-related timeliness goal—which it missed by 67 days—"a substantial margin," VA acknowledges. These performance measures, which are objective, measurable, and quantifiable, adequately indicate progress towards the performance goals. However, the goals are not outcome-oriented and, therefore, do not measure the results VA wants the compensation and pension (C&P) programs to have for disabled veterans and their families. Instead, these goals measure performance related to the process—claims processing. VA has created placeholders in its performance plans and report for future results-oriented performance for the C&P programs. VBA has contracted for a program evaluation of its dependency and indemnity compensation benefit, which is part of the compensation program. VA expects this evaluation to be completed in June 2000.

VA's FY 1999 performance report reflects limited assurance that its performance information is credible. However, VBA has improved in this area. VA's IG had audited

three timeliness-related performance measures and found that VA's data systems could not ensure accurate data or prevent manipulation of data. VBA has taken steps to improve the reliability of its claims processing data, including conducting reviews of selected claims to ensure that data were properly entered into VBA's claims tracking system.

VA made significant changes in its C&P claims processing goals and measures after the issuance of its FY 1999 performance plan in February 1998. VA's final FY 1999 performance goals were included in the FY 2000 performance plan. VA's changes included the following:

- Adding a key performance goal for claims processing accuracy.
- Consolidating six C&P claims processing timeliness measures into one measure. The consolidated rating-related actions measure includes the following types of actions: original and reopened disability compensation claims, original and reopened pension claims, original dependency and indemnity compensation claims, routine examinations, and reviews due to hospitalization. VA stated that it selected these types of actions for inclusion because they are the most difficult and time-consuming. VA's FY 1999 performance report did not provide actual performance data for the six timeliness measures that VA no longer includes in its performance plans. By externally reporting combined compensation and pension data, VBA will not provide a true picture, in its performance plans and performance reports, of the individual performance of the compensation and pension programs.
- Adding a joint VBA-Board of Veterans Appeals goal and measure of the timeliness of resolution of appeals to the Board of VBA claims decisions.
- Adding a measure of the number of days rating-related actions are pending in VBA before initial decisions are made on them.

VA did not include in its performance report an evaluation or assessment of the effect of FY 1999 performance on expected FY 2000 performance levels. However, it is clear that VA revised its future goals to make them more realistic, based on its FY 1999 performance.

Unmet FY 1999 Performance Goals and Measures for This Key Outcome

- The national accuracy rate for core rating work was 68% (goal: 75%).
- The average time from receipt of claim to VA's decision, for disability rating-related claims was 166 days (goal: 99 days).
- The average time required to resolve appeals of VA compensation and pension claims decisions to the Board of Veterans Appeals was 745 days (goal: 590 days).
- The average time that rating-related compensation and pension actions will be pending was 144 days (goal: 91 days).

VA provided clear statements why it did not meet the three key claims processing goals. The accuracy goal was not met because the implementation of initiatives to improve accuracy took longer than expected. For example, VBA experienced difficulties in

disseminating to its regional offices data needed to identify areas requiring staff training. Among the reasons cited for not meeting claims processing timeliness goals were that

- the goal was unrealistic because it was based on the performance of the best-performing field offices;
- VBA shifted its emphasis from timeliness to quality, which meant staff had to take more time to do a better job of processing claims;
- claims tend to be more complex than in the past, due to the nature of disabilities, and because of decisions of the Court of Appeals for Veterans Claims; and
- VBA did not anticipate the effect of its claims processing improvement initiatives on timeliness or anticipate the amount of training required.

VA failed to meet the goal for appeals resolution timeliness in large part because of the continuing high rate of remands (claims sent back by the Board of Veterans Appeals to VBA for redevelopment).

VA's FY 1999 performance report and FY 2001 performance plan and VBA's FY 2001 business plan identified reasonable plans and actions to achieve unmet performance goals. For example, VA identified two major initiatives designed to improve claims processing accuracy: (1) the STAR program, implemented in FY 1999, which provides data on accuracy at VA field offices and identifies training needs and other measures to improve quality; and (2) TPSS, an initiative to improve the training and performance of claims processing staff. VA also identified a need to hire and train new claims processing staff to compensate for significant losses of experienced staff expected over the next 5 years.

Because the rating-related days pending goal is not a key performance goal, VA did not explain in its performance report why it failed to meet the goal or what strategies it will implement to meet this goal in the future.

VA's Fiscal Year 2000 Performance Goals and Measures to Ensure Veterans' Benefits Claims Are Processed Timely and Accurately

Goals and Measures Changed

- Increase to 81% (from 75%) the national accuracy rate for core rating work.
- Decrease to 160 days (from "decrease to 99 days") the average time from receipt of claim to VA's decision for disability rating-related claims.
- Decrease to 670 days (from "decrease to 590 days") the average time required to resolve appeals of VA compensation and pension claims decisions to the Board of Veterans Appeals.
- Decrease to 150 days (from "decrease to 91 days") the average time that rating-related compensation and pension actions will be pending.

GAO Observations on the FY 2000 Performance Plan for This Key Outcome

VA revised its FY 2000 performance goals to make them consistent with actual FY 1999 performance. VA presented these revised FY 2000 goals in its FY 2001 performance plan. For three of the four claims processing timeliness and accuracy measures, VA set more realistic goals after FY 1999 actual performance was found to be significantly worse than planned.

- Rating-related timeliness: VA substantially raised this goal—from 99 days in FY 1999 to 160 days in FY 2000—based on FY 1999 performance of 166 days.
- Appeals resolution timeliness: VA substantially raised this goal—from 590 days in FY 1999 to 670 days in FY 2000—based on FY 1999 actual performance of 745 days.
- Rating-related actions—average days pending: VA substantially raised this goal—from 91 days in FY 1999 to 150 days in FY 2000—based on actual FY 1999 performance of 144 days.

VA's FY 1999 performance report and FY 2000 and FY 2001 performance plans and VBA's FY 2001 business plan describe means and strategies to improve claims processing accuracy and timeliness in FY 2000 and beyond. The VBA FY 2001 business plan, which supplements the FY 2001 performance plan, also includes implementation schedules and identifies estimated implementation costs.

VA's Fiscal Year 2001 Performance Goals and Measures to Ensure Veterans' Benefits Claims Are Processed Timely and Accurately

Goals and Measures Changed

- Increase to 85% (from 81%) the national accuracy rate for core rating work.
- Decrease to 142 days (from 160 days) the average time from receipt of claim to VA's decision for disability rating-related claims.
- Decrease to 650 days (from 670 days) the average time required to resolve appeals of VA compensation and pension claims decisions to the Board of Veterans Appeals.
- Decrease to 120 days (from 150 days) the average time that rating-related compensation and pension actions will be pending.

GAO Observations on the FY 2001 Performance Plan for This Key Outcome

For each performance measure, the FY 2001 goal reflects expected improvement over expected FY 2000 performance.

- Core rating accuracy: VA expects the core rating accuracy rate to improve from 81% in FY 2000 to 85% in FY 2001.
- Rating-related timeliness: VA expects the average number of days to process rating-related claims to fall from 160 days in FY 2000 to 142 days in FY 2001.

- Appeals resolution timeliness: VA expects the average number of days to resolve appeals to decline from 670 days in FY 2000 to 650 days in FY 2001.
- Rating-related actions—average days pending: VA expects average days pending to fall from 150 days in FY 2000 to 120 days in FY 2001.

As with the final FY 2000 performance goals, VA's FY 2001 goals reflect actual FY 1999 performance.

VA's FY 2001 performance plan represents an improvement over the FY 2000 performance plan in terms of its discussion of means and strategies for improving C&P claims processing accuracy and timeliness. For example, the plan's discussion of the national core rating accuracy measure identifies seven initiatives to improve claims processing performance, including (1) increasing claims processing staffing and (2) implementing TPSS and STAR. As noted in our discussion of the FY 2000 performance goals and measures, the VBA FY 2001 business plan includes more detailed discussions of means and strategies and of estimated costs.

The discussion of the key claims processing timeliness measure in VA's FY 2001 performance plan identifies the need to coordinate with DOD to (1) develop initiatives for preseparation medical exams and other claim development activities prior to separation and (2) obtain DOD military service and medical records electronically.

Also, the FY 2001 performance plan reflects improvements in VA's strategic plan that make it more veteran-focused and includes strategic goals that cut across VA programs. For example, the goals to improve claims processing accuracy and timeliness support VA's strategic goal to provide "one-VA world-class service."

VA has improved its discussion of the budgetary resources needed to implement initiatives to improve claims processing performance. The FY 2001 performance plan includes a table showing estimated FY 2001 budget obligations for the compensation and pension programs to support VA's strategic goals, as stated in the plan. For example, the table shows that VA estimates $20 billion to help achieve the strategic goal to "restore disabled veterans" (compensation benefit payments) and $550 million to help "provide world-class service" (including improvements in claims processing performance). Also, VBA's FY 2001 business plan, which is part of VBA's FY 2001 budget request, provides budget and staffing estimates for specific initiatives to improve claims processing performance. VA indicates that it is still working on a proposal to restructure its budget accounts to link performance with program activities.

VA's FY 2001 performance plan includes a discussion of VBA's efforts to improve the reliability of its C&P claims processing data. For example, on a weekly basis, VBA staff extract selected claims for data entry review and identify questionable data entry transactions. VBA regional offices that have the highest percentages of questionable transactions undergo further reviews.

VA's FY 2001 performance plan identified information technology initiatives for improving claims processing accuracy and timeliness, including

- the Personnel Information Exchange System, to allow for electronic exchange of military personnel records with DOD;
- the Virtual VBA project, to allow for electronic claims processing; and
- the Benefits Delivery Network, to examine options for continuing operation of the current computer network for nonmedical benefits until a more modern and less fragile system can be developed.

VA's FY 2001 performance plan does not include performance goals for these initiatives. However, VBA's FY 2001 business plan provides additional information on these initiatives, including implementation schedules.

Key Agency Outcome: Disabled Veterans Acquire and Maintain Suitable Employment

Table I-3 shows VA's two performance goals and measures that relate to the key agency outcome of having disabled veterans acquire and maintain suitable employment and whether or not these goals were met in FY 1999, as reported in VA's FY 1999 performance report.

Table I-3: Goals and Measures to Ensure Disabled Veterans Acquire and Maintain Suitable Employment and Their FY 1999 Status, as Reported by VA

Goal/measure	FY 1999 status
Key performance goal	
Improve to 45% the percentage of all veteran participants who leave VA's vocational rehabilitation program who will be rehabilitated.	Goal met (53%)
Related performance goal	
Decrease to 88 days the average time veterans beginning the employment services (job ready) phase of VA's vocational rehabilitation program will need to obtain suitable employment.	Goal met (53 days)

GAO Observations on VA's FY 1999 Goals and Measures to Ensure Veterans Acquire and Maintain Suitable Employment

VA met both final FY 1999 performance goals for this outcome. (VA's final FY 1999 performance goals were included in its FY 2000 performance plan.) VA adequately explains the degree to which the rehabilitation rate goal was met. The FY 1999 performance report also includes descriptions of means and strategies to improve the vocational rehabilitation program's future performance in helping veterans obtain and maintain suitable employment.

The rehabilitation rate goal and measure is objective, measurable, quantifiable, and results-oriented, and generally shows VA's progress in refocusing the program on helping

service-disabled veterans to become employable and to obtain and maintain suitable employment. However, we believe that the rehabilitation rate measure does not allow VA to fully assess program results because it (1) focuses on veterans who left the program, rather than on all veterans eligible for the program, and (2) does not consider how long it took veterans to complete the program.

The employment timeliness goal and measure complements the rehabilitation rate by measuring VA's progress in reducing the time required to find suitable employment for job-ready veterans.

VA's FY 1999 performance report provides limited assurance that its performance information is credible. According to the performance report, vocational rehabilitation program staff conduct semiannual case reviews, during which they validate data entered into the Benefits Delivery Network case status system by VBA field staff. However, VA noted in its FY 2000 performance plan that its data systems were inadequate and is implementing a new case management system to track the progress of each program participant and provide decisionmaking information. VBA's FY 2001 business plan describes this initiative in more detail.

Unmet FY 1999 Performance Goals and Measures for This Key Outcome

VA had no unmet performance goals and measures for this outcome.

VA's FY 2000 Performance Goals and Measures to Ensure Veterans Acquire and Maintain Suitable Employment

Goals and Measures Changed

- Increase to 60% (from 45%) the percentage of all veteran participants who exit VA's vocational rehabilitation program who will be rehabilitated.
- Decrease to 52 days (from 88 days) the average time veterans beginning the employment services (job ready) phase of VA's vocational rehabilitation program will need to obtain suitable employment.

GAO Observations on the FY 2000 Performance Plan for This Key Outcome

VA revised its FY 2000 performance goals to make them consistent with actual FY 1999 performance. These revised goals appear in VA's FY 2001 performance plan.

- VA's original FY 2000 rehabilitation rate goal (in its FY 2000 performance plan) was 50%, but its actual FY 1999 performance was 53%. VA raised its final FY 2000 goal to 60%.
- VA's original FY 2000 employment timeliness goal was 75 days, but its actual FY 1999 performance was 53 days. VA lowered its final FY 2000 goal to 52 days.

VA did not include in its performance report an evaluation or assessment of the effect of FY 1999 performance on expected FY 2000 performance levels. However, it is clear that the goal revisions are related to VA's FY 1999 performance.

VA's FY 1999 performance report and FY 2000 and FY 2001 performance plans and VBA's FY 2001 business plan all describe means and strategies to continue to improve the vocational rehabilitation program's performance. Among VA's key strategies are to improve (1) program staff's abilities to assist veterans in obtaining and maintaining suitable employment more quickly and efficiently through training programs and (2) veterans' access to the vocational rehabilitation program, for example, by providing staff with tools to perform their jobs outside of VBA offices.

VA's FY 2001 Performance Goals and Measures to Ensure Veterans Acquire and Maintain Suitable Employment

Goals and Measures Changed

- Increase to 65% (from 60%) the percentage of all veteran participants who exit VA's vocational rehabilitation program who will be rehabilitated.
- Decrease to 50 days (from 52 days) the average time veterans beginning the employment services (job ready) phase of VA's vocational rehabilitation program will need to obtain suitable employment.

GAO Observations on the FY 2001 Performance Plan for This Key Outcome

VA set FY 2001 performance goals to improve the vocational rehabilitation program's performance—and to meet VA's strategic goals. As with the final FY 2000 performance goals, VA's FY 2001 goals reflect actual FY 1999 performance.

VA also revised the strategic goal for each of these performance measures; these goals are presented in the FY 2001 performance plan. VA did not explicitly explain the reasons for these changes in its FY 2001 performance plan; however, it is likely that the changes reflect the fact that the vocational rehabilitation program's FY 1999 performance approached, or exceeded, the strategic goals.

- VA's rehabilitation rate strategic goal had been 55%, while its actual FY 1999 performance was 53%. VA raised the strategic goal to 70%.
- VA's employment timeliness strategic goal had been 75 days, but actual FY 1999 performance was 53 days. VA lowered the strategic goal to 50 days—which it expects to achieve in FY 2001.

VA's FY 2001 performance plan represents an improvement over the FY 2000 plan in terms of its discussion of means and strategies and major management challenges related to these key performance goals. For the key rehabilitation rate goal, VA provides

a more detailed description of means and strategies to meet future performance goals and the strategic goal. The means and strategies focus on providing training to program staff and improving veterans' access to the program. The FY 2001 plan also discusses management challenges related to this goal, as identified by GAO and others. For example, the plan notes that VBA has not fully re-focused the vocational rehabilitation program from training to employment and notes that continued refocusing will require training and employment-focused incentives for program staff, among other initiatives.

Also, VBA's FY 2001 business plan provides supplementary information on means, strategies, and major management challenges. The business plan also addresses VBA's plans to improve employment timeliness.

In its FY 2001 VBA business plan, VA also provides schedules and cost estimates for specific initiatives designed to help the vocational rehabilitation program meet its performance goals. Further, VA describes human capital initiatives (some in cooperation with the Department of Labor) to improve the ability of VA staff to assist veterans in obtaining and maintaining suitable employment. VBA (1) has developed a skills assessment system to identify the training needs of individual staff members and (2) plans to implement training programs to teach vocational rehabilitation and employment staff how to better assist veterans, for example, teaching employment interviewing skills to veterans.

VA's FY 2001 performance plan includes a brief description of data sources and validation for this key performance measure. The performance plan notes that VA's IG has conducted, or is in the process of conducting, audits of VA's key performance data. However, the vocational rehabilitation and employment key performance measure has not been audited yet. VA's performance plan does not identify any significant data limitations. As noted above, VA is developing a strategy to obtain more reliable data for measuring its performance.

VA's FY 1999 performance report notes that the vocational rehabilitation program requires improved information technology support. The FY 2001 performance plan noted that many routine program tasks that could be automated, such as scheduling and reporting, are being done manually or using inadequate technology. However, the FY 2001 performance plan does not include performance goals for information technology improvements.

The FY 2001 performance plan implements improvements in VA's strategic plan that make it more veteran-focused and includes strategic goals that cut across VA programs. For example, the vocational rehabilitation results measure supports a strategic goal to "restore the capability of disabled veterans to the greatest extent possible and improve their quality of life and that of their families." The employment timeliness goal and measure support the new strategic goal to provide "one-VA world-class service."

VA has improved its discussion of the budgetary resources needed to implement initiatives to improve the performance of its vocational rehabilitation program. The FY 2001 performance plan includes a table showing estimated FY 2001 budget obligations for the vocational rehabilitation program to support VA's strategic goals, as stated in the

plan. For the vocational rehabilitation program, VA estimated $392 million to support the strategic goal to "restore disabled veterans" and $119 million to support the strategic goal to "provide world-class service." VA indicates that it is still working on a proposal to restructure its budget accounts to link performance goals with program activities.

Key Agency Outcome: Reduced Availability and/or Use of Illegal Drugs

Table I-4 shows VA's one performance goal and measure that relates to the key agency outcome of having reduced availability and/or use of illegal drugs and whether or not this goal was met in FY 1999, as reported in VA's FY 1999 performance report.

Table I-4: Goal and Measure to Have Reduced Availability and/or Use of Illegal Drugs and Its FY 1999 Status, as Reported by VA

Goal/measure	FY 1999 status
Related performance goal	
55% of patients with primary addictive disorders will show improvement in their ASI composite score at 6 months after an initial ASI assessment (FY 1997 baseline of 38,000 patients).	Goal met (56%)

GAO Observations on VA's FY 1999 Goal and Measure to Have Reduced Availability and/or Use of Illegal Drugs

VA did not have any directly related performance goals and measures for this outcome. However, VA met its one indirectly related FY 1999 performance goal. This performance goal is results-oriented and provides an indication of whether VA's substance abuse program is having a positive effect on veterans with addictive disorders. VA measures its success by evaluating the annual change in a quantifiable measure—ASI composite score.

The performance report identified the source of the data used to make this assessment. However, it did not clearly state what steps it took to verify the accuracy of the ASI composite scores used to assess its performance. While we have no indication that the data are unreliable, during previous reviews of VHA programs as well as VA performance plans, we expressed concerns about the reliability of VA data overall.

VA's performance report states that the Department continues to make progress toward addressing the data verification methods used by VHA. For example, it is developing a data quality strategy to provide the necessary internal controls processes that have been lacking in the system with regard to data validity, reliability, and integrity. However, it is unclear whether the data used to evaluate the success of VA's substance abuse programs are included in VA's data improvement efforts.

In 1991, we recommended that the Secretary of Veterans Affairs report inadequate internal controls over lower scheduled drugs as a material weakness in his 1991 Federal Managers' Financial Integrity Act report. We also recommended that the pharmacy managers properly store, dispense, and inspect lower scheduled drugs. According to VA financial management officials, in response to our recommendations, VHA has implemented a number of initiatives to improve its control over addictive drugs to detect and deter the diversion of controlled substances. VA expects to complete all initiatives required to correct this material weakness by September 2000.

Unmet FY 1999 Performance Goals and Measures for This Key Outcome

VA had no unmet performance goals and measures for this outcome.

VA's FY 2000 Performance Goals and Measures to Have Reduced Availability and/or Use of Illegal Drugs

Goal Changed

- Increase to 60% (from 55%) the percentage of patients with primary addictive disorders who will show improvement in ASI composite score at 6 months after an initial ASI assessment (FY 1997 baseline of 38,000 patients).

GAO Observations on the FY 2000 Performance Plan for This Key Outcome

VA's performance report does not include estimated levels of performance for FY 2000. Because this is not a key performance goal, the performance report and VA's FY 2000 and 2001 performance plans are silent on whether the Department's FY 1999 performance had any effect on its expected performance levels for FY 2000. However, VA's FY 2000 goal reflects expected improvement over its FY 1999 performance.

VA's FY 2001 Performance Goals and Measures to Have Reduced Availability and/or Use of Illegal Drugs

Goal and Measure Changed

- Increase to 65% the percentage of patients seen in specialized substance abuse treatment settings who have an initial ASI and a 6-month follow-up (from "increase to 60% the percentage of patients with primary addictive disorders who will show improvement in their ASI composite score at 6 months after an initial ASI assessment").

GAO Observations on the FY 2001 Performance Plan for This Key Outcome

In its FY 2001 performance plan, without explanation, VA changed from a result-oriented goal to a more process-oriented goal to measure the success of its substance abuse program. The FY 2001 plan states that VA (1) modified its performance goals to ensure that they are consistent with final data for FY 1999, (2) added new performance goals, and (3) deleted some goals in last year's plan to reflect VA's latest evaluation as how best to measure its success. However, it provides no specific explanation of why this goal was revised.

The FY 1999 and FY 2000 goals were to improve the ASI composite score for a specified percentage (55% and 60%, respectively) of patients in VA's substance abuse treatment program. In contrast, the FY 2001 goal is to increase to 65% the percentage of patients in the program who receive a 6-month follow-up ASI assessment.

As noted above, neither its FY 1999 performance report nor FY 2001 performance plan provides much detail for goals VA does not designate as "key." VA defines key goals as those that are critical to the success of the Department. VA's goal related to the assessment of VA's efforts to reduce the availability and/or use of illegal drugs is not considered a key goal. Although this is not a key goal, the estimated FY 2001 obligations for the substance abuse treatment program account for about 2% ($390.7 million) of VA's FY 2001 medical care obligations and represents almost a 10% increase over VA's FY 1999 program obligations ($356.7 million).

VA's performance plan provides little detail on how it ensures the credibility of the data used to assess specific goals. VHA's FY 2001 budget request, which supplements the FY 2001 performance plan, provides the data source used to measure the goal—documentation in the electronic record—but it doesn't explain how the data will be verified.

In previous years, GAO has expressed its lack of confidence in the credibility of VA data. The FY 2001 performance plan states that the validity of VHA's electronic databases has been found to be adequate for most data elements assessed during a number of studies. It also identifies other steps, such as performing medical record reviews using computerized algorithms, to enhance data reliability.

ENCLOSURE II

OBSERVATIONS ON THE DEPARTMENT OF VETERANS AFFAIRS' EFFORTS TO ADDRESS ITS MAJOR MANAGEMENT CHALLENGES

The table on the following pages identifies the major management challenges confronting VA. The first column lists the major management challenges identified by GAO and those identified by VA's IG. The second column summarizes the progress, as discussed in its FY 1999 performance report, VA has made in resolving these major management challenges. The third column discusses the extent to which VA's FY 2001 performance plan includes performance goals and measures to address these management challenges.

Major management challenge	Progress in resolving major management challenge, as discussed in the FY 1999 performance report	Applicable goals and measures in the FY 2001 performance plan
(1) VA's health care infrastructure does not meet its current and future needs.		
VA's facilities are deteriorating, inappropriately configured, or no longer needed because of their age and VA's shift from providing specialized inpatient services to providing primary care in an outpatient setting.	VA's FY 1999 performance report does not provide specific goals or measures for addressing medical facilities that are deteriorating, inappropriately configured, or no longer needed. In April 2000, we testified that VA is struggling to address its management challenge to realign its health care infrastructure. VHA has delayed the development of a capital asset realignment plan. For example, we noted that VA's actions to address the need for consolidation of hospital assets in the Chicago area have been ineffective.	None. VA notes that efforts to restructure health care services includes consolidation and integration of facilities and realignments of services and programs within facilities. This has resulted in a significant decline in the number of operating inpatient beds—a trend expected to continue in the future. In the FY 2001 performance plan, VA noted that it has established a capital asset management plan.
Unneeded vacant space creates a financial drain on VA, and maintaining unproductive assets siphons valuable resources away from providing direct medical services.	There is no goal or measure in the FY 1999 performance report to address the elimination of vacant space and unproductive assets. Also, the report does not assess VA's progress in eliminating unneeded vacant space at its medical facilities. As discussed above, we have noted VHA's difficulties in addressing the need to realign its health care infrastructure. However, VA is in the process of	None. Although there is no goal for eliminating vacant space or unproductive assets, the means and strategies for meeting VA's goal to reduce average cost per patient refer to efforts to "right size" facilities. VA plans to consolidate and realign services and facilities where there are costly redundancies and opportunities to achieve economies of scale, or when service or workload measures fall below minimum levels necessary to

Major management challenge	Progress in resolving major management challenge, as discussed in the FY 1999 performance report	Applicable goals and measures in the FY 2001 performance plan
	addressing its capital asset realignment challenges. VA agreed to develop criteria for conducting a market analysis of their health care system by the beginning of June 2000, and we agreed to assist VA. VA met a related FY 1999 performance goal to reduce average health care costs per patient by 13% since FY 1997. VA reported that it reduced costs by 16%, in part, through a shift of health care resources and patient treatment from inpatient to outpatient care.	ensure cost-effectiveness and clinical quality.
(2) VA lacks adequate information to ensure that veterans have access to needed health care services.		
VA lacks accurate, reliable, and consistent information for measuring the extent to which veterans receive equitable access to care across the country.	VA has expanded access to care for veterans. In FY 1999, VA provided care to more veterans and at more access points. However, VA's FY 1999 performance report does not address VA's efforts to ensure equitable geographic distribution of access to health care. In FY 1999, VA met a key performance goal to expand veterans' access to its health care system—increase the number of unique patients treated in the health care system by 14.3% from the 3,142,000 patients treated in FY 1997. VA reported a 14.9% increase, to approximately 3.6	While the FY 2001 plan contains goals focused on the continuing expansion of access to VA health care, the plan does not address VA's efforts to ensure equitable access to health care across the country. VA's FY 2001 performance goals are to increase the number of unique patients by 24% since FY 1997 and to increase the number of community-based outpatient clinics to 635. The expected increase in unique patients would, if achieved, exceed VA's strategic goal of 20%.

Major management challenge	Progress in resolving major management challenge, as discussed in the FY 1999 performance report	Applicable goals and measures in the FY 2001 performance plan
	million unique patients. VA also reported a 43% increase in the number of community-based outpatient clinics, from 362 in FY 1998 to 519 in FY 1999. However, it did not quite meet its goal of having 532 community-based outpatient clinics in place by the end of FY 1999. In its performance report, VA noted that, to correct resource imbalances, it is implementing the workload-based Veterans Equitable Resource Allocation (VERA) methodology. Also, a VHA work group has identified and distributed best practices for allocating funding from Veterans Integrated Service Networks (VISN) to individual facilities.	The plan discussed VA's efforts to address this major management challenge, including (1) implementing timely and detailed indicators of changes in VERA workload indicators and (2) requiring VISNs to report annually on how, in their allocations of resources, they address equitability of access.
VA lacks accurate, reliable, and consistent information for measuring the extent to which all veterans enrolled in VA's health system are receiving the care they need.	VA fell short of its FY 1999 performance goals for improving customer satisfaction, the use of clinical guidelines, and coordination of care. Specifically, (1) the percentage of patients rating VA health care as very good or excellent was only 65%, as opposed to the goal of 79%; (2) VA's scores on the chronic disease and prevention index were 89% and 81%, respectively, compared to the goals of 91% and 87%; and (3) the percentage of patients who know there is one provider or team in charge of their care was 76%,	VA's FY 2001 performance goals for customer satisfaction, prevention, and coordination of care are to (1) increase the percentage of patients rating VA health care as very good or excellent to 68%; (2) improve the chronic disease and prevention index scores to 95% and 90%, respectively; and (3) increase the percentage of patients who know there is one health care provider or team in charge of their care to 85%. For the customer satisfaction and coordination of care measures, the FY 2001 goals are

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	compared to the goal of 87%.	more realistic than VA's FY 1999 goals.
VA lacks accurate, reliable, and consistent information for measuring the extent to which VA is maintaining its capacity to care for special populations, such as veterans with spinal cord injuries, amputations, or traumatic brain injuries, or who are blind.	VA's progress in improving its care for special populations varies by population. First, VA did not meet its goal that 78% of spinal cord injury patients rate their care as very good or excellent. Actual performance was 55%; VA stated that the goal was unrealistic due to a lack of benchmarking data in the private sector. Second, VA fell 3% short of achieving its goal to have 79% of rehabilitated amputees discharged to a community setting. Third, VA exceeded its goal to discharge 64% of first admissions for traumatic brain injury to community settings (actual: 65.8%). Last, VA exceeded its goal that 97.7% of respondents to its National Blind Rehabilitation Customer Satisfaction Survey were fully or highly satisfied with their care (actual: 98%). In April 2000, we reported that VA cannot be sure that it is maintaining its capacity to treat veterans with special disabilities due to extensive problems with VA's data, such as the use of unreliable proxy measures. Also, VA cannot tell whether it has maintained, enhanced, or diminished quality of care for veterans with special	The FY 2001 performance plan contains 12 goals related to special populations. Examples are (1) increase to 58% those spinal cord injury patients who rate their inpatient and outpatient care as very good or excellent, (2) increase to 98% the proportion of patients responding to the National Blind Rehabilitation Customer Satisfaction Survey who are satisfied or completely satisfied with their care, (3) increase the percentage of hospitalized first admission traumatic brain injury patients discharged to the community setting to 67%, and (4) continue to have 98% of respondents to the National Blind Rehabilitation Customer Satisfaction Survey indicate they are fully or highly satisfied with their care.

Major management challenge	Progress in resolving major management challenge, as discussed in the FY 1999 performance report	Applicable goals and measures in the FY 2001 performance plan
	disabilities. We recommended that VA designate a single official to be accountable for ensuring that it maintains special disability program capacity.	
VA's IG also identified resource allocation in VA's health care system as a major management challenge and plans to continue monitoring VHA's progress in improving the balance of distribution of staffing and other resources.	In its performance report, VA noted that, to correct resource imbalances, it is implementing the workload-based VERA methodology. Also, a VHA work group has identified and distributed best practices for allocating funding from VISNs to individual facilities.	None. The FY 2001 performance plan identifies VERA and the VISN-to-facility best practices initiative as strategies to address this management challenge.
(3) VA lacks outcome measures and data to assess the impact of managed care initiatives.		
VA does not know how its rapid move toward managed care is affecting the health status of veterans because measures of the effects of its service delivery changes on patient outcomes have not been established.	VA did not address this management challenge in its FY 1999 performance report.	None.
(4) VA needs to overcome difficulties in managing its nonhealth benefits programs.		
VA cannot adequately ensure that its disability compensation benefits for veterans are appropriately and equitably distributed because its disability rating schedule does not accurately reflect veterans' economic losses resulting from their disabilities.	VA did not directly address this management challenge in its FY 1999 performance report. VA noted that it is in the process of developing results-oriented outcomes for the C&P programs.	None. However, both the performance plan and VBA's FY 2001 business plan (which supplements the performance plan) note that VA is in the early stages of developing outcomes and related performance goals and measures for the disability compensation program. One possible outcome VA has identified would be to offset veterans' average loss of earning capacity due to

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		service-connected disability. The performance goal and measure would be based on a comparison of the incomes of veterans and survivors in receipt of disability compensation compared with nonrecipients in similar circumstances.
Claims processing in the C&P programs continues to be slow.	VA did not meet its key FY 1999 performance goals to (1) complete processing of rating-related C&P claims actions within an average of 99 days (actual: 166 days), (2) resolve appeals of rating decisions within an average of 590 days (actual: 745 days), and (3) produce accurate rating-related decisions 75% of the time (actual: 68%). We testified in May 2000 that VA's problems with large claims backlogs and long waits for decisions have not improved, despite years of study. Many of these problems stem from the growing complexity of claims processing due to (1) increasing numbers of service-connected disabilities per veteran and (2) increasing procedural and documentation requirements. VA has a number of initiatives to streamline its claims-processing performance, but it is unclear how much improvement will be gained.	In FY 2001, VA expects to (1) reduce processing time for rating-related C&P claims to an average of 142 days, (2) reduce the average days to resolve appeals of VA's claims decisions to an average of 650 days, and (3) improve the accuracy of decisions for its core rating-related work to 85%. The timeliness goals for FY 2000 and FY 2001 are significantly more realistic than VA's FY 1999 goals. In the FY 2001 performance plan, VA noted that it had changed some of its performance goals to reflect FY 1999 performance; this appears to have been the case with these timeliness goals.

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The vocational rehabilitation program has yielded limited results in finding jobs for veterans.	VA met its key FY 1999 goal that at least 45% of veterans who exited its vocational rehabilitation and employment program were rehabilitated; that is, they obtain and maintain suitable employment (actual: 53%). Also, VA met a related goal that, once vocational rehabilitation program participants are considered job-ready, they find suitable employment within an average of 88 days (actual: 53 days).	VA's key FY 2001 goal for this management challenge is to increase the percentage of veterans who exit its vocational rehabilitation and employment program and are rehabilitated to 65%. Also, VA raised its strategic goal from 55% to 70%, based on actual FY 1999 performance. VA also expects that the time required to find suitable employment for job-ready veterans will decrease to an average of 50 days.
VA has inadequate control and accountability over the direct loan and loan sales activities within VA's Housing Credit Assistance program. (VA's IG also identified as management challenges (1) the timeliness of C&P claims processing and (2) debts from defaults on home loan guarantees and direct home loans.)	VA did not address this management challenge in its FY 1999 performance report.	None. The plan does not include goals that address the direct loan program. However, the plan identifies loan sales as a major management challenge and discusses continuing actions to improve accounting for the loan sales program. VA plans to correct this problem in FY 2000.
(5) VA needs to manage its information systems more effectively.		
VA has made progress in addressing year 2000 challenges but still has some issues to address.	VA did not address this management challenge in its FY 1999 performance report. However, VA successfully transitioned to the year 2000 without any significant incidents.	Not applicable because it is no longer deemed a major management challenge.

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VA lacks adequate control and oversight of access to its computer systems. (VA's IG also identified year 2000 computer problems and computer security as management challenges.)	VA did not address this management challenge in its FY 1999 performance report.	None. However, the plan states that VA has (1) produced a comprehensive information security program requirements and budget plan; (2) concurred with GAO's recommendation to designate information systems security as a Federal Managers' Financial Integrity Act material weakness; (3) established an action plan to remedy this weakness by 2003; (4) established a permanent central security group under the chief information officer; (5) initiated a contract for a departmentwide assessment of information security risks and development of a plan to manage these risks; (6) acquired a web-based security awareness training curricula; (7) initiated a contract for a commercial critical incident response capability service; and (8) published a strengthened departmentwide policy on system accounts, passwords, and other internal controls.
VA has not yet clearly linked its process for selecting, controlling, and evaluating information technology investments to any specific performance measures in its annual performance plan.	Although VA's performance report does not discuss progress on this management challenge, GAO recently testified that the agency has improved its process for (1) selecting high-cost information technology projects, (2) monitoring and	None. However, the plan states that VA has developed and implemented a capital investment process for information technology and has conducted in-process and post-implementation reviews of information

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	managing these investments, and (3) conducting post-implementation reviews of these information technology projects. However, the process for monitoring, managing, and evaluating low-cost (that is, less than $250,000) information technology investment projects requires improvement.	technology capital investment projects.
Other areas identified by VA's IG		
(6) Health care quality management is one of the most serious and potentially volatile challenges facing VA.		
The potential for serious medical errors to increase as VA moves into the more rapid pace of patient care in the ambulatory care setting.	VA did not address this management challenge in its FY 1999 performance report. However, VA has identified continuous improvement of patient safety as part of its strategy for improving the overall health care of enrolled veterans through high-quality, safe, and reliable health services. VA has established a National Center for Patient Safety to lead its efforts to improve patient safety.	None. VA acknowledges the potential for serious error and cites its efforts to (1) hold network directors accountable for outpatient care performance measures and (2) implement nationally developed clinical practice guidelines. In FY 2001, VA plans to develop baseline measures for measuring its performance in ensuring patient safety.
The caliber of leaders who are able to manage a "full service" VA operation and processes for monitoring and tracking quality of care in the 22 VISNs. Also, VHA's inability to determine the role, staffing, and interactive relationships within VHA's Office of Medical Inspector.	VA did not address this management challenge in its FY 1999 performance report.	None.

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(7) Debt prevention and collection practices are deficient for C&P payments, education payments, and medical care cost recovery.		
The IG recommended that delinquent medical care cost recovery debts be referred to VBA for collection.	VA did not address this recommendation in its FY 1999 performance report. However, VA noted in its FY 2000 performance plan that it implemented the practice of referring medical care debts that are delinquent beyond 90 days to VA's Debt Management Center.	None.
The IG recommended that VBA and VHA increase collaboration in the Income Verification Match program.	VA did not address this recommendation in its FY 1999 performance report.	None.
The IG recommended that VBA improve the quality and uniformity of its debt waiver decisions.	VA did not address this recommendation in its FY 1999 performance report.	None.
(8) The timeliness and quality of medical examinations conducted for the purposes of deciding C&P claims need to be improved.		
Untimely or poor-quality examinations lead to repeat examinations, resulting in remands of appealed cases and significant processing delays.	VA did not address this issue in its FY 1999 performance report.	None. However, VA's FY 2001 performance plan identified an initiative to improve the timeliness and quality of C&P medical examinations by providing training to VA physicians on how to perform such examinations.
(9) VA is not effectively managing its FECA program.		
A pilot effort by VA's IG and VHA found VA employees were fraudulently receiving workers' compensation benefits under FECA,	VA did not address this issue in its FY 1999 performance report.	None. However, the FY 2001 performance plan identifies initiatives to control FECA costs, such as (1) developing pilot programs for long-

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and private health providers were aiding and abetting them.		term case management and fraud prevention and (2) developing a plan for a one-time review of all open and active workers' compensation cases.
VA could reduce future workers' compensation payments by returning current claimants to work if they are no longer disabled.	VA did not address this issue in its FY 1999 performance report.	None.
(10) VA needs to develop and implement a more effective method to identify inappropriate benefit payments.		
VA needs to offset disability compensation payments from active duty military reservists' training and drill pay, but this has not occurred since at least FY 1993.	VA did not address this issue in its FY 1999 performance report.	None. However, the FY 2001 performance plan identified initiatives to address inappropriate benefit payments, such as a joint initiative with DOD to identify individuals receiving dual VA and DOD compensation.
VA needs to implement a more effective method to identify deceased and incarcerated beneficiaries and to terminate their C&P benefits in a timely manner.	VA did not address this issue in its FY 1999 performance report.	None. However, the FY 2001 performance plan identified initiatives to address inappropriate benefit payments, including working with (1) the Bureau of Prisons to identify federal prisoners in receipt of VA benefits and (2) the Social Security Administration to identify incarcerated veterans whose VA benefits may be subject to reduction or terminations.
(11) VA has erroneous data in numerous automated data collection systems that are needed to support GPRA objectives.		
VA's IG has found erroneous data in the medical care program, C&P	VA did not provide specific performance goals for meeting this management	None. However, the plan mentions several ongoing and future actions to

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program, and education program systems.	challenge. However, the performance report described initiatives to improve data system quality.	improve internal controls over data. Also, the IG is continuing to audit VA's most critical data elements.
Data errors in medical care program systems.	The IG has audited VHA's data on unique veteran health care users. The IG found that the number of unique patients in FY 1997 was overstated by 5.7%. VHA agreed to implement the IG's recommendations to (1) establish edit checks on data input into the National Patient Care Database and (2) establish an edit check to identify false Social Security numbers. VHA held a Data Quality Summit in December 1998, and established five task forces to address data quality issues. This effort has resulted in recommendations to improve ambulatory care data quality, such as improvement of documentation for coding of outpatient care.	The IG is currently auditing data for the Chronic Disease Index and Prevention Index. The IG has not yet audited data for the bed days of care measure or the Addiction Severity Index.
Data errors in C&P program systems.	The IG has audited VBA's data on the average days to complete original compensation claims, original disability pension claims, and reopened compensation claims. This audit identified significant vulnerabilities of VBA's data systems to reporting and data entry errors to show better performance	None. However, VBA is continuing its accuracy review program.

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	than was actually achieved. VBA has developed a system to review randomly selected transactions for accuracy. VBA regional officials with the highest percentages of inaccuracies undergo an additional review and are required to develop a corrective plan.	
Data errors in the education program systems.	VA did not address this issue in its FY 1999 performance report.	None. No education data elements were included in the 11 most critical data elements for audit by the IG.

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