DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration

VHA VISION 2020

April 2003

FOREWORD

Profound changes have occurred in the Department of Veterans Affairs (VA) health care system and even more change is expected as we continue to enhance quality, increase access, improve service satisfaction and optimize patient functioning. The Veterans Health Administration's (VHA) transformation has led to a coordinated continuum of care and a system characterized by achievement of performance outcomes that improve services to veterans. For all 18 key health care indicators, from diabetes care to cancer screening and immunizations, we have exceeded the performance of private sector and Medicare providers.

We will continue to develop our national, integrated health care delivery system. The future system will require VHA components to function together and in concert with public and private health care facilities to meet the health care needs of the enrolled veteran population and to minimize duplication of services. As we chart a new direction, this system will continue to promote efficiency, assure high quality care, and provide optimal access for the veteran population. We will achieve a level of quality and access that sets a national standard of excellence for the health care industry.

VHA Vision 2020 describes our achievements and discusses the key strategies that will enable us to continue to provide comprehensive, first-class health care to the nation's veterans and achieve our goals for research, education and emergency preparedness in the coming years.

Robert H. Roswell, M.D.
Under Secretary for Health

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INTRODUCTION

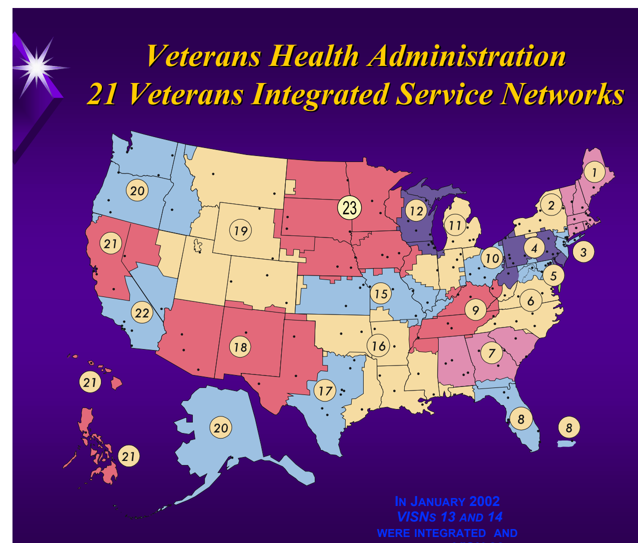
The Department of Veterans Affairs (VA) has responsibility for providing federal benefits to veterans and their dependents. Headed by the Secretary of Veterans Affairs, VA is the second largest of the 15 Cabinet Departments and operates nationwide programs of health care, income security benefits, and national cemeteries.

VA directly touches the lives of millions of veterans every day through its three administrations.

- **Veterans Health Administration (VHA)**, with 162 VA hospitals nationwide, operates the largest health care system in the United States. VA medical facilities operate within a Veterans Integrated Service Network (VISN), working together to provide efficient, accessible health care to veterans. VHA also conducts research and education, and provides emergency medical preparedness and disaster response.

- **Veterans Benefits Administration (VBA)** provides benefits and services to the veteran population through 57 VA regional offices. Some of the benefits and services provided by VBA to veterans and their dependents include compensation and pension, education, loan guaranty, and insurance.

- **National Cemetery Administration (NCA)** provides burial benefits to veterans and eligible dependents. The delivery of these benefits involves managing 120 National Cemeteries nationwide, administering the State Cemetery Grants Program that complements the National Cemeteries network, providing grave markers worldwide, and Presidential Memorial Certificates to next of kin of deceased veterans.



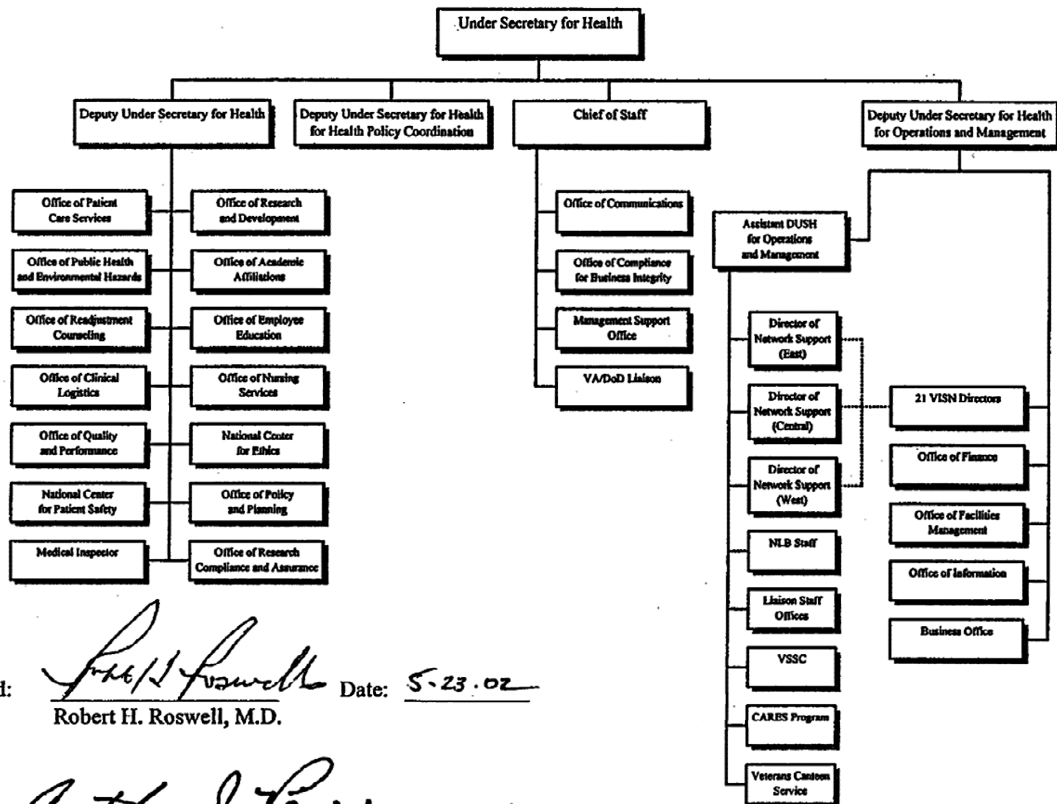
Perhaps the most visible of all VA benefits and services is health care. From 54 hospitals in 1930, VA's health care system has grown to 162 hospitals, with at least one in each of the 48 contiguous states, Puerto Rico and the District of Columbia. During the last five years, VHA has put its health care facilities under 21 networks, which provide more medical services to more veterans and family members than at any time during VA's long history.

The Under Secretary for Health in VA heads the VHA and is responsible for managing the nation's largest integrated health care system. With a medical care budget of more than $28 billion, VHA employs more than 180,000 health care professionals

at 162 hospitals, more than 850 community and facility-based clinics, 137 nursing homes, 43 domiciliaries, 206 readjustment counseling centers, and various other facilities throughout the country. VHA health care facilities provide a broad spectrum of medical, surgical and rehabilitative care. In addition to its medical care mission, the veterans health care system is the nation's largest provider of graduate medical education and a major contributor to medical and scientific research.

Who We Are

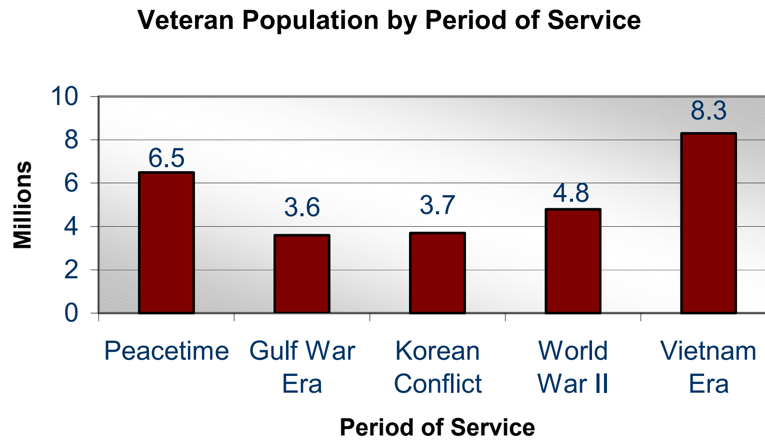
Office Of Under Secretary for Health



Approved: Anthony J. Principi Date: 5-24-02

Who We Serve

Beginning with our Nation's struggle for freedom more than two centuries ago, approximately 42 million men and women have served our country during wartime. Of the 25.6 million living veterans, most (75 percent) served during a war or an official period of hostility.



Over 6.2 million enrolled veterans look to VHA for health care services and more than 4.3 million veterans received care in FY 2002.

CHAPTER 1

CHARTING A NEW DIRECTION

- *VHA LEADERSHIP: THE NEXT GENERATION*
- *TURNING INFORMATION INTO INSIGHT*
- *REFOCUSING ON CORE VETERANS*
- *IMPLEMENTING CARES*

VHA LEADERSHIP: THE NEXT GENERATION

In May 2002, the Under Secretary for Health reorganized Veterans Health Administration (VHA) headquarters. Under this reorganization, there is increased centralization and alignment, greater uniformity, increased interaction with other federal agencies, particularly the Department of Health and Human Services (HHS), and centralization of all business functions. The reorganization created three Deputy Under Secretary positions to oversee Health, Health Policy Coordination, and Operations and Management. Previously, VHA had only one Deputy Under Secretary overseeing all of VHA.

> ***To enhance our ability to identify best practices and make our system a more uniform national health care system for veterans, we will be restructuring the function of VHA's National Leadership Board, with focus on corporate performance across the VISNs.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

In July 2002, following recommendations by a task force charged to examine VHA's governance structure, the Under Secretary for Health implemented a new system to improve VHA's management and leadership functions. The task force recommended reconfiguration of the existing National Leadership Board (NLB). This Board now serves in an advisory capacity to its Chair, the Under Secretary for Health, having an active and extensive role in determining VHA policy, strategy, and oversight of organizational performance. The NLB also serves as a forum to share responsibility for VHA governance, coordinates and oversees the activities of VHA, ensures alignment with VA priorities and goals, develops and disseminates information both internal and external to VHA, and facilitates the inclusion of diverse views of organizational components within VHA.

The NLB is comprised of key leaders within VHA, including all Network Directors, all Chief Officers, and other senior leaders designated by the Under Secretary for Health. In addition, several senior leaders within VA are non-voting members of the NLB, including six Assistant Secretaries, General Counsel, and the Under Secretaries for the National Cemetery Administration and Veterans Benefits Administration.

The NLB consists of an Executive Committee and six functional committees (Strategic Planning, Health Systems, Finance, Informatics and Data Management, Communications, and Human Resources). The Executive Committee provides leadership to the VHA governance process and operation of the NLB by ensuring effective process management, determining the NLB agenda, assessing NLB performance, instituting improvements, and enhancing the focus and efficiency of the NLB. The remaining six committees each have functional areas of responsibility including:

- **Recommending and formulating policy, strategic direction and planning;**
- **Identifying legislative proposals and initiatives;**
- **Providing organizational performance oversight;**
- **Ensuring effective deployment and communication of policies, plans, and strategies;**
- **Identifying the educational and developmental needs of committee and/or Board members;**
- **Developing performance and quality measures for functional areas of responsibility;**
- **Ensuring that all four VA missions are appropriately considered; and**
- **Ensuring alignment of VHA and VA.**

The full NLB and its committees meet monthly to coordinate emerging issues and develop ongoing policy and planning initiatives to govern VHA's extensive health care system.

TURNING INFORMATION INTO INSIGHT

Turning Information Into Insight is the theme of VHA's efforts to provide decision makers with insightful, accurate data to support planning, policy, and budget decisions. The centerpiece of this effort was the development of an innovative health care actuarial model to project utilization and associated expenditures for the enrolled veteran population.

> ***VA's budgeting, policymaking, and capital asset realignment initiative have been transformed by the quality of the data provided by the VHA Health Care Demand Model and its ability to analyze scenarios and proposed health care policies.***
>
> ***Anthony J. Principi, Secretary***

The VHA Health Care Demand Model was developed through a public-private partnership, and is based on private sector benchmarks that have been risk adjusted for the characteristics of the VHA enrollee population and on actual VHA unit costs. The model is also adjusted for the degree of health care management in VHA versus the community standard and for veterans' degree of reliance on VHA versus other providers.

The assumptions and methodologies have been subjected to rigorous review, and the model has been enhanced each year by improving the methodology and integrating new data sources and planning models. The model was also fine-tuned based on knowledge gained from actual-to-projected analyses. The model is readily adaptable to changes in the underlying assumptions.

The VHA Health Care Demand Model projects veteran enrollment, utilization, and expenditures, including detailed projections for approximately 50 health care service categories. These forecasts, along with data on health outcomes, access, system capacity, quality, and patient satisfaction, are the foundation of VHA's efforts with ***Turning Information Into Insight***.

The demand model has revolutionized VHA's budget, planning, and policy-making processes. In the past, VHA budgets (and most federal budgets) were based on historical expenditures that were adjusted for inflation and then increased based on proposed new initiatives. Using the demand model, VHA developed its FY 2003 and 2004 budgets based on actuarial forecasts of expenditures. This transition from a historical to an actuarial model as the basis of budget formulation represents not only a significant innovation for VHA, but for the federal government.

The model has also become integral to planning and policy development. During the development of the FY 2003 and FY 2004 budgets, VHA compared the actuarial expenditure projections with expected resources and identified significant gaps between veteran demand for VA health care and the resources to pay for that care. VHA then used the model to test the impact of proposed policy options, such as requiring copayments and limiting enrollment, on expenditures and revenue. Data from the model were also used to analyze the impact of these policies on veteran access to care and VHA's performance indicators. The proposed health care policies in VA's FY 2004 President's Budget, which are discussed in the next section, were developed through this process.

The model also supports local, regional, and national strategic planning by providing demand projections and scenario analyses for VHA's nationwide capital asset evaluation that is assessing the optimal alignment of VHA resources and service sites.

Refocusing on Core Veterans

The recent changes in VA's health care system have been profound, transforming it to a more efficient, effective and accessible system. VA is providing better care to our nation's veterans, closer to their homes and using the latest technology, while continuing to place a strong emphasis on comprehensive specialty

care. However, VA has been unable to provide all enrolled veterans with timely access to health care services because of the tremendous growth in the number of veterans seeking VA health care. It is also clear that continued workload growth of the magnitude seen in recent years would be unsustainable in the current federal budget climate.

> ***When we have veterans who are entitled to care, who aren't getting the care as quickly as we would like to provide it, then my obligation is to do everything I possibly can to free up any resources that will help address that issue.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

Therefore, in both the FY 2003 and FY 2004 budgets, VA proposed health care policies to address the gap between full demand and anticipated resource availability through a combination of enrollment and benefit policy changes and increased collections. In FY 2004, VA's $27.5 billion budget request, which represents an unprecedented 7.7 percent increase over FY 2003's expected level, also includes health care policies designed to balance demand with available resources.

In FY 2002, Secretary Principi took steps to assure that VA would afford priority access to veterans with service-connected disabilities. VA is refocusing attention on its core medical care mission of providing needed services to veterans with service-connected disabilities, lower income veterans, and those needing specialized care. VA will continue open enrollment for service-connected and low income veterans in Priorities 1-7; however, VA has suspended enrollment for Priority 8 veterans who were not enrolled in VA prior to or on January 17, 2003. The suspension of Priority 8 enrollment is the first in a series of policies designed to better align veteran demand and VA's health care resources. Although an estimated 164,000 veterans would be impacted in FY 2003, the continuation of this policy has a profound impact on future demand and budget requirements. This policy results in 520,000 fewer enrollees and an $800 million cost avoidance by FY 2005, growing to 1.1 million fewer enrollees and a $2.8 billion cost avoidance by FY 2012 were Priority 8 enrollment suspension to continue.

This action alone does not address the remaining budget requirements to provide health care for VA's veterans in Priorities 1-7, who are expected to cost, on average, an additional $2.1 billion each year, reaching a total annual budget of over $43 billion by FY 2012. In addition, $3.4 billion will be required by FY 2012 to support the care for those currently enrolled Priority 8 veterans unaffected by this enrollment suspension. Chart 1.1 contains a description of each of the priority groups.

Chart 1.1 VA Health Care Enrollment Priority Groups

Enrollment Priority 1

- Veterans with service-connected disabilities rated 50% or more disabling

Enrollment Priority 2

- Veterans with service-connected disabilities rated 30% or 40% disabling

Enrollment Priority 3

- Veterans who are former POWs
- Veterans awarded the Purple Heart
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with service-connected disabilities rated 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Enrollment Priority 4

- Veterans who are receiving aid and attendance or housebound benefits
- Veterans who have been determined by VA to be catastrophically disabled

Enrollment Priority 5

- Non-service-connected veterans and non-compensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid benefits

Enrollment Priority 6

- World War I veterans
- Mexican Border War veterans
- Veterans solely seeking care for disorders associated with:
  - exposure to herbicides while serving in Vietnam; or
  - exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
  - for disorders associated with service in the Gulf War;
  - for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998; or
  - Compensable 0% service-connected veterans

Enrollment Priority 7

Veterans with income and/or net worth *above* the VA Means Test threshold and income *below* the HUD geographic index who agree to pay specified co-payments

- Subpriority a: Non-compensable 0% service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority c: Non-service-connected veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date
- Subpriority e: Non-compensable 0% service-connected veterans not included in Subpriority a above
- Subpriority g: Non-service-connected veterans not included in Subpriority c above

Enrollment Priority 8

Veterans with income and/or net worth *above* the VA Means Test threshold and the HUD geographic index who agree to pay specified copayments

- Subpriority a: Non-compensable 0% service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority c: Non-service-connected veterans enrolled as of January 16, 2003 and who have remained enrolled since that date
- Subpriority e: Non-compensable 0% service-connected veterans applying for enrollment after January 16, 2003
- Subpriority g: Non-service-connected veterans applying for enrollment after January 16, 2003

Additional Information:

The term service-connected means, with respect to a condition or disability that VA has determined that the condition or disability was incurred in or aggravated by military service. Some veterans may have to agree to pay copayments to be placed in certain priority groups.

Although VA expects to have 7 million veterans enrolled by the end of FY 2003, there are another 17.5 million veterans who have yet to seek care from VA. There are approximately 6 million veterans age 65 and over who are not enrolled. These veterans, because of their age, are high consumers of health care and are particularly attracted to VA for its pharmaceutical benefits. Suspending the enrollment of Priority 8 veterans who have higher incomes and are more likely to have insurance and other care choices, allows VA to continue efforts towards eliminating waiting lists and longer waiting times to benefit those who need VA most.

VHA is looking for further management efficiencies and increasing interagency coordination with Department of Defense (DoD) and HHS. To that end, VA has reached a landmark agreement with HHS to establish a **Medicare+Choice (M+C)** employer group plan through which VA will provide nonenrolled Priority Group 8 veterans aged 65 or older who cannot enroll in VA's health care system, the option of receiving their Medicare benefit through VA. This agreement is fully supported by the White House, the Office of Management and Budget (OMB), and the Centers for Medicare and Medicaid Services (CMS). The plan calls for VA to contract with an M+C organization to offer a special M+C plan called VA+Choice. VA would define the benefits under VA+Choice, and enrollees in VA+Choice would be able to receive Medicare benefits through VA facilities and providers. At a minimum, the plan will include the benefits required under M+C, including all Medicare Parts A and B services. VA will determine any additional benefits it wishes the M+C organization to offer and member cost sharing for those benefits. The VA+Choice plan will become effective later in 2003 as details are finalized between VA and HHS.

HHS is happy to join the Department of Veterans Affairs in developing this new option for veterans who might otherwise be unable to obtain health care through the VA. This is a creative marriage of our federal health programs to serve our veterans efficiently and effectively.

Tommy G. Thompson, Secretary, Department of Health and Human Services

Implementing CARES

VA operates and maintains more than 4,700 buildings and 18,000 acres of land. Some of the buildings and land VA owns are not well suited to veterans' health care needs. The cost to maintain and operate VA health care facilities that cannot provide efficient and accessible services diminishes resources that could otherwise be used to provide better care in more appropriate settings. VA developed **CARES – Capital Asset Realignment for Enhanced Services** – in response to a March 1999 General Accounting Office (GAO) report that concluded VA could significantly reduce the amount of funds necessary to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets and apply the savings to health care for veterans. CARES will improve quality as measured by access and improve the delivery of health care in a cost-effective manner, while maximizing positive opportunities and minimizing any adverse impacts on staffing, communities, and other VA missions. Through CARES, VA is realigning and enhancing its health care system to meet veterans' needs effectively and efficiently, now and in the future.

As VA begins the process of making CARES decisions in communities across the country, it is important to remember the program's objectives: more effective use of VA resources to provide more care, to more veterans, in places where veterans need that care most.

Leo S. Mackay, Jr., PhD, Deputy Secretary

The CARES process will strategically address the future infrastructure, i.e., beds, outpatient capacity, and other services, to meet the health care needs of veterans including emergency backup needs. VA recognizes there is a cost for maintaining readiness and must balance this cost with providing quality and timely health care for veterans. Preparing staff and facilities for emergency situations also preserves the department's ability to care for veterans. VA currently has a system in place that develops periodic estimates of the number of beds that can be made available to fulfill its Department of Defense (DoD) backup requirements. The planning process incorporates network-based data, strategic health care planning input, and cooperative participation toward achieving the stated vision and goals of the CARES program. In an effort to save federal dollars, this process also seeks to improve the sharing of facilities and services between VA and DoD. CARES planning will ensure that enhanced use opportunities are addressed in a comprehensive manner and also identify opportunities for converting vacant space into alternative uses or disposing of excess assets in the most effective manner.

The pilot study for CARES was completed in 2001 for Network 12 (Chicago, Wisconsin, and the Upper Peninsula of Michigan). VA is now conducting CARES in the remaining 20 Networks. A draft National CARES Plan will be published for public comment and evaluated by an independent CARES Commission appointed by the Secretary of Veterans Affairs. The independent commission will hold hearings and solicit stakeholder comments from Veterans Service Organizations (VSOs), medical school affiliates, government entities and local community groups. Options will then be developed based on consistent, objective criteria to ensure a cost-effective health care system that best serves America's veterans today and into 2022. Following this process, the Commission will forward its recommendations to the Secretary, who will make his decision on the National CARES Plan in late 2003. The CARES Commission will respond as "Stewards of America's Resources" to any final stakeholders concerns or Congressional inquiries.

This comprehensive analysis and restructuring of VA health care will change only the way VA delivers care – health care services will not be reduced. The goal of CARES is to enhance outpatient and inpatient care, as well as special programs such as spinal cord injury, blind rehabilitation and seriously mentally ill, and long-term care. Once CARES is completed, VA will have a national plan for directing resources where they are most needed; preserving VA's missions and special services; and, at the same time, continuing to provide high quality care to more veterans in more locations. CARES is not a one-time process; the initiatives and plans identified will be validated and reassessed to ensure they reflect current VA policies.

CHAPTER 2

STRATEGIC VISION

- *FUTURE DIRECTION AND CHALLENGES*
- *ELEMENTS OF VHA'S STRATEGIC VISION*
- *VHA'S STRATEGIC PLAN*

FUTURE DIRECTION AND CHALLENGES

Health care is remaking itself. There are powerful societal, demographic, and industry-wide forces at work. In the 20th century, bricks and mortar constituted the basic infrastructure of the health care delivery system. The Institute of Medicine's report, ***Crossing the Quality Chasm: A New Health System for the 21st Century (2001)***, called for fundamental changes in a troubled and ailing health care system. The report defined "the quality chasm" as the gap between what scientific evidence has proven is best for the patient and the care the patient actually receives. This report called for changes at four levels – patient experiences; small practice settings or microsystems that deliver care (e.g., provider groups, multidisciplinary teams); health care organizations (e.g., hospitals); and the health care environment (e.g., payment policies, legal liability, regulatory processes). These changes require substantial improvements built around the core need for health care to be safe, effective, patient-centered, timely, efficient, and equitable.

> ***The changes in the VA health care system have been profound, and the benefits have been recognized both inside and outside the Department. We provide better care to our nation's veterans, closer to their homes, and using the latest technology. However, we also face significant challenges, which we must meet to assure that our nation maintains a comprehensive, integrated health care system for all veterans who choose to come to VA for their care.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

VA health care is now far more patient-centered and is increasingly the benchmark for health care management and delivery. VHA is the benchmark for all 18 clinical performance indicators critical to the care of veterans and directly comparable externally. The results of VA's hard work and culture of quality measurement were further validated by the Institute of Medicine's ***Leadership by Example (2002)*** report, which praised VA's use of performance measures to improve quality in clinical disciplines and in ambulatory, hospital and long-term care, stating that VA's integrated health care system is one of the best in the nation.

Accountability for improvement and achievement is important in VA. Dynamic performance contracts between Chief Officers/Network Directors and the Under Secretary for Health are the foundation of VA's quality improvements. These performance contracts provide a basis for focusing and evaluating the work of all VHA employees throughout the system. Performance measures have led to consistent application of clinical guidelines and have supported improvements in quality and in each of the other strategic goal areas.

By the end of 2004, VHA plans to increase its medical work force of 180,000 by more than 800 doctors and 2,500 nurses. With a nationwide nursing shortage, an aging workforce and non-competitive wages, the recruitment effort will be challenging, but VHA plans to move aggressively. VHA management is working on a comprehensive workforce plan, including proposed legislation to improve physicians' pay and benefits that will be submitted to Congress in the spring. The bill would base physician salaries on regional market conditions.

Boosting physician recruitment and enrollment and benefit policy changes will not be enough to eliminate the wait list. VHA also is developing a **care coordination program** to provide home care to more patients, which would allow practitioners to manage more patients in settings appropriate to their condition and desired by the patient. This new program will eliminate the need for frequent visits by patients, as care will be moved to the home and to the workplace, allowing patients to manage care themselves. Interactive sessions via the Internet, telephone lines, and telemedicine units will help physicians determine whether complications have developed and, if so, arrange for care when needed.

ELEMENTS OF VHA'S STRATEGIC VISION

In recent years, VHA has emerged as a well-respected, benchmark-setting leader in health care. However, we have a professional obligation to not only maintain that excellence but build upon it to address the ever-changing challenges to provide the right services to veterans, at the right time, and in the right place. To guide those decisions, and to deliver an integrated health care system in the 21st Century, VHA has identified a new vision for the future. As VHA focuses on our role in the future of health care, we see an organization that will:

- **Be a patient-centered health care system for veterans;**
- **Provide comprehensive services to an expanding patient base;**
- **Be a fully integrated health care system providing consistent, uniform, and predictable care across the nation;**
- **Promote a diversified funding base;**
- **Serve as a major component of national emergency response;**

- **Lead in understanding and providing services that are uniquely related to veterans' health;**
- **Provide continuously improving, cost-effective care through a dedicated, well-qualified staff;**
- **Be the leader in the use of health information technology;**
- **Focus on core service delivery;**
- **Coordinate publicly funded health care for the benefit of veterans;**
- **Be a leader in expanding the evidence base for health care and translating it into changes in delivery;**
- **Maintain a prominent role in health care professional education; and**
- **Practice effective population health care for enrolled veterans particularly those with special needs.**

VHA's Strategic Plan

To achieve our strategic vision, VHA's National Leadership Board (NLB), through the Strategic Planning Committee (SPC), developed a comprehensive framework for a new strategic direction. A new **VHA Strategic Plan** outlines the steps we will take and the milestones of this new strategic direction, and aligns VHA's Goals and Objectives with those of the Department of Veterans Affairs. To complete the Strategic Plan, I have, along with the Secretary, endorsed a set of 30 specific Strategies to achieve our Goals and Objectives that will be the focus of our efforts, resources, and initiatives in the months and years ahead (see Chart 2.1).

During the past few years, VHA has witnessed unprecedented growth in patient demand that has created new challenges and the need to operate more efficiently and effectively. As a system, we have responded to these challenges in creative and innovative ways which have resulted in improving clinical outcomes and access to care, maintaining reasonable wait times in the face of increased patient demand for services, enhancing patient satisfaction, and reducing costs. Clearly the road ahead will find us facing new challenges in our quest to provide more and better services to a growing number of veterans. The VHA Strategic Plan will focus our efforts, creating solutions to these challenges, guiding decision-making, and showing us the way to be the provider of choice for America's veterans and a health system unparalleled in the industry in offering outstanding clinical care, research advancements, and educational opportunities for health care professionals.

Chart 2.1 VHA Strategic Plan 2003-2008

VA STRATEGIC GOALS	VHA GOALS	VHA OBJECTIVES	VHA STRATEGIES
1. Restore the capability of veterans with disabilities to the greatest extent possible and improve the quality of their lives and that of their families.	1. Maximize the physical, mental, and social functioning of veterans with disabilities and be recognized as a leader in the provision of specialized health care services. (VA Objective 1.1)	1. Maximize the independent functioning of veterans in the least restrictive setting.	(1) Improve and enhance home care services and develop an assisted living strategy. (2) Promote the use of care management to facilitate care in the least restrictive and most efficient setting.
		2. Provide coordinated, comprehensive, and integrated care to promote health and improve patient functioning.	(3) Reduce variability of health outcomes by providing for a more consistent delivery of services.
2. Ensure a smooth transition for veterans from active military service to civilian life.	2. Ease the reentry of new veterans into civilian life by increasing awareness of, access to, and use of VA health care, benefits and services. (VA Objective 2.1)	3. Optimize the use of health care information and technology for the benefit of the veteran.	(4) Accelerate development of Health Data Repository, HealtheVet, and telehealth initiatives.
3. Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation.	3. Provide high quality, reliable, accessible, timely and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care. (VA Objective 3.1)	4. Increase provider and veterans' knowledge of the impact of military service on health.	(5) Increase collaboration between VBA, VHA, and DoD during the military discharge process. (6) Collaborate with DoD to develop a complete lifelong health record for veterans. (7) Collaborate with VBA to invigorate and update the Transitional Assistance Program. (8) Intensify efforts to implement Veterans' Health Initiative, including fully incorporating each veteran's military history and potential consequences of service into the Computerized Patient Record System.
		5. Continuously improve the quality and safety of health care for veterans to be the benchmark for health care outcomes.	(9) Be a leader in the advancement of knowledge and practice of quality and patient safety initiatives to include: (a) the use of preventive medicine practices and guidelines for chronic disease management; (b) increasing the use of validated standardized processes such as increasing the use of automated systems to reduce the occurrence of adverse events; and (c) developing a culture of safety where reporting of close calls and adverse events results in the development and implementation of corrective actions that prevent harm to patients while under our care.
		6. Improve patients' satisfaction with their VA health care.	(10) Implement a "service-recovery" program. (11) Standardize patient satisfaction surveys with real time results.
		7. Improve access, convenience, and timeliness of VA health care services.	(12) Provide incentives for ongoing, continuous healthcare system redesigns to streamline work, and to analyze, identify, and promulgate improved health care practices. (13) Collaborate with public and private organizations to reduce redundancies and fill gaps in services to veterans.
		8. Create a health care environment characterized by patient-centered services where individual health care decisions are made on the basis of current medical knowledge, consistent with patients' informed preferences and needs.	(14) Implement initiatives to support shared decision-making and patient empowerment.

VA STRATEGIC GOALS	VHA GOALS	VHA OBJECTIVES	VHA STRATEGIES
4. Contribute to the public health, emergency management, socio-economic well-being, and history of the Nation.	4. Improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans as well as support to national, state, and local emergency management and homeland security efforts. (VA Objective 4.1)	9. Prepare to respond to disasters and national emergencies.	(15) Partner with other Federal, state, and community agencies to develop a national emergency preparedness plan that clearly articulates VA's role and capabilities to respond to emergencies. (16) Conduct training and emergency preparedness drills using standardized scenarios consistent with VA's Emergency Management Program Guidebook.
	5. Advance VA medical research and development programs that address veterans' needs, with an emphasis on service-connected injuries and illnesses, and contribute to the Nation's knowledge of disease and disability. (VA Objective 4.2)	10. Conduct medical research that leads to demonstrable improvements in veterans health.	(17) Maintain full research compliance and standardized protection of human subjects. (18) Increase the proportion of research funding directed to projects addressing veteran-related issues, cooperative studies, and translational research.
	6. Sustain partnerships with the academic community that enhance the quality of care to veterans and provide high quality educational experiences for health care trainees. (VA Objective 4.3)	11. Promote excellence and innovation in the education of future health care professionals.	(19) Improve the training and awareness in military health related issues. (20) Provide appropriate support for training, education, and resident supervision.
VA ENABLING GOAL	**VHA ENABLING GOALS**	**VHA ENABLING OBJECTIVES**	**VHA ENABLING STRATEGIES**
Deliver world-class service to veterans and their families by applying sound business principles that result in effective management of people, communications, technology, and governance.	7. Recruit, develop, and retain a competent, committed and diverse workforce that provides high quality service to veterans and their families. (VA Enabling Goal E-1)	12. Recruit, support, and retain a knowledgeable, diverse, engaged, and continuously learning workforce.	(21) Develop a comprehensive and coherent workforce development plan that incorporates High Performance Development Model, succession planning, diversity training, and Alternate Dispute Resolution orientation. (22) Implement pay policies and Human Resource practices to facilitate hiring and retaining sufficient health care workers to meet capacity demands across the full continuum of care.
	8. Improve the overall governance and performance of VA by applying sound business principles, ensuring accountability, and enhancing our management of resources through improved capital asset management; acquisition and competitive sourcing; and linking strategic planning, budgeting, and performance planning. (VA Enabling Goal E-4)	13. Effectively communicate the contributions of VA health care, research, and education.	(23) Implement the VHA communication plan.
		14. Expand Federal, state, local, and private partnerships to foster improvements in the coordination and delivery of health care and other services.	(24) Expand VA sharing and collaboration with DoD, Indian Health Service, and state veterans' organizations.
		15. Promote cooperation and collaboration throughout VA to provide seamless service to veterans.	(25) Expand the Compensation and Pension Record Interchange.
		16. Optimize the availability and efficient use of resources and services.	(26) Deploy VHA initiative to increase competitive sourcing. (27) Fully implement Procurement Reform Task Force recommendations.
		17. Increase revenue and efficiency through private sector partnerships, technology, and improved business practices.	(28) Assess the feasibility of Federal imaging, lab, and prescription centers. (29) Take full advantage of research-related intellectual property opportunities
		18. Develop innovative approaches to the design and evaluation of health care delivery systems.	(30) Re-engineer health care processes to incorporate technologic advances and to address shortages of health care professionals.

CHAPTER 3

FOCUS ON VETERANS HEALTH CARE

- ACCESS
- SPECIAL EMPHASIS PROGRAMS
- GERIATRICS AND LONG TERM CARE
- PATIENT SAFETY
- QUALITY INDICATORS
- VETERAN SATISFACTION
- AWARDS FOR QUALITY
- ACCREDITATION
- RESEARCH
- PROFESSIONAL EDUCATION AND TRAINING
- DISASTER RESPONSE

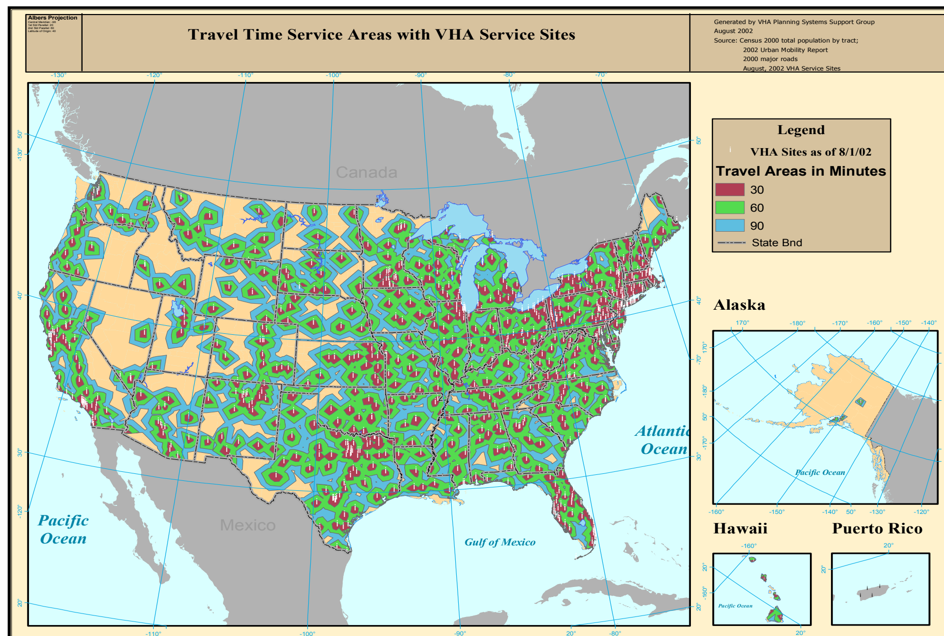
ACCESS

Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, effective October 1, 1998, mandated VA to establish and implement a national enrollment system to manage the delivery of health care services to veterans. Enactment of this legislation precipitated serious problems with clinic waiting times, delays, and long cycle times. The number of veterans enrolled is a statistic that is both frustrating and encouraging. While the increase has strained the health care system, it indicates the desirability of VHA's inexpensive and high-quality care.

Since 1997, VHA has reduced the cost of care per veteran by 26 percent, not by cutting corners, but by delivering care more efficiently and more effectively. VHA has more than 1,300 sites of care and provides health care services at locations much closer to where patients live. Eighty-seven percent of VHA's patients now live within 30 minutes of a VHA medical facility.

The VA health care system is not only focused on the quality of care a veteran receives, but also on improving a veteran's access to care. VHA expects to treat 66 percent more patients in FY 2003 than were treated in 1996. This increase, mostly from nonservice-connected veterans, significantly reduced VHA's ability to treat patients in a timely manner, including the highest priority veterans – those with service-connected conditions, those with lower incomes and those with special health care needs, such as blindness, amputations or spinal cord injuries. FY 2004's proposed budget for the medical care program, together with a comprehensive set of legislative and regulatory proposals, will allow VHA to focus its health care assets on providing medical care to those with service-connected disabilities, the indigent and those with special health care needs.

Chart 3.1



SOURCE: PSSG website http://vaww.pssg.med.va.gov/

> ***We expect to treat 4.8 million patients in fiscal year 2004, while continuing to reduce the time veterans must wait to see a doctor. Our goal is to have veterans wait no more than 30 days for a non-emergency, primary care visit.***
>
> ***Anthony J. Principi, Secretary***

As of January 2003, approximately 200,000 veterans were on waiting lists. These numbers are not static. As new enrollees join the list, enrollees come off of the waiting list to become new patients in the system. VHA is fostering multiple efforts to reduce waiting times.

- Developing the **Advanced Clinic Access (ACA)** initiative in collaboration with the Institute for Healthcare Improvement: The core of ACA is a training program that provides strategies and change concepts to assist clinic staff in making their processes more efficient to reduce wait times, improve access, and decrease costs.

- Developing a national **Waiting Times Web Site** and computerized wait list and scheduling package: This effort enhances measurement of wait times for every patient seeking access to VHA services and improves scheduling, efficiency and effectiveness.

- Developing monitors to identify the percent of active patients assigned to primary care providers and the percent of primary care provider capacity that is utilized by active patients.

- **Suspending new enrollment for Priority Group 8 veterans**. Effective January 17, 2003, new enrollments were suspended in VA's health care system for veterans in Priority Group 8, those who are not being compensated for a military-related disability, and whose incomes are above HUD low-income levels. The decision will affect approximately 164,000 Priority Group 8 veterans projected to enroll in FY 2003; the 1.4 million Group 8 veterans enrolled prior to January 17 will continue to receive VA health care.

- **Recruiting additional primary care and specialty provider staff** to keep pace with the current demand for care and assure VHA's ability to meet the comprehensive needs of veterans.

VHA continues to place a strong emphasis on comprehensive specialty care for which it has long been highly respected within the medical community, while now also emphasizing coordination of care through the universal assignment of primary care providers. With this transformation to a primary care delivery model, and by employing new models of care coordination and delivery, veterans have gained access to an integrated health care system, focused on addressing their needs before hospitalization becomes necessary.

Historically, health care in this nation has been managed from the perspective and needs of the provider. As a hospital system, VHA waited until veterans required hospital care. Even now, appointments are scheduled based on the provider's best guess as to when the patient will need to be seen and when an appointment might be available, rather than based on when the patient actually requires care. VHA is not alone; this is the approach taken by most health care systems today. However, VHA believes that better health care management strategies are now possible.

VHA is identifying new ways to partner with patients to more effectively manage health and disease processes continuously, 24 hours a day, 365 days a year. VHA needs to be able to see the patient "just in time" when a complication or need starts to develop. This shift constitutes a fundamental change in how VHA views health care and this approach will have a groundbreaking impact on both primary care and long-term care. While the impact on primary care and the management of many chronic conditions will be substantial, the impact on long-term care will be even more profound, especially as the VHA system will experience a significant increase in veterans over 85 years of age by 2010 (1.02 million in 2000, 2.65 million in 2010).

VA's health care system is growing and changing at a very rapid pace to provide the best possible care to our Nation's veterans.

Laura J. Miller, Deputy Under Secretary for Health for Operations and Management

To oversee many of the initiatives needed to implement a patient-centered model for primary and long-term care, the Under Secretary for Health has created a Care Coordination Office. While the responsibilities of this office have not been formalized, it will foster the use of technology in care coordination and will guide the development and implementation of policies and initiatives in chronic disease management and long term care.

Special Emphasis Programs

VHA seeks to maximize the ability of the special veteran population to become full and productive members of society. To this end, VHA has developed world-class facilities, staffed by world-class doctors, nurses, and other allied health care professionals who are devoted to treating our Nation's veterans.

Today's VA health care system supports a number of clinical and administrative initiatives that have been designated as Special Emphasis Programs (SEPs). Typically, SEPs are clinical services that address illnesses specific to the service-connected veteran population, constitute areas of special VA expertise, or are unique programs that address the psychosocial needs of certain identified veterans.

Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, effective October 1, 1998, mandated that the VHA ensure capacity for veterans with spinal cord injuries and diseases, blinded veterans, veterans with amputations, and veterans with chronic disabling mental illnesses. The law also requires the publication of data in an annual report (the "Capacity Report") to Congress demonstrating VA's compliance with the provisions of this mandate.

This section presents a brief overview of selected SEPs and a few highlights of accomplishments.

SEP Overviews

Homeless Veterans Programs

Nearly 25% of the homeless population are veterans. Many more veterans who live in poverty are at risk of becoming homeless. VHA provides substantial hands-on assistance and maintains the largest network of homeless assistance programs in the country. VHA's specialized homeless veterans treatment programs strive to offer a continuum of services that include: aggressive outreach to those veterans living on streets and in shelters, who otherwise would not seek assistance; clinical assessment and referral to needed medical treatment for physical and psychiatric disorders, including substance abuse; long-term sheltered transitional assistance, case management, and rehabilitation; employment assistance and linkage with available income supports; and supported permanent housing.

- ❖ Approximately 75% of veterans in a Domiciliary Care for Homeless Veterans Program or Community-based Contract Residential Care Program were discharged to an independent or a secured institutional living arrangement.

- ❖ In FY 2003, more than 7,000 transitional and permanent beds will be available for veterans who are homeless.

- ❖ During the past year, more than 20,000 homeless and at-risk veterans received medical care from VHA, and more than 19,000 veterans received transitional and supported housing, directly or in partnerships with grant and per diem or contract residential care providers.

- ❖ On January 27, 2003, the Department of Housing and Urban Development (HUD), HHS and VA announced a $35 million program to provide permanent housing, health care and other supportive services to those experiencing chronic or long-term homelessness.

For more information visit homeless programs online at http://vaww.va.gov/homeless or http://www.va.gov/homeless.

Seriously Mentally Ill (SMI)

VHA has committed itself to expanding state-of-the-art treatments of serious mental illness, using the Assertive Community Treatment (ACT) model. VHA now operates one of the nation's largest networks of ACT-like programs, called Mental Health Intensive Case Management (MHICM). Another aspect of VHA's care for the seriously mentally ill is a commitment to using state-of-the-art medications. This results in improved clinical outcomes, decreased incidence of side effects and increased compliance with prescribed medications.

- ❖ In FY 2002, VHA provided support to more than 293,000 veterans who are severely mentally ill.

- ❖ Approximately 20% of those veterans were hospitalized during the past year and over 80% were discharged to a community living situation at the end of their hospitalization.

For more information visit Seriously Mentally Ill programs online at http://vaww.mentalhealth.med.va.gov or http://www.mentalhealth.med.va.gov.

Readjustment Counseling

Readjustment counseling is provided through a national system of community-based counseling or Vet Centers. The Vet Center program service mission features a holistic mix of direct counseling and multiple community-access functions: psychological counseling for veterans exposed to war trauma to include post-traumatic stress disorder (PTSD), and/or veterans who were sexually assaulted during military service; family counseling when needed for the veteran's readjustment; community outreach and education; and extensive case management and referral activities. The latter activities include a full range

of supportive social services designed to improve general levels of post-military social and economic functioning for veterans.

- In FY 2002, VHA provided readjustment counseling services to over 132,000 veterans.

- In FY 2002, 99% of veterans using Vet Centers reported being satisfied with services including readjustment counseling and said they would recommend a Vet Center to other veterans.

For more information visit Vet Centers online at http://vaww.va.gov/station/VetCenter/index.htm.

Spinal Cord Injury & Disorder (SCI&D)

The mission of the SCI&D program is to promote the health, independence, quality of life, and productivity of individuals with spinal cord injury/disorders. This is accomplished through the efficient delivery of acute rehabilitation, medical/surgical care, patient/family education, psychological, social, and vocational care, research, and professional training of residents and other professionals in the continuum of care for persons with spinal cord injury/disorders.

- During FY 2002, 98% of the spinal cord injury (SCI) patients were discharged to non-institutional settings in the community. In FY 2003, VHA plans to meet or exceed this target.

- Two Centers of Excellence were established to develop new therapies for veterans with SCI. The Center at the Bronx VAMC will explore the use of Pharmaceuticals to treat the secondary disabilities of spinal cord injury, and the Center at the Miami VAMC will study pain management, recovery of motor and sensory function, and other related issues.

For more information visit SCI&D online at http://vaww.va.gov/health/sci/disorders.

Traumatic Brain Injury (TBI)

VA offers a full continuum of TBI rehabilitation through the Defense and Veterans Head Injury Program (DVHIP) which was established in 1992 as a collaboration between DoD, VA and the Brain Injury Association (BIA) to ensure that military and veteran personnel with brain injuries receive coordinated, comprehensive care. VHA offers a range of TBI rehabilitative care services, from acute rehabilitation through community re-entry. Each participating medical center has a designated TBI case manager who facilitates patient participation in the program and expedites facility transfers and community placement.

- VHA has four lead Traumatic Brain Injury Centers: Minneapolis, MN; Richmond, VA; Palo Alto, CA; and Tampa, FL. These facilities provide leadership as VA and DoD work to provide a nationwide system of case-managed TBI care. In addition to the lead Centers, there are 22 other VA TBI Network sites. Rehabilitation services at the other network sites vary from acute rehabilitation on a general rehabilitation inpatient unit to sub-acute rehabilitation and case management to facilitate coordination of care. Some network sites without an inpatient

rehabilitation bed service have developed programs within the framework of existing resources and offer special programming for specific problems.

For more information visit TBI online at http://vaww.va.gov/health/rehab or http://www.va.gov/health/rehab.

Gulf War Veterans (GWV)

The GWV program provides strategic direction for clinical, research, education and outreach programs for these veterans and ensures that available benefits are provided to eligible claimants. This objective is accomplished by working collaboratively with other VA offices; federal, state, and local government agencies; and non-profit community and private providers. The ultimate goal is to ensure quality health care for Gulf War Veterans.

We want the best researchers and the best ideas brought to bear on this long-standing problem. Research into Gulf War illnesses is an area ripe for important discoveries.

Leo S. Mackay, Jr., PhD, Deputy Secretary

- The GWV illnesses research portfolio includes 224 federal research projects sponsored by VA, DoD, or HHS. The scope of the research portfolio is broad, from small pilot studies to large-scale epidemiology studies involving large populations and major research center programs. By the end of FY 2001, 124 projects had been completed and 100 projects were still ongoing. Cumulative expenditures through FY 2002 were $213 million. The overall emphasis has been the greatest in the areas of symptoms and general health status, and brain and nervous system function.

- In FY 2004, VA plans to make available up to $20 million for research into Gulf War illnesses, which is twice the amount spent by VA in any previous year.

For more information visit Gulf War Veterans online at http://vaww.va.gov/health/environ/persgulf.htm.

Women Veterans

The mission of the Center for Women Veterans is to ensure women veterans have access to VA benefits and services, ensure that VA health care and benefits programs are responsive to the gender-specific needs of women veterans, to perform outreach to improve women veterans' awareness of VA services, benefits and eligibility, and to act as the primary advisor to the Secretary for Veterans Affairs on all matters related to programs, issues, and initiatives for and affecting women veterans. The Center's goals were developed to assess women veterans' services within and outside the Department on an ongoing basis, to assure that VA policy and planning practices address the needs of women veterans and foster VA participation in general federal initiatives focusing on women's issues.

- ❖ Second only to elderly veterans, women veterans are the fastest growing segment of the veteran population. There are approximately 1.4 million women veterans. They comprise 5.5 percent of the total veteran population and 5 percent of all veterans who use VA health care services. VA estimates that by 2010 women veterans will comprise 10 percent of veterans using VA health care services.

In addition to the Center for Women Veterans, the Women Veterans Health Program Office is located in the Office of Public Health and Environmental Hazards to support the Women Veterans Coordinators in all VA medical centers.

For more information visit Women Veterans online at http://vaww.va.gov/womenvet, http://vaww.va.gov/wvhp, or http://www.va.gov/womenvet.

Blind Rehabilitation

The mission of the Blind Rehabilitation Program is to coordinate a health care service delivery system that provides a continuum of care for blinded veterans extending from their home environment to the local VHA facility and to the appropriate rehabilitation setting. These services include adjustment to blindness counseling, patient and family education, benefits analysis, comprehensive residential inpatient training, outpatient rehabilitation services, the provision of assistive technology, and research.

- ❖ Over 17,000 veterans successfully completed VHA's blind rehabilitation program in FY 2002. As a result of their participation, these veterans became more self-sufficient in their daily activities and achieved a higher level of independence.

For more information visit Blind Rehabilitation online at http://vaww.va.gov/blindrehab or http://www.va.gov/blindrehab.

Preservation-Amputation Care & Treatment (PACT)

VHA's PACT program was established in 1993 to meet the changing needs of the veteran population, i.e., more neuropathic and vascular problems and fewer traumatic amputations. It represents a model of care developed to prevent or delay amputation through proactive early identification of patients who are at risk of limb loss. The PACT program incorporates interdisciplinary coordination of surgeon, rehabilitation physician, nurse, podiatrist, and therapist, as well as the services of social work, ambulatory care, medicine and prosthetic/orthotic personnel to track every patient with amputations, or those at risk for limb loss, from the day of entry into the VA health care system, through all appropriate care levels, back into the community.

- ❖ Issued VHA Directive 2001-030, Preservation-Amputation Care and Treatment (PACT) program that placed greater emphasis upon prevention of amputations through improved screening and evaluation processes among the diabetic population and others with neuropathic/vascular problems and end stage renal disease.

- 84% of diabetic patients screened for foot problems and identified as "at risk" for amputation were referred to a foot care specialist.

For more information visit PACT online at http://vaww.va.gov/health/rehab or http://vaww.va.gov/health/rehab.

Prosthetics & Sensory Aids (PSAS)

The mission of the PSAS Strategic Healthcare Group is to provide specialized quality patient care by furnishing properly prescribed prosthetic equipment, sensory aids and devices in the most economical and timely manner in accordance with authorizing laws, regulations and policies. PSAS serves as the pharmacy for assistive aids and as case manager for prosthetic equipment needs of the disabled veteran. The objectives of PSAS are to restore the capability of disabled veterans to the greatest extent possible, improve their quality of life, and to continually assess veterans' satisfaction with VHA-prescribed prosthetic and sensory aids.

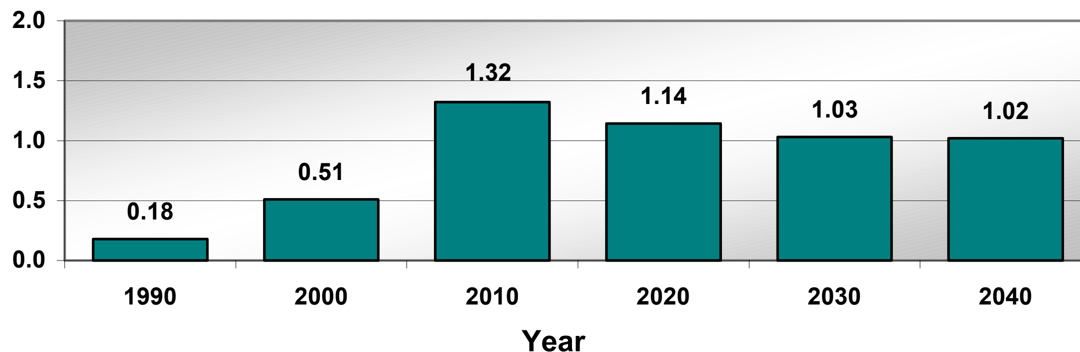
- The Eligibility Reform Act of 1996 dramatically increased the prosthetic workload. In 1996, PSAS spent over $304 million to treat patients and by FY 2001 that amount had doubled to approximately $635 million. Over one million patients sought PSAS's services in FY 2002.

For information visit Prosthetics & Sensory Aids online at http://vaww.va.gov/med/clincare/c_prosthetic.cfm.

Geriatrics And Long Term Care

The veteran population is projected to decline from 26.5 to 22.0 million between 2000 and 2010, but over the same time period those age 75 and older will increase from 4.5 to 4.7 million and those 85 and older will nearly triple from 510,000 to 1.3 million. These most vulnerable of our older veterans, particularly those over 85, are especially likely to require long-term care and to need health care of all types. Also of importance is the fact that current VA patients are not only older in comparison to the general population, but they generally have lower incomes, lack health insurance, and are much more likely to be disabled and unable to work.

Chart 3.2



Source: 2001 VetPop Adjusted to Census 2000

The projected peak in the number of elderly veterans during the first decade of this century will occur approximately 20 years in advance of that in the general U.S. population. Thus the current demographics of the veteran population are one of the major driving forces in the design of the VA health care system. The lessons learned from VHA's experiences in delivering health care to the aging veteran population will be of great importance to the entire nation.

As the VA health care system has redefined itself in recent years as a "health care" system instead of a "hospital" system, VHA's approach to geriatrics and extended care has evolved from an institutionally focused model to one that includes a continuum of home and community-based extended care services in addition to nursing home care. One of VHA's strategic objectives in this area is to provide care in the least restrictive setting.

In its 1998 report, "**VA Long Term Care at the Crossroads**," the Federal Advisory Committee on the Future of Long-Term Care in VHA made 20 recommendations on the operation and future of VHA long-term care services. These recommendations served as the foundation for VHA's national strategy to revitalize and reengineer long-term care services. A major recommendation was that VHA expand home and community-based care while retaining three nursing home programs (VA, contract community, and State Home). VHA is making progress on that strategy. Between 1997 and 2002, the VHA average daily census (ADC) in home and community-based care increased from 11,433 to 17,465. VHA has a budget performance measure that calls for an ambitious 22 percent increase in the number of veterans receiving home and community-based care. VHA plans continued increases to achieve a level of 34,500 ADC in home and community-based programs in FY 2006 by expanding both the services VHA provides directly and those it purchases from affiliates and community partners. VHA will meet most of the increased need for long-term care through home health care, adult day health care, respite, and home-maker/home health aide services.

> ***Nursing home care will become an option of last resort, where it is medically infeasible or inadvisable for a veteran to receive care at home or in an assisted living facility.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

VHA is exploring computerization and new technologies, such as telemedicine, to expand care of veterans in the home and other community settings. This technology can be used to monitor how patients feel and whether they are taking their medications properly. Technology can also be used to monitor blood pressure, blood glucose levels for diabetics, and weight for patients with heart failure. With telehealth support, veterans will be able to stay in their homes or in assisted living facilities with their spouses in the towns where they have a support network. By using interactive technology to coordinate care and monitor veterans in the home environment, VHA can significantly reduce hospitalizations, emergency room visits and prescription drug requirements, while providing veterans with a more rewarding quality of life and greater functional independence.

VHA's plans for long-term care include an integrated care management system that incorporates all of the patient's clinical care needs; more care in home and community-based settings, when appropriate to the needs of the veteran; emphasis on research and educational initiatives that will improve delivery of services and outcomes for VHA's elderly veteran patients; and development of new models of care for diseases and conditions that are prevalent among elderly veterans.

For more information visit Long Term Care online at http://vaww.va.gov/med/clincare/c_geriatric.cfm.

Patient Safety

VA's National Center for Patient Safety (NCPS) was created in 1998 to take the lead in integrating patient safety efforts and innovations, and to develop and nurture a culture of safety throughout VHA. NCPS's primary goal is nationwide reduction and prevention of harm to patients caused by adverse events consequent to medical care. NCPS also directs four applied research centers known as Patient Safety Centers of Inquiry (PSCI), that are charged to develop practical solutions to eliminate, reduce, or prevent selected classes of patient safety adverse actions.

HIGHLIGHTS

- VHA has an internal reporting system for adverse events and close calls that is coupled with rigorous root cause analysis. The rest of the medical community now looks to VHA for innovations in reducing medical adverse events. Australia, Japan, Denmark, the United Kingdom, and other countries have adopted strategies and parts of the VHA patient safety program. In addition, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) patient safety goals have been significantly influenced by the work of VHA.

- VA has established a program with NASA to create a voluntary external patient safety reporting system for health care adverse events and close calls in VA health care facilities. The system's guiding principles are voluntary participation, confidentiality protection, and non-punitive reporting.

- VHA is recognized as a national leader in the application of information management technology through its development and widespread use of an electronic medical record system and Bar Code Medication Administration program.

- VHA was the recipient of two of the first annual John E. Eisenberg Awards in Patient Safety Awards. See Section titled *Awards for Quality*.

For more information visit NCPS online at http://vaww.ncps.med.va.gov.

QUALITY INDICATORS

> ***VA is a national leader in developing quality measurements to provide the best health care for our veterans. Both health care and veteran satisfaction have improved as a result of our quality improvements.***
>
> ***Anthony J. Principi, Secretary***

VA's health care system is one of the most effective and successful health care systems in the Nation. VHA's performance now surpasses many government targets for health care quality as well as measured private sector performance. VHA is the benchmark for all 18 clinical performance indicators critical to the care of veterans, and directly comparable externally. This includes use of beta-blockers after a heart attack, breast and cervical cancer screening, cholesterol screening, immunizations, tobacco use screening and counseling, and multiple aspects of diabetes care.

Table 3.1 **VA's PERFORMANCE COMPARED TO NON VA**

Footnotes describe adjustments made to match indicator measures as closely as possible with Non-VA benchmarks.

CLINICAL PERFORMANCE INDICATOR	VA Base (FY)	VA 2001	VA 2002	MA/MC[1]	Best Reported
Advised smokers to quit at least once in past year	33% (Q4-96)	93%	NA[2]	NA	66% NCQA (2001)
Beta blocker on discharge after heart attack	NA	94%	97%	83% / 89%	94% MMCP (2001)
Breast cancer screening	68% (Q4-96)	80%	80%	55% / 74%	75% MMCP (2001)
Cervical cancer screening	64% (Q4-96)	89%	89%	60% / NA	80% NCQA (2001)
Cholesterol screening in all patients	NA	88%	91%	44% / 71%	73% BRFSS (3) (2001)
Cholesterol measured after heart attack[4]	NA	89%	92%	NA	77% NCQA (2001)
LDL Cholesterol less than 130 after heart attack[5]	NA	71%	74%	NA	59% NCQA (2001)
Colorectal cancer screening	34% (Q4-96)	60%	64%	NA	44% BRFSS (3) (1999)
Diabetes: HgbA1c done past year	59% (Q4-95)	93%	94%	68% / 82%	86% MMCP (2001)
Diabetes: Poor control[6] (lower number is better)	NA	20%	17%	55% / 33%	37% NCQA (2001)
Diabetes: Cholesterol (LDLC) measured	NA	91%	94%	NA	87% MMCP (2001)
Diabetes: Cholesterol (LDLC) controlled (<130)	NA	68%	70%	NA	50% NCQA (2001)
Diabetes: Eye Exam	44% (Q4-95)	66%	72%	43% / 63%	69% MMCP (2001)
Diabetes: Renal Exam	NA	72%	78%	38% / 45%	46% NCQA (2001)
Hypertension: BP < 140/90 most recent visit	46% (Q4 00)	52%	55%	45% / 47%	54% NCQA (2001)
Immunizations: influenza, patients 65 and older[7]	27% (Q4-96)	73%	74%	72%[8] / NA[9]	65% BRFSS (3) (2001)
Immunizations: pneumococcal, patients 65 and older[10]	26% (Q4-96)	85%	87%	65%[11] / NA[12]	60% BRFSS (3) (2001)
Mental Health follow-up within 30 days of inpatient discharge	72% (Q4-98)	84%	81%	55% / 59%	73% NCQA (2001)

SOURCE: Office of Quality and Performance

[1] MA = Medicaid, MC = Medicare 2000-2001.
[2] VA scores for counseled at least 3X per year (FY02 69%), NCQA scores at least once per year. VA not calculated for 02 for once per year.
[3] BRFSS scores are *median*; VA scores are *average.*
[4] VA evaluates cholesterol q 2 yr ongoing (FY01 if ever an AMI; FY02 if AMI in past 5 years); NCQA evaluates 1st year after myocardial infarction (heart attack) only.
[5] see #4.
[6] Diabetes: poor control defined by VA > 9.5; NCQA > 9.5 values for most recent HgbA1c.
[7] This VA number matches NCQA methodology to exclude high-risk patients less than 65. VHA Network Directors performance measure includes high risk patients and patients 65 or older (FY02 68%).
[8] Medicare sample using BRFSS methodology, median for all noninstitutionalized persons $\geq$ 65 (including managed care).
[9] Medicaid only reports childhood and adolescent rates.
[10] This VA number matches NCQA methodology to exclude high-risk patients less than 65. VHA Network Directors performance measure includes high risk patients and patients 65 or older (FY01 79%, FY02 81%).
[11] Medicare sample using BRFSS methodology, median for all noninstitutionalized persons $\geq$ 65 (including managed care).
[12] Medicaid only reports childhood and adolescent rates.

These improvements don't just look good on paper; they save lives, reduce hospitalizations, preserve function, lower costs, and improve patient quality of life. VHA is essentially identical to the best private sector health care performance on the last two indicators. VHA's performance measurement program creates a framework for accountability, specifying the improvement VHA will achieve, not simply recording where VHA has been. The recent Institute of Medicine study entitled ***Leadership By Example (2002)*** praised VHA's approach to translating the best scientific evidence of research into increasingly effective patient care. According to the study, "VHA's integrated health care information system, including its framework for using performance measures to improve quality, is considered one of the best in the nation."

The recent Institute of Medicine study entitled *Leadership By Example (2002)* can be viewed online at http://www.iom.edu.

The U.S. can no longer practice 20th century medicine. Government needs to lead the metamorphosis to 21st century patient-centered quality health care through better use of health information technology. Consistent, publicly reported quality measurement is essential to improve health care delivery and patient satisfaction.

Frances M. Murphy, MD, MPH, Deputy Under Secretary for Health Policy Coordination

HIGHLIGHTS

- During 2002, VHA received national recognition for its delivery of high-quality health care from the Institute of Medicine in its report ***Leadership by Example (2002)***.

- VHA will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. VHA will employ this approach most extensively in the management of chronic disease and disease prevention.

- VHA is also leading by example by providing a Web "portal" for patients to better manage their health and health records. Though still in development, VHA's "My Health*e*Vet" will create an Internet environment to allow patients to find information to answer health questions, alert clinicians to problems, and review their health records. In the future, patients will be able to reorder medications and even schedule appointments online.

For more information visit Quality and Performance online at http://vaww.oqp.med.va.gov/default.htm or http://www.oqp.med.va.gov.

VETERAN SATISFACTION

Presidential Executive Order 12862 was issued in September 1993 requiring agencies to publish customer service standards, survey their respective customers and use customer feedback information to manage the agency. Veteran patient satisfaction surveys are designed to promote health care quality assessment and improve strategies that address patients' needs and concerns as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group, which had been a leader in assessing non-VA patient experiences with health care. VHA's Performance Analysis Center for Excellence (PACE) of the Office of Quality and Performance (OQP) is the analytical, methodological, and reporting staff for Veteran Satisfaction Surveys.

The veteran satisfaction surveys are aimed at capturing patient perceptions of care based on the following Veteran Service Standards (VSS):

- Access
- Patient Preferences
- Coordination of Care (visit and overall)
- Continuity
- Education
- Courtesy
- Emotional Support
- Transition
- Physical Comfort
- Involvement of Family and Friends
- Pharmacy
- Specialist Care

VHA, inclusive of 21 VISNs, individual VAMCs, and Community Based Outpatient Clinics (CBOCs) rely on the analyses, interpretations, and delivery of these survey data for making administrative and clinical decisions for improving the quality of care delivered to veterans. As a result of the survey process, VHA has been able to consistently deliver understandable, applicable, impartial and comparable data and information based on sound scientific practices regarding patient perspectives towards the care received in the VA health care system. The information provided by the surveys drives process improvement at all levels of the organization (i.e., National, VISN, VAMC, and CBOC) including the development of VHA's strategic plan. The survey instrument, methods, and analyses are standardized across the country and over time. This allows a valid comparison to be made for each VISN's satisfaction score to the National VHA satisfaction scores on each of the VSS. These practices also provide the mechanisms for yearly trend analyses, which are critical for measuring improvement.

PACE currently administers the veterans' satisfaction surveys. Surveys are sent to patients who have received care in a variety of settings including inpatient, outpatient, and home-based primary care, and certain special emphasis programs. Veteran satisfaction will continue to be benchmarked to other large organizations. A new inpatient and outpatient survey, the Survey of Healthcare Experiences of Patients (SHEP) incorporates a new sample methodology and was put into operation in the second quarter of FY 2002. The inpatient survey is conducted semi-annually and the outpatient surveys are conducted quarterly. All surveys are administered by mail to a sample of veterans meeting qualifying criteria. PACE

is responsible for designing the survey instrument, drawing the sample, performing the analysis, and reporting results.

HIGHLIGHTS

- Results of the FY 2002 SHEP surveys show substantial improvement in overall quality ratings for both inpatient and outpatient care. For inpatients, preliminary analyses suggest a 5-point increase was seen nationally. Significant increases above the 2001 average of 64 percent were observed in 19 out of 21 VISNs. Eleven VISNs met or exceeded the Exceptional goal for the year (70 percent). In the outpatient setting, a 10-point gain in satisfaction was observed nationally. Fourteen of 21 VISNs met or exceeded the Exceptional goal (72 percent) while another three VISNs met or exceeded the Fully Satisfactory goal (70 percent).

- Although these results are impressive, the very size of the improvements described suggest that part of the increase in satisfaction may be due to changes from the old satisfaction survey formats to the expanded content and altered formats of the SHEP. VISN-level outpatient results show modest, but significant improvements for 6 of 11 VSS in courtesy, emotional support, overall coordination, specialist care, and Pharmacy Service (both at the facility and by mail). A significant 3-point decline in continuity was also noted in FY 2002. Further analyses and the increased availability of SHEP data owing to more frequent sampling and roll-up should allow VHA to better describe the drivers of patient satisfaction in future reports.

- The VSS representing visit coordination relates to the communication of test results, follow-up and referral appointments, and whether the patient was given information on who to contact for information after the patient's visit. Despite the challenges presented in this measure, improvement was noted between FY 2000 and FY 2002 in 17 of 22 VISNs on this standard, illustrating the commitment by VHA to address and improve patient education/information. The gains in the education/information VSS continued in FY 2002.

- VHA scored 82 (on a scale of 100) on the externally conducted American Customer Satisfaction Index for hospitalized patients. This is significantly above the mean private sector health care score of 68. Loyalty and customer service scores were even higher at 91 and 90 and exceeded scores in health and other sectors.

While transforming VA health care to a more efficient, effective, and accessible system, VA has become an industry leader in customer satisfaction, as is shown by its consistent benchmark-level scores on the American Customer Satisfaction Index (ACSI), an econometric measure of government and private sector satisfaction.

Robert H. Roswell, MD, Under Secretary for Health

PACE conducts national satisfaction surveys that allow VHA to better understand and meet patient expectations. The surveys have been updated this year to target the dimensions of care that concern veterans the most, as well as patient reported information on functional status and healthy behaviors. Results of this new survey are available on a quarterly basis.

For more information or to review survey results visit veteran satisfaction online at http://vaww.oqp.med.va.gov/oqp_services/veterans_satisfaction/vss.asp.

AWARDS FOR QUALITY

In VHA, we hold ourselves accountable for improvement and achievement. VHA's improved quality, even transformation, over the last several years has been framed by aggressive performance contracts between Chief Officers/Network Directors and the Under Secretary for Health. These contracts provide a basis for focusing and evaluating the work of leaders, managers, clinicians, and all staff throughout the system. Performance measures have led to consistent application of the best scientific evidence in the form of clinical guidelines and have supported improvements in quality and in each of our other strategic goal areas including access, satisfaction, patient functional status, cost effectiveness and community health.

Jonathan B. Perlin, MD, PhD, MSHA, FACP, Deputy Under Secretary for Health

The following are a few noteworthy awards VHA received during the past 2 years.

- VHA's medical center in Grand Junction, Colorado, won the **President's Quality Award Trophy** – the highest award for management given to federal employees and agencies. This award, which is based on the same criteria that is used for the national Malcolm Baldridge Award, recognizes outstanding performance in quality management and customer satisfaction.

- In June 2002, **VetPro**, VHA's electronic credentialing program and its federal partner, the Federal Credentialing Program, received an e-Gov Trailblazer Award for innovation in the use of electronic tools in government.

- VHA is a leader in patient safety and quality and has adopted patient safety procedures in all its health care facilities. To avoid errors in transcription, VHA implemented an electronic patient record to ensure that patients are provided the right prescription, in the right dose, at the right time. In 2001, Harvard University presented VHA's patient safety program with the prestigious **Innovations in American Government Award**.

- Five VHA facilities were among the winners of the **Robert W. Carey Awards for Excellence**. These annual awards recognize VA organizations that have excelled in quality achievement and that serve as models against which other organizations can assess their efforts, effectiveness and performance in delivering service and satisfying customers. One of the winners of the Category Award was the Research and Development/Cooperative Studies Program, Clinical Research Pharmacy Coordinating Center in Albuquerque, NM. This center provides pharmaceutical support service for large intramural and extramural multi-center clinical trials inside and outside the United States. Another recipient of the Category Award was the VA Medical and Regional Office Center in Honolulu. Excellence in health care quality allowed the Center to achieve a perfect score of 100 in its Joint Commission accreditation, placing it in the top 2 percent of the Nation.

- Two VA health care systems recently received **Quality Achievement Awards**, the Loma Linda Healthcare System and the Northern Arizona VA Health Care System. Additionally, the VA Medical and Regional Office Center at White River Junction in Vermont was recognized with an Achievement Award for providing efficient "one-stop shopping" for veterans and other beneficiaries.

- The American Pharmaceutical Association (APhA) Foundation, and the Health Care Quality Alliance (HCQA), a coalition dedicated to assuring quality is the core value of the nation's health care agenda, have awarded VA the **2002 Pinnacle Award** in the Institutional category for implementing the Bar Code Medication Administration System. The Pinnacle Awards recognize an individual, a group of individuals, or a health care organization for a significant scientific contribution and/or exemplary leadership in the improvement of quality in the medication use process.

- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Forum give the **Eisenberg Awards for Healthcare Quality and Reporting**. The VHA National Center for Patient Safety in Ann Arbor, Michigan, was a co-winner in the category of System Innovation for leadership in developing and implementing a systems approach to error reduction within VHA's hospitals. In the category of Advocacy, the Lexington, Kentucky VA Medical Center was singled out for its national leadership in openly and voluntarily disclosing health care errors to harmed individuals and/or their families.

For more information visit Quality Awards online at http://vaww.oqp.med.va.gov/oqp_services/quality_awards/quality_awards.asp.

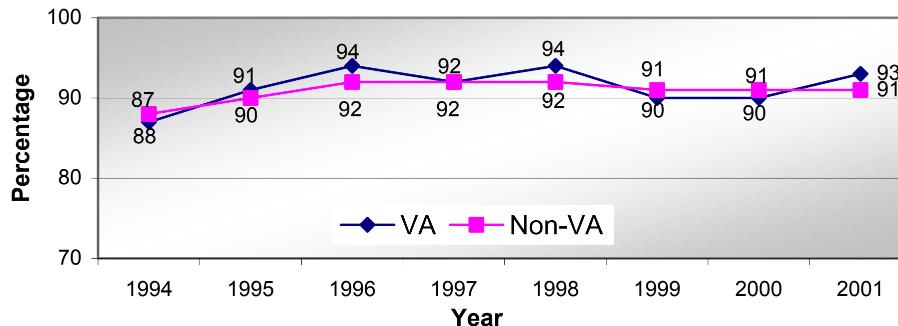
ACCREDITATION

An accreditation program ensures that accepted standards of health care operation are met. VHA's Accreditation Program is comprised primarily of health care organization accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and rehabilitation program accreditation by the Rehabilitation Accreditation Commission.

JCAHO hospital accreditation is nationally recognized as a symbol of quality and is considered one of VHA's major external quality reviews. JCAHO hospital accreditation confers recognition that health care organizations meet certain standards of quality and safety, and also confers deemed compliance with quality standards of payers, both public (e.g., Medicare) and commercial. Accreditation scores provide an important comparison with non-VA health care organizations regarding performance in meeting a wide range of standards. All VHA health care facilities are accredited. The average hospital score in 2001 for the 59 VAMC's surveyed was 92.7 as compared to the national average of 91.4.

Chart 3.3

VA/Non-VA Average Grid Scores for JCAHO Hospital Accreditation Program



Source: Accreditation, Office of Quality and Performance

In addition, VHA's Consolidated Mail Outpatient Pharmacies (CMOP), which dispense in excess of 65 million prescriptions a year to VHA facilities, were accredited by JCAHO for the first time in 1999 and all were resurveyed in November 2002. All seven were fully accredited with six of the seven CMOP's achieving Accreditation with Commendation. Also, beginning in FY 2002, VHA's Opiod Treatment Programs (OTPs) began to undergo JCAHO accreditation review.

Since 1996, VHA rehabilitation programs have been accredited by the Rehabilitation Accreditation Commission. VHA's commitment to provide specialized treatment and quality rehabilitation care to veterans with a disability is supported through a system-wide, long-term venture with the Rehabilitation Accreditation Commission to achieve national accreditation for all appropriate rehabilitation programs. Standards published by the Rehabilitation Accreditation Commission are consumer-focused, field-driven, and state-of-the-art national standards for rehabilitation.

For more information visit accreditation online at http://vaww.oqp.med.va.gov/oqp_services/accreditation/accreditation.asp.

RESEARCH

Today's VA Research; Leading Tomorrow's Health Care

VHA's research program is specifically directed toward ensuring that the best science based information is used to improve health care, and that our research portfolio increasingly focuses on the clinical and health services research that specifically addresses the needs of veterans.

> ***VHA is widely recognized as a leader in such research areas as aging, women's health, AIDS, post-traumatic stress disorder, and other mental health issues.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

Research is a never-ending quest for new knowledge, with each answer revealing a new set of questions. VHA's Office of Research and Development (ORD), pursues this quest by supporting one of VA's central missions — providing its veteran patients with the most effective and efficient health care possible.

ORD oversees VHA's research in biomedicine, rehabilitation, health services and clinical trials, more specifically, pursuing programs' goals, including supporting the highest quality research, education and patient care, translating research results into improved patient care; and capitalizing on the value of the nation's largest health care system with more than 1,300 sites as a resource for research.

ORD organizes its program around 17 areas of high priority for veterans: acute and traumatic injury; aging; military and environmental exposures; mental illness; special populations (high-risk or underserved); sensory disorders and loss; health services/outcomes research; substance abuse; emerging pathogens/bioterrorism; cancer; heart diseases; lung disorders; kidney diseases; diabetes and major complications; digestive diseases; infectious diseases; and other chronic diseases.

Research is not limited to the laboratory. In VHA, you will find researchers caring for patients in medical centers and clinics. ORD's scientists link VHA and the larger scientific and medical communities through VHA's relationships with the nation's medical schools and other government agencies, such as the National Institutes of Health. VHA collaborates with organizations that share interests, including the Juvenile Diabetes Foundation, the American Diabetes Association, the National Parkinson Foundation, and the National Stroke Association.

VHA research is embarking on many exciting new endeavors. More than ever, research is the connection between patient care and improved outcomes. VHA takes great pride in the research that keeps VHA at the forefront of modern medicine and health care.

Health Services Research and Development Service (HSR&D) works to identify and evaluate innovative strategies that lead to accessible, high quality, cost-effective care for veterans and the nation. HSR&D is an intramural research program that funds eligible VHA clinicians and investigators to address VHA health care priorities such as: patient outcomes, quality of care, access to care, cost and cost-effectiveness, alternative organizational and delivery models, and development of new research methods and measurement tools. A high priority for HSR&D is putting research findings to work. One way this is accomplished is through the broad dissemination of findings to targeted groups of policy makers, decision makers, and practicing VHA clinicians. The goal is to ensure that innovations are adopted into clinical practice and result in improvements in health care for veterans.

Medical Research Service (MRS) focuses fundamental research on disorders of significance to the veteran population. As the biomedical arm of the ORD, MRS funds and administers research on the etiology, pathogenesis, diagnosis, and treatment of virtually the full range of diseases and disorders affecting veterans. The primary goals of MRS are: to support meritorious fundamental research relevant to veterans' health care needs; to develop and enhance an intramural research environment that promotes success; to recruit and retain productive clinician and non-clinician scientists; and to train the next generation of VHA scientists.

Cooperative Studies Program (CSP) aims to conduct clinical research on health issues that are vital to our nation's veterans; define research results that establish new standards of care and improve veterans' health; improve the efficiency of the VA health care system; and improve the health of the population as a whole. With this mission in mind, the CSP organizes research involving multiple medical centers within VHA and reaps greater benefits than can be achieved from a single site study.

Rehabilitation Research and Development (Rehab R&D) Service is an intramural program for improving the quality of life of impaired and disabled veterans. Rehab R&D is dedicated to the well-being of America's veterans through a full spectrum of research: from approved rehabilitation research projects, through evaluation and technology transfer to final clinical application. The veterans served not only help define research goals, but also participate in research efforts, and often test the outcomes and ultimate usefulness of research results in their daily lives.

HIGHLIGHTS

- ORD oversees a program funded by more than $1.2 billion from VA and other sources.

- Investigators at more than 110 VA medical centers are conducting more than 14,000 active research projects designed to enhance the health care VHA provides for veterans.

- Published *Impacts 2002,* which summarizes a number of studies that demonstrate VHA's commitment to making a difference in veterans' health care. The highlighted studies are organized into categories of importance to the veteran population, such as aging, chronic diseases, health systems (e.g., health care delivery, organization, quality and outcomes), mental illness, sensory disorder and loss, substance abuse, and special populations (e.g., women, ethnic and cultural groups).

For detailed information regarding research activities visit Research Services online at http://vaww.va.gov/resdev/.

PROFESSIONAL EDUCATION AND TRAINING

VHA conducts the largest coordinated education and training effort for health care professionals in the nation. The Office of Academic Affiliations (OAA) has a substantial impact on the current and future health workforce of the VA health care system and the nation.

VHA's partnership with 107 medical schools and 1,200 other colleges and universities offering health professional training programs ensures that VHA brings state-of-the-art thinking to patient care. Conversely, as VHA improves technologies such as computerization, advances accountability through measurement, and develops delivery models that better address patient needs, VHA improves health care for the country, as a significant percent of all health professionals and 70 percent of physicians experience some portion of their training in VHA.

VHA is much more than a network of medical facilities for sick and disabled veterans. In fact, every citizen who seeks medical care, veteran and non-veteran alike, benefits from VA care and its statutory charge to train health care professionals for VHA and the nation. Indeed, VHA is the cornerstone of medical education in America as evidenced by the following facts.

- More than 76,000 health care professionals receive part of their clinical training in VHA facilities each year.

- Many nurses, psychologists, social workers, podiatrists, dentists, pharmacists, optometrists, physicians and other health care trainees, receive much of their education in the care of patients at VHA facilities.

- ❖ More than 40 health care disciplines are represented annually in the 5,000-plus clinical educational programs involving VHA facilities and VA staff.

- ❖ VA is the second largest financial supporter of education for medical professionals, after Medicare.

- ❖ As academic medical centers are under increasing financial pressures to reduce education for health care professional training, VHA maintained existing programs that train for VA and the nation.

- ❖ Programs initiated at VHA have led to the development of new medical specialties such as geriatrics, which focuses on care of the elderly.

- ❖ VHA-based training in addiction psychiatry, pain management, and spinal cord injury medicine are addressing the needs of the nation as well as the needs of our veterans.

- ❖ VHA is developing new programs using teams of health care providers specializing in services to veterans, such as palliative care teams that provide care to patients at the end-of-life.

- ❖ VHA trains health care professionals in the total care of the patient, because VA health care provides total care to eligible veterans.

- ❖ More than 80% of current trainees highly value their VHA educational experience, and if given the opportunity, would choose to train in VA again.

- ❖ VHA is a valued partner in American medical education, and has "partnership" agreements with 107 of the nation's medical schools.

VHA's medical education mission is an essential feature of the VA health care system that is critical to providing high quality health care for veterans. Over a half-century ago in 1946, a "radical" strategy was proposed to achieve quality in health care: an academic partnership between the Veterans Administration—later to become the Department of Veterans Affairs—and academic medicine. This partnership has grown into the most comprehensive academic health system partnership in history. As the nation's health care system continues to evolve, VHA will continue to be on the leading edge with innovative programs benefiting all Americans.

For more information visit Academic Affiliations online at http://vaww.va.gov/oaa/ or http://www.va.gov/oaa/.

Disaster Response

VHA has three well-known missions: medical care, education, and research. It also has a lesser-known mission: contingency support in emergencies. This function has grown over time from that of providing back-up support to the DoD in times of war and other national emergencies to a comprehensive emergency management program using an all-hazards approach emphasizing mitigation, preparedness, response, and recovery. This approach has stood many tests in times of disaster, most recently following the events of September 11, 2001.

VHA's fourth mission includes:

- VA contingencies;
- DoD contingencies;
- Support of the National Disaster Medical System (NDMS);
- Support of the Federal Response Plan;
- Response to radiologic emergencies;
- Provision for Continuity of Government (COG); and
- Continuity of Operations (COOP).

Under the COG and COOP plans, VA maintains five sites, including the Crisis Response Center in VA Central Office. Following September 11, VHA operations were successfully relocated to Site B for a brief period of time.

Many people carry out the actual work of managing emergencies locally and nationally. However, the backbone of VHA's emergency management is the Emergency Management Strategic Healthcare Group (EMSHG), an out-based central office group with 34 Area Emergency Managers (AEMs) located across the country. Three District Managers supervise the AEMs. They have worked closely with the VHA Center for Engineering and Occupational Safety and Health to produce an Emergency Management Program Guidebook. This will assist VAMCs and CBOCs to develop a Comprehensive Emergency Management Program. VHA has deployed personnel and supplies as requested to all major disasters declared by the President, such as Hurricanes Andrew and Floyd and the Houston floods. Over 1,000 VA employees have participated in disaster relief efforts. In addition, VA has provided significant on-site support for high-risk events such as the Olympic Games, the Papal Visit, and the Inauguration.

In 2002, the Secretary created a new office within VA, the **Office of Policy, Planning, and Preparedness (PPP)**, which assumed overall responsibility for VA emergency preparedness. The new PPP organization enhances VA's readiness and ability to support the Nation's response to the war on terrorism. PPP was created to establish a department-level focus, augment continuity of operations, emergency preparedness, readiness and security, and enhance strong partnerships with other agencies. As a result of this decision, VA offers continued services to veterans, a national infrastructure of resources, participation in homeland security, and 24/7 staffing at the five VA Readiness Operations Centers (ROCs). The collaboration between VHA's EMSHG and PPP makes VA "A Force Multiplier in Homeland Security" in terms of VA skilled personnel and strategically located facilities.

HIGHLIGHTS

- VA is one of four partners in the National Disaster Medical System and provides support to the Federal Response Plan. VA will support DoD and other agencies to address casualties coming off the battlefield overseas, and civilian casualties at home. VA's efforts will be coordinated with the new Department of Homeland Security, DoD, HHS, and other government agencies.

- After the terrorist attacks on September 11, 2001, VA Central Office ensured continuity of operations nationwide. Veterans Integrated Service Networks (VISNs), headquartered in the Bronx and Baltimore, activated command centers. In the aftermath of the attack, VA deployed critical care burn nurses to the Cornell Medical Center Burn Unit in New York City, and the Washington Hospital Center Burn Unit, in Washington, DC. In New York City, VA deployed staff and shared inventory with other emergency health care facilities to bring supplies to emergency workers and the National Guard. VA was also part of a coordinated effort to deliver emergency pharmaceuticals and medical supplies to New York City for the rescue operations. EMSHG Area Emergency Managers deployed to New York City to assist with response and recovery efforts.

- Staff from VA's National Center for PTSD assisted DoD in its relief efforts at the Pentagon after September 11. Education was provided for counselors as well as debriefing and psycho-educational support for relief staff, including Red Cross personnel and DoD Casualty Assistance Officers. Special procedures ensured that life insurance beneficiaries were paid within 48 hours after receiving a claim.

- A plan was developed to procure personal protective and decontamination equipment to protect the medical staff and others at risk of chemical, biological, or radiological exposure so that VHA could continue to treat veterans at a VHA facility in the event of a catastrophic incident.

- VA experts have collaborated with HHS in defining a proposed VHA role in a smallpox vaccination program and have supported HHS in forming the USA Freedom Corps Medical Reserve Corps cadre of volunteer health care professionals to provide medical care in case of an attack.

- In FY 2003, VA is seeking ways to enhance the preparation and handling of emergency situations while continuing to maintain its fundamental mission of servicing veterans and their families. To this end, VA is conducting a systematic evaluation of its Comprehensive Emergency Management (CEM) program that will address mitigation, preparedness, response, and recovery.

For more information visit EMSHG online at http://vaww.va.gov/emshg/ or http://www.va.gov/emshg.

CHAPTER 4

SERVICE EFFICIENCY AND EXCELLENCE

- *INFORMATION TECHNOLOGY*
- *PROCUREMENT*
- *COMPETITIVE SOURCING*
- *WORKFORCE PLANNING*

INFORMATION TECHNOLOGY

VA is committed to reforming the way its information technology (IT) business is conducted. VA has developed a **One-VA enterprise strategy**, embarked on a nationwide telecommunications modernization program, and laid a solid foundation for a Departmental cyber security program.

In FY 2004, the Department will continue to implement the One-VA Enterprise Architecture and integrate this effort into key Departmental processes such as capital planning, budgeting, and project management oversight. The goal is to use this architecture to develop the common infrastructure and systems development environment necessary to build and support systems that allow a comprehensive approach to expanded electronic government. These new systems will allow for integrated, comprehensive, consistent, veteran-centric, and universally available electronic access to all veteran services and information. The foundational systems under development are: telecommunications infrastructure, cyber security infrastructure, and corporate and regional data processing with continuity of operations (COOP). Successfully completing these system initiatives will allow VA to expand electronic government services.

VA's Enterprise Architecture is a business line-oriented approach that seeks to understand and capture the major business processes that are required to provide America's veterans with the benefits they have earned in a consistent, timely, efficient, comprehensive, well-managed, and cost effective environment. The Enterprise Architecture will allow for a single, shared database for all veteran information. It will also allow for a common interface for each user category for a consistent look and feel and for a customer application profile that requires an end user to provide necessary information once. Lastly, it will ensure a standardized, One-VA approach to electronic government across the spectrum of government to citizen, government to government, government to business, and internal government efficiencies.

> ***Information technology is at the heart of most changes in VA health care. We use technology to more readily and accurately process clinical and administrative information, to automate processes that were done manually, to deliver care across distances, to train staff and to improve quality and reduce errors.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

VA's Computerized Patient Record System is acknowledged in the Institute of Medicine's *Leadership By Example (2002)*, as second to none for supporting clinicians in providing quality health care. VA is also leading by example by providing a Web "portal" for patients to better manage their health and health records. Though still in development, VA's "My Health*e*Vet" will create an Internet environment where veterans, family, and clinicians may come together to optimize veterans' health care. Early national phases of My Health*e*Vet will provide powerful health education information and health self-assessment tools. In the future, veterans will be able to reorder medications, view appointments and review their health records online. This computerized patient record system builds upon the Veterans Health Information Systems and Technology Architecture (VistA) to be patient/data centric; to use the best modern technology; to move to an enterprise-wide approach; to standardize health data and communications; to substantially enhance the health systems supporting veterans care; and to secure health systems and veterans health information.

The FY 2004 budget includes funds to continue to move VHA toward My Health*e*Vet, the ideal health information system. Major projects under My Health*e*Vet include building a Health Data Repository that will provide a longitudinal healthcare record, a replacement scheduling system, an enrollment system, implementation of VistA imaging at all health care facilities, and purchase of a Patient Financial Services System. Also included are funds to support the Federal Health Information System that provides VA health care practitioners access to Department of Defense health records. VHA also collaborates with the Indian Health Service on collaborative health information systems and State Veterans Homes who are interested in acquiring and implementing VistA in their long term care facilities.

In the field of telemedicine, VHA is ahead of other medical providers. VHA has a natural advantage in this area because of its network of facilities nationwide, its experience with chronic disease, and its need to develop creative alternatives to managing its financial resources. VHA conducts as many as 300,000 telemedicine cases each year in 31 clinical specialties. The projects range from home care administered with the aid of telemedicine technology, to remotely evaluating x-rays. VHA will remain a leader in this field.

PROCUREMENT

With annual spending of about $6 billion, VA is the second largest purchaser of goods and services in the federal government after DoD, yet ranks sixth in procurement overhead costs. Procurement initiatives begun in 2002 will extend the VA's buying power for its health care system even more. The reforms include standardizing the purchase of items used throughout the system, pursuing more opportunities for joint purchasing with DoD and advocating the government-wide use of Universal Product Numbers to improve inventory management.

In addition, VA continues to implement aggressive strategies to leverage purchasing power, standardize equipment and supplies, ensure that any provider working part-time for VA supplies services for every hour paid by VA, and maintain other management costs at or below 2003 levels. VA will also achieve efficiencies at the local level.

In the past year, top leadership in VA and DoD created a Joint Executive Council that developed an overarching shared vision for the future and began to implement changes. Two priorities are jointly underway which will greatly enhance the seamless delivery of services to veterans – the information technology efforts on enrollment systems and electronic patient records. Many impressive collaborations have been made in other areas such as shared facilities and equipment, coordinated human resources, procurement, and other common business practices and training. VA has shown significant progress and expects continued results as the delivery systems become coordinated.

> ***[VA and DoD] have made unprecedented progress in sharing and coordinating medical care resources.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

VA and DoD have made substantial progress in increasing joint procurement activities. The foundation for this progress was established in December 1999 when VA and DoD signed a Memorandum of Agreement (MOA) to combine their purchasing power and eliminate redundancies. As of July 1, 2002, there were 63 joint VA/DoD contracts and four blanket purchase agreements (BPA) for pharmaceuticals. The cost avoidance resulting from these contracts and BPAs was approximately $350 million in 2001 and over $100 million in 2002. VA and DoD are converting DoD's Distribution and Purchasing Agreements to the Federal Supply Schedule for medical/surgical products. In addition, the electronic interface for VHA's Consolidated Mail Out Pharmacy (CMOPs) has been completed and is compliant with the Health Insurance Portability and Accountability Act and cyber security requirements. Initial prescription processing began in August 2002. Facilities and CMOPs filled 105.5 million prescriptions in FY 02.

COMPETITIVE SOURCING

VA has more than 1,300 sites of care and provides health care services at locations much closer to where veterans live. Eighty-seven percent of VA's patient population now lives within 30 minutes of a VA medical facility. VA is providing care to nearly 48 percent more veterans than it did in 1997. At the same time, VHA has reduced the cost of care per veteran by delivering care more efficiently and more effectively. Towards this end, VA is implementing management initiatives that will produce an unprecedented offset to the overall cost of the projected growth in workload and utilization. VA has undertaken a rigorous competitive sourcing plan to determine whether commercial activities should be performed in-house using government facilities and personnel, or with private procurement processes.

> ***We remain firmly committed to managing our medical care resources with increasing efficiency each year.***
>
> ***Anthony J. Principi, Secretary***

Competitive sourcing asks managers to make very hard management choices -- choices that affect real jobs held by very dedicated and loyal career civil servants. A key element to the success of any private sector company is the regular evaluation of whether necessary services should be provided in-house by company employees or by another company, the ultimate "make or buy" decision. This initiative strives to focus the federal government on its mission -- delivering high quality services to our citizens at the lowest cost.

Over each of the last five years, VA as a whole has steadily increased its contractual services spending while decreasing the number of full-time employees. In addition, VA's 2001 FAIR Act inventory identified approximately 85% of VA's workforce as being engaged in commercial activities. The Deputy Secretary charged VA's Office of Policy and Planning with establishing and coordinating a working group to develop a more streamlined competitive sourcing process for VA. The work group developed a three-tiered streamlined process, with more focus on cost-benefit analysis and less focus on solicitation to make the management decision about whether to contract out or retain the work in-house. The Office of Management and Budget approved this process in April 2002 for use throughout VA. The following reflects an overview of the process.

- ***Tier 1*** competitive sourcing process focuses on cost-benefit analysis for the day-to-day make or buy decisions at the local level for 10 or fewer FTE;

- ***Tier 2*** focuses on a more detailed and rigorous but internal cost analysis using market research for competitive sourcing for 11 or more FTE; and

- ***Tier 3*** requires a formal A-76 study based on the premise that a federal agency must rely on a formal procurement process in order to make a decision about whether to contract out an activity or conduct it in-house.

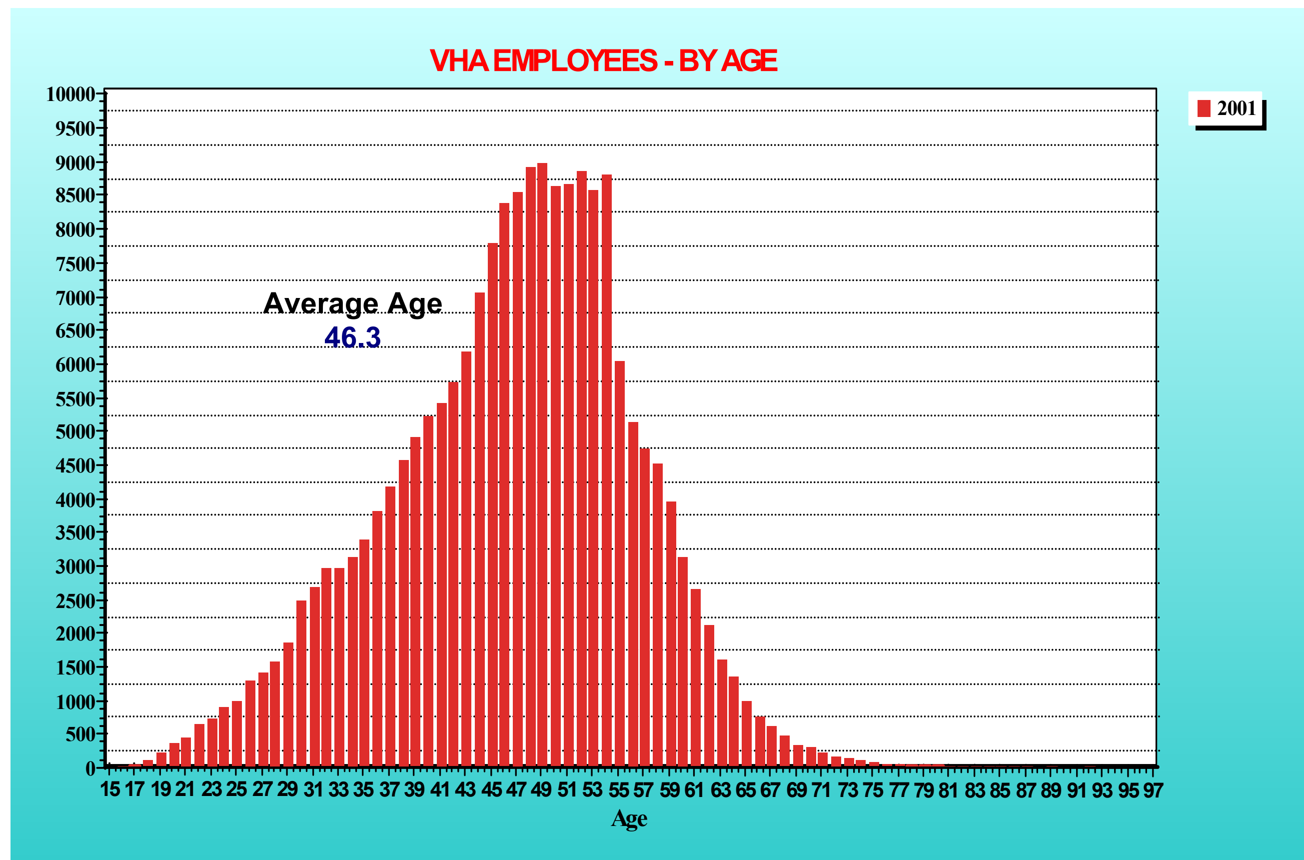
VA has completed and circulated for implementation throughout the Department a Directive on Competitive Sourcing. For 2002, VHA, which represents about 97% of VA's total commercial activities, conducted 1,626 cost comparison studies. These studies covered 4,061 FTE positions and resulted in 3,189 being contracted out and 872 being retained in-house. VHA has increased the amount of contract services to $2.6 billion – a 32% increase over the last five years. VHA's total contract service expenditures equate to approximately 43,000 full-time employees. One of the key factors contributing to VHA achievements in competitive sourcing is the transformation of the health care delivery approach, moving increasingly from inpatient to outpatient care and toward the use of Community Based Outpatient Clinics (CBOCs) to improve access for veterans. For each CBOC opened, VA determines whether it is more cost effective to operate the facility with VA employees. Out of 609 operating CBOCs, 146 are staffed with contract personnel.

The Department will compete 52,000 jobs over the next five years (such as laundry, food and sanitation services), with an estimated cost savings of approximately $3 billion. To that end, VHA began reviewing all laundries in CY 2003. In addition, a Work Group was tasked in January 2003 to identify other functions for review; educate the Field on the competitive sourcing process; improve reporting of local and national existing contracts which would include credit for work in progress such as CMOPs, CBOCs, Scarce Medical, MCCF, etc.; and improve reporting of local day-to-day sourcing decisions.

WORKFORCE PLANNING

Throughout the last decade, VHA has experienced a dramatic transition. This remarkable transformation from a hospital system to a health care system created a new model with a culture that requires a new kind of employee. Concurrent with the organizational changes came a dramatic shift in the VHA workforce profile. By 2005, 98% of VHA's Senior Executives, 80% of VHA's Chiefs of Staff, and 75% of VHA's Nurse Executives will be eligible to retire. Exacerbating the problem is the tight labor market and the inability of the federal government to keep pace with private sector salaries and incentives.

Chart 4.1 VHA Employees by Age – 2001



Source: VACO Management Support

> ***To work down the waiting lists, and to continue to provide the quality and safety our veterans deserve, and to provide care with the efficiency that the budgetary environment demands, VHA needs to recruit and retain appropriate health care professionals.***
>
> ***Robert H. Roswell, MD, Under Secretary for Health***

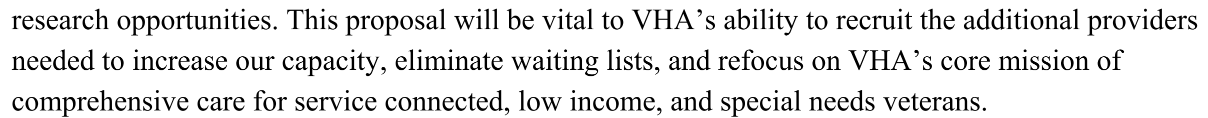
National nursing leaders and health care organizations are projecting a shortage of registered nurses that will be unlike any experienced in the past. The current and future numbers of professional, registered nurses may be insufficient to meet the national health care needs. At the same time, changes in health care delivery will require larger numbers of well-educated nurses who perform increasingly complex functions in hospitals and the community. VA expects to face increasing challenges in maintaining its nursing workforce and must remain competitive in pay and workforce innovations.

VA is also facing a critical situation in which its compensation system for physicians and dentists is unresponsive to the demands of the current market. The effect of noncompetitive pay and benefits is seen in dramatic increases in VA's scarce-specialty, fee-basis, and contractual expenditures. In addition, the short supply of some clinical sub-specialties in the medical community is causing rapid increases in salaries, benefits, and prerequisites. VA's special pay authorities have not been revised since 1991. VA's current pay authorities are stretched to the maximum, and the Department can no longer offer competitive salaries for these medical sub-specialists. More importantly, the current statutory compensation structure does not offer a way for VA to link physician and dentist compensation to quantitative and qualitative outcomes.

The development of a comprehensive succession plan was fundamental to VHA's continued ability to provide quality care for the nation's veterans. Recognizing this, VHA charged a succession planning committee in 2000 with developing a comprehensive strategy to meet this challenge. The committee used the following definition: *VHA Succession Planning encompasses all processes and activities needed to ensure that our current and future missions are supported by the highest quality work force.* The committee benchmarked best practices, assessed VHA's workforce, analyzed drivers of employee satisfaction, and examined statutes, regulations and policies. The final report approved by the Under Secretary for Health and published in January 2002 included more than 100 action items.

A Deployment Committee was established to address and track the categories identified in the report, i.e., workforce planning, leadership development, technical skills development, supervisory development, employee satisfaction, and legislative and policy initiatives. VHA has been working diligently in each of these areas. Some of the accomplishments to date include development and implementation of a succession planning Web site, workforce analysis and planning included in VHA's Strategic Planning Process for FY 2002, a workforce performance measure included in FY 2003 performance agreements, Web-based workforce/diversity planning and analysis tools, an Executive Career Field (ECF) Candidate Development Program, Technical Development Programs that focus on VA-specific disciplines, increased use of available Human Resource authorities (e.g., Relocation Bonuses & Retention Pay), and legislative and human resource policy changes. Other projects underway include revising the performance appraisal and recognition system, employee satisfaction and organizational development programs, redesign of employee surveys, supervisor training and new employee orientation. All of these projects are designed to meet the dynamic changes occurring in VHA.

VHA is also developing a comprehensive workforce improvement proposal that would enhance VHA's ability to recruit high-quality specialists thereby improving access; increase the attractiveness of full-time VA positions thereby reducing the need for contract/part-time physicians; enhance the ability to financially reward performance and expertise to further VHA goals thereby improving care; improve balance in financial relationships between VA and affiliates; and enhance the ability to pay for actual services needed (24 hour coverage, intermittent service). VHA expects to submit this proposal by late spring of 2003. The new opportunities this proposal can provide include a focus on emerging veteran-specific health care needs; an enhanced tertiary capacity with less fragmented care; a facilitation of sharing with DoD because of increased medical expertise and training opportunities; and increased



research opportunities. This proposal will be vital to VHA's ability to recruit the additional providers needed to increase our capacity, eliminate waiting lists, and refocus on VHA's core mission of comprehensive care for service connected, low income, and special needs veterans.

For more information visit VHA Succession Planning online at http://vaww.va.gov/succession/.

GLOSSARY OF ACRONYMS

ACA .... Advanced Clinic Access
ACSI .... American Customer Satisfaction Index
ACT .... Assertive Community Treatment
ADC .... Average Daily Census
AEM .... Area Emergency Managers
APhA .... American Pharmaceutical Association

BIA .... Brain Injury Association
BPA .... Blanket Purchase Agreements
BRFSS .... Behavioral Risk Factor Surveillance System

CARES .... Capital Asset Realignment for Enhanced Services
CBOC .... Community Based Outpatient Clinic
CEM .... Comprehensive Emergency Management
CMOP .... Consolidated Mail Out Pharmacy
CMS .... Centers for Medicare and Medicaid Services
COG .... Continuity of Government
COOP .... Continuity of Operations
CSP .... Cooperative Studies Program
CY .... Calendar Year

DoD .... Department of Defense
DVHIP .... Defense and Veterans Head Injury Program

ECF .... Executive Career Field
EMSHG .... Emergency Management Strategic Healthcare Group

FTE .... Full Time Employee
FY .... Fiscal Year

GAO .... General Accounting Office
GWV .... Gulf War Veterans

HCQA .... Health Care Quality Alliance
HHS .... Department of Health and Human Services
HSR&D .... Health Services Research and Development Service
HUD .... Department of Housing and Urban Development

IOM..................Institute of Medicine
IT......................Information Technology

JCAHO.............Joint Commission on Accreditation of Healthcare Organizations

MOA ....Memorandum of Agreement
MCCF ....Medical Care Cost Fund
MHICM ....Mental Health Intensive Case Management
MMCP ....Medicare Managed Care Plan
MRS.................Medical Research Service

NASA...............National Aeronautics and Space Administration
NCA ....National Cemetery Administration
NCPS ....National Center for Patient Safety
NCQA ....National Committee for Quality Assurance
NDMS..............National Disaster Medical System
NLB ....National Leadership Board

OAA.................Office of Academic Affiliations
OMB ....Office of Management and Budget
OQP ....Office of Quality and Performance
ORD.................Office of Research and Development
OTP..................Opiod Treatment Programs

PACE ....Performance Analysis Center for Excellence
PACT ....Preservation-Amputation Care and Treatment
POW.................Prisoner of War
PPP...................Office of Policy, Planning and Preparedness
PSAS................Prosthetics & Sensory Aids
PSCI.................Patient Safety Centers of Inquiry
PSSG................Planning Systems Support Group
PTSD................Post-Traumatic Stress Disorder

Rehab R&D......Rehabilitation Research and Development
ROC ....Readiness Operations Centers

SCI ....Spinal Cord Injury
SCI&D ....Spinal Cord Injury & Disorder
SEP...................Special Emphasis Program
SHEP................Survey of Healthcare Experiences of Patients
SMI ....Seriously Mentally Ill
SPC ....Strategic Planning Committee

TBI .... Traumatic Brain Injury

VA.................... Department of Veterans Affairs
VACO .... VA Central Office
VAMC .... VA Medical Center
VBA .... Veterans Benefits Administration
VHA .... Veterans Health Administration
VISN .... Veterans Integrated Service Network
VISTA.............. Veterans Health Information Systems & Technology Architecture
VSO .... Veteran Service Organization
VSS .... Veteran Service Standards
VSSC .... VISN Support Service Center

http://vaww.va.gov/vhaopp/report01/vision/vision2020.pdf
http://www.va.gov/vhareorg/vision2020.pdf