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2003 Departmental Performance Plan

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With the 2003 Performance Plan, we continue our efforts to raise the level of confidence of America's veterans in the Department of Veterans Affairs' (VA) ability to improve the timeliness and accuracy of claims processing, to expand access to high quality health care, to meet the burial needs of veterans, and to maintain national cemeteries as shrines.

This plan describes how we will achieve our strategic goals, objectives, and performance goals with the funds we request in the 2003 Budget. Along with the budget submissions covering each VA program, this plan provides information to Congress, veterans service organizations, and the general public concerning not only what we do, but more importantly, how we intend to meet our commitments to the Nation's veterans and their families.

Executive Summary

By the end of 2003, the Department will have made significant strides toward achieving our long-term strategic goals, objectives, and performance targets. This plan describes how we will do it.

The Performance Plan contains several sections. We describe the improvements to our performance planning efforts, particularly our increased focus on key priorities established by the Secretary. After summarizing the Department's mission, vision, and program descriptions, we present detailed information on the goals, objectives, and performance measures identified as critical to the success of the Department by VA's senior leadership. The Performance Plan also contains discussions of:

- the means and strategies that will be used to achieve our performance targets;
- external factors that may have an impact on our ability to achieve those targets;
- major management challenges;
- data verification and validation activities;
- crosscutting activities VA has ongoing with other government and private sector organizations;
- program evaluation efforts;
- budget account restructuring activities;
- efforts that are in place to enhance accountability for performance;

- efforts we are taking in support of the President's management agenda;
- steps we will take to make sure this plan is communicated to VA staff and to our external stakeholders.

Finally, we present two sets of data tables. The first displays all of our performance measures by Departmental goal and objective; the second displays the measures by program.

Introduction

VA directly touches the lives of millions of veterans every day through its health care, benefits, and burial programs. The 2003 Performance Plan describes how VA will fulfill its obligations to provide high-quality service, to deliver benefits to veterans in a way that satisfies the American public's commitment to honor veterans' service, and to compensate them for their sacrifices.

The 2003 Performance Plan presents the performance targets VA is striving to achieve as a means of bringing us closer to accomplishing our strategic goals and objectives. This Plan supports the Secretary's priorities:

- Provide specialized health care services;
- Improve the quality and timeliness of claims processing;
- Focus vocational rehabilitation resources;
- Provide meaningful readjustment assistance;
- Meet community standards for home loan guaranty benefits;
- Provide high-quality health care;
- Provide timely access to health care;
- Refocus medical care on higher-priority veterans;
- Maintain high level of service to insurance policy holders;
- Ensure the burial needs of veterans and their eligible family members are met;
- Ensure graves in national cemeteries are marked in a timely manner;
- Focus medical research programs;
- Improve response in event of a National Emergency; and
- Maintain national cemeteries as shrines.

By the end of 2003, we will improve the timeliness of claims processing so we complete cases in an average of 100 days, while continuing to improve the quality of our decision-making. Veterans will be able to schedule primary care and specialty appointments at VA health care facilities within 30 days 89 percent of the time and 87 percent of the time, respectively, and waiting times for scheduled appointments will be less than 20 minutes 72 percent of the time. Over 76 percent of veterans will have reasonable access to a burial option at a national cemetery or state veterans cemetery. The overall appearance of national cemeteries will provide a dignified and respectful setting for deceased veterans and for those who visit these national shrines.

At VA, we will conduct our operations using sound business principles. The plan describes a number of performance enablers and management reforms, including the President's management agenda initiatives, which will allow us to achieve our goals while managing public resources with prudence.

This document provides a synopsis of the more detailed planning, performance, and resource information, presented in an integrated fashion throughout Volume 1 (Benefit Programs), Volume 2 (Medical Programs), and Volume 4 (General Operating Expenses) of our budget submission. Taken together, the Performance Plan and the individual budget volumes present a comprehensive picture of what VA is striving to achieve, how we propose to measure our progress, and the resources required to accomplish our strategic goals and objectives.

Participation in VA Programs

The Department carries out its responsibilities through the following programs:

Medical Care	Compensation	Housing
Medical Education	Pension	Insurance
Medical Research	Education	Burial
	Vocational Rehabilitation and Employment	

Projected Number of Veterans and Dependents Who Will Participate in VA Programs, 2003

Program	Participants	Program	Participants
Medical Care:		Vocational Rehabilitation:	
Unique Patients	*4,893,900*	Veterans Receiving	
Veterans	*4,460,700*	Services/Subsistence	*64,900*
Non-Veterans	*433,200*		
Compensation:		Housing:	
Veterans	*2,431,400*	Loans Guaranteed	*240,000*
Survivors/Children	*310,000*		
		Insurance:	
Pension:		Administered	
Veterans	*336,900*	Policies (Veterans)	*1,815,900*
Survivors	*218,700*	Supervised Policies (Service Members and Veterans)	*2,388,000*
Education:		Burial:	
Veterans and		Interments	*90,500*
Servicepersons	*331,900*	Graves Maintained	*2,573,300*
Reservists	*70,800*	Headstones and	
Survivors/Dependents	*48,400*	Markers	*341,200*

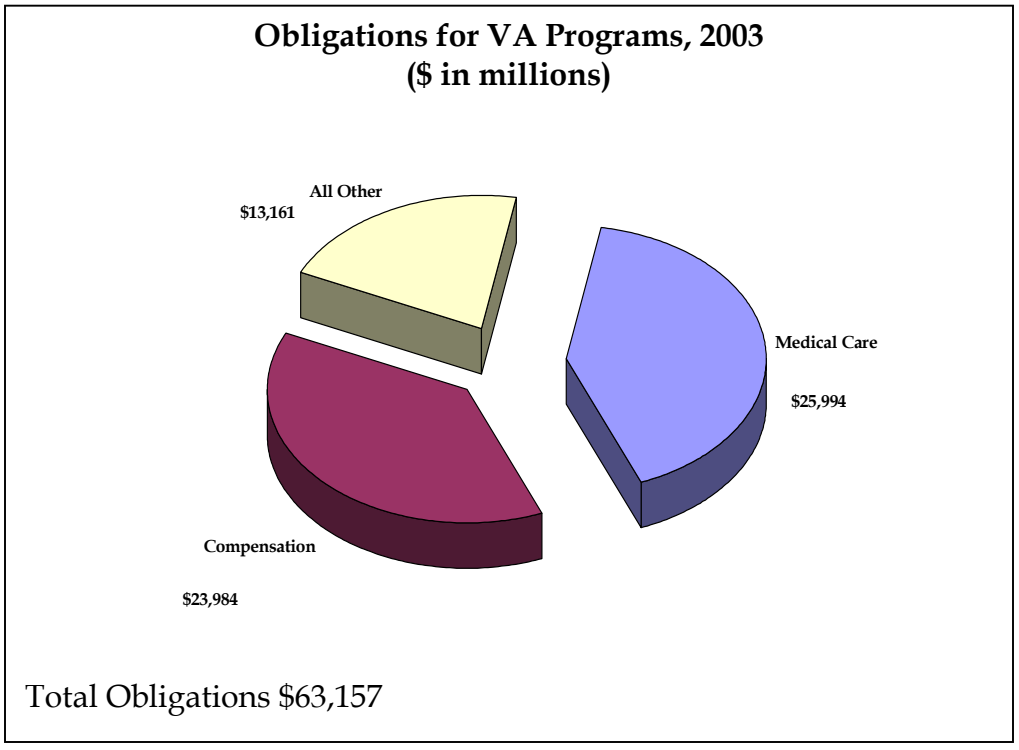
VA's Key Performance Goals for 2003

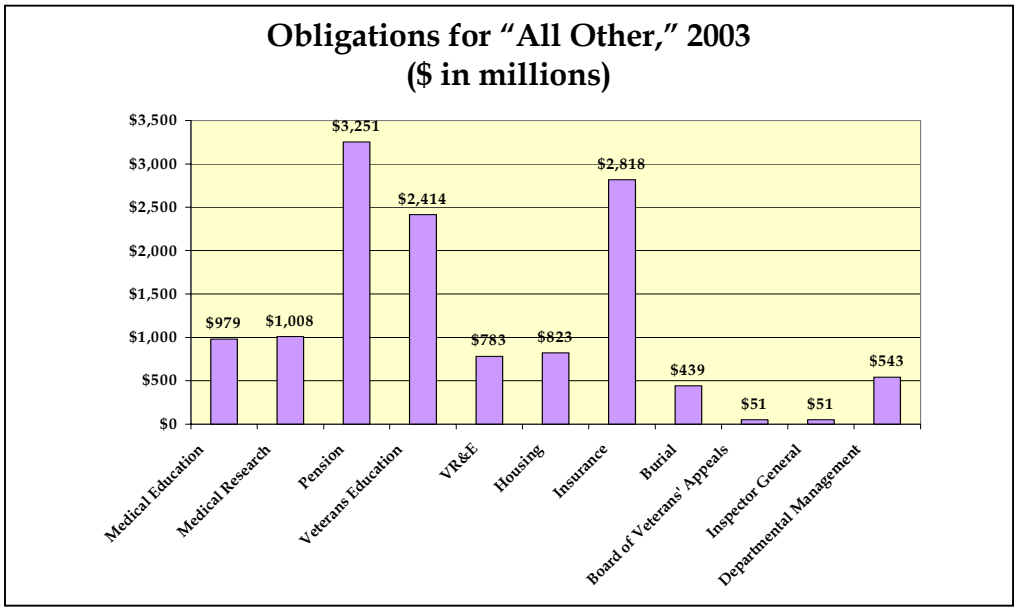
Performance Measure	1999 Actual	2000 Actual	2001 Actual	2002 Est.	2003 Plan	Strategic Target
Strategic Goal 1: Restore the capability of disabled veterans to the greatest extent possible and improve the quality of their lives and that of their families						
Proportion of discharges from SCI center bed sections to non-institutional settings	93%	97%	98%	95%	**95%**	95%
Compensation and pension rating-related actions - average days to process	166	173	181	208	**165***	74
***The Secretary has set an intermediate goal of 100 days during the summer of 2003.**						
National accuracy rate for core rating work	68%	59%	78%	85%	**88**	96%
Vocational Rehabilitation and Employment Rehabilitation rate	53%	65%	65%	67%	**68%**	70%
Strategic Goal 2: Ensure a smooth transition for veterans from active military service to civilian life						
Montgomery GI Bill usage rate	56%	55%	56%	58%	**61%**	70%
Average days to complete:						
Original education claims	26	36	50	38	**30**	10
Supplemental education claims	16	22	24	21	**17**	7
Foreclosure avoidance through serving (FATS) ratio	38%	30%	40%	39%	40%	40%
Strategic Goal 3: Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation						
Chronic Disease Care Index II	N/A	N/A	77%	78%	**79%**	82%
Prevention Index II	N/A	N/A	80%	80%	**80%**	85%
Percent of patients rating VA health care service as very good or excellent:						
Inpatient	65%	66%	64%	66%	**68%**	72%
Outpatient	65%	64%	65%	67%	**69%**	72%
Percent of Veterans Service Standard (VSS) problems reported per patient (decrease is intended direction)						
Patient Education	31%	30%	30%	29%	**29%**	27%
Visit Coordination	16%	15%	16%	15%	**15%**	13%
Percent of primary care appointments scheduled within 30 days of desired date	N/A	N/A	87%	88%	**89%***	90%
Percent of specialist appointments scheduled within 30 days of desired date	N/A	N/A	84%	85%	**87%***	90%
Note: Data on the percent of patients who are able to schedule a non-urgent appointment with their primary care provider within 30 days, or with a specialist within 30 days, exclude new enrollees who are pending scheduling of their first appointment.						
Percent of patients who report being seen within 20 minutes of their scheduled appointment at VA health care facilities	N/A	N/A	63%	70%	**72%**	90%

Performance Measure	1999 Actual	2000 Actual	2001 Actual	2002 Est.	2003 Plan	Strategic Target
Bar Code Medication Administration (BCMA) contingency plan and conduct test of plans annually	N/A	N/A	N/A	100%	**100%**	100%
Balanced Scorecard: Quality-Access-Satisfaction-Cost	88%	90%	98%	101%	**102%**	100%
Average days to process insurance disbursements	3.2	3.2	2.8	3.2	**3.2**	3.0
Percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence	67.0%	72.6%	72.6%	73.9%	**76.2%**	85.0%
Percent of respondents who rate the quality of service provided by the national cemeteries as excellent	84%	88%	92%	93%	**96%**	100%
Percent of graves in national cemeteries marked within 60 days of interment	N/A	N/A	N/A	Baseline	**TBD**	TBD
Strategic Goal 4: Contribute to the public health, emergency preparedness, socioeconomic well being and history of the Nation						
Institutional Review Board compliance with National Committee for Quality Assurance accreditation and maintenance, as appropriate, of AAALAC or NRC accreditation or certification	N/A	N/A	0%	10%	**40%**	100%
Percent of respondents who rate national cemetery appearance as excellent	79%	82%	96%	96%	**98%**	100%

FY 2003 Obligations

During 2003, VA obligations are projected to total over $63 billion for these programs. Approximately 95 percent of this sum will go directly to veterans in the form of monthly payments of benefits or for direct services, such as medical care.





Improvements to the Strategic Plan and the Performance Plan

VA employees are deeply committed to providing high-quality benefits and services to veterans as a unified Department, and to having the most positive impact on the lives of our Nation's veterans. From the time they leave active military service, veterans may have a variety of social, medical, and economic needs that are met through VA programs. Acting as an integrated Department, we can best assure those needs are met through effective strategic and performance planning. We continually consult with the Office of Management and Budget (OMB), the Congress, and other stakeholders for their suggestions on improving our strategic and performance plans. In September 2000, we published a new Strategic Plan centered on three veteran-focused strategic goals, one strategic goal focused on support of national policy, and an enabling goal. The Performance Plan builds on the Strategic Plan by supporting the resource request necessary to achieve our long-term and short-term goals. This year's Performance Plan incorporates our stakeholders' suggestions. The discussion below describes the significant changes we are making to these documents to make them more useful to a wider audience.

Strategic Plan Improvements

- VA will revise and publish our strategic plan in the spring of 2002 to reflect the vision and priorities of the new VA leadership. Significant changes to the goals are not expected, but some priorities could change.
- The revised strategic plan will cover the period FY 2003 to FY 2008. The goals will continue to be overarching and define the results we expect to produce. The goals will remain veteran-focused and will represent the shared interest of the Department's organizations.

Strategic Management Improvements

VA has initiated a new governance process to provide a systematic approach for developing recommendations for the Secretary regarding policy, planning, and management issues that:

- Establishes a Strategic Management Council (SMC) chaired by the Deputy Secretary. The SMC membership includes the Deputy Under Secretaries, the General Counsel, the Assistant Secretaries, the Chair of the Board of Veterans' Appeals, the Chief of Staff, the Counselor to the Secretary, and the Senior Advisor to the Deputy Secretary. This council has responsibility for reviewing all major policy and management issues, assessing options, and making recommendations to the Secretary through the VA Executive Board.
- Establishes a VA Executive Board (VAEB) chaired by the Secretary to review and approve proposals for new or revised policies. The VAEB also reviews and approves the Department's Strategic Plan, Annual Performance Plan and Report, Accountability Report, and other major management documents

including the annual budget submissions, annual legislative program, capital investment proposals, and workforce plans.

- Beginning in 2002, the Deputy Secretary conducts monthly performance reviews with the Under Secretaries of each Administration and the Assistant Secretaries. The reviews focus on variance from plan for key performance measures, resource measures (financial and FTE), and workload indicators.

Performance Plan Improvements

- This year's Performance Plan is structured around strategic goals and priorities established by the Secretary. We incorporate interim objectives, pending publication of the strategic plan in the spring of 2002. Key performance measures are those that directly support one of the secretarial priorities. This improves the focus of the plan by putting attention on issues that are most important to veterans, Congress, and our stakeholders.
- We continue the presentation of resources by strategic goal and objective. This information represents a significant advancement in demonstrating the relationship between resources and results. As our accounting tools improve, this information will be more precise.
- We begin performance budgeting pilots to test concepts and methods for improving the linkage between resources and performance.

Performance Measurement

Each year, we evaluate performance for the previous year, and set new annual performance targets that demonstrate our commitment to continuous improvement. In many instances, the performance improvements we project from one year to the next, as well as the performance advancements we actually achieve, are dramatic. In other cases, the improvement is necessarily more limited. The degree of improvement is due to a variety of factors, such as the availability of resources for each program, the timing associated with implementing initiatives and new strategies, and the priorities established by the Department. Nevertheless, we continuously strive to improve our performance in all programs every year.

While the vast majority of our performance measures remain the same from one year to the next, our list of measures does change in response to changing circumstances.

First, we modify our strategic goals and objectives in connection with our ever-improving strategic management process. When these long-term goals and objectives change, we alter some of our performance goals and measures to ensure that they are consistent with the Strategic Plan. Second, we are constantly striving for better ways to measure performance. This is an ongoing process, and every year we will introduce new measures that reflect a more sophisticated and

mature performance measurement process. Third, there are instances in which our actual performance has met or exceeded our original goals, and further performance improvements are unlikely or unreasonable. In these cases, we either drop the performance measure, or replace it with a different one.

Mission, Vision, Core Values, and Program Descriptions

Since the earliest days of our country, support for veterans and their families has been a national concern. Beginning in 1636, when the Plymouth Colony passed a law to provide lifetime support for any soldier who returned from battle with an injury, we have responded to the needs of veterans. From this humble but necessary beginning, through all our wars, veterans' programs have evolved to the comprehensive set of health care, benefits, and services VA administers today. Veterans' programs have four broad purposes:

- to restore the capability of those who suffered harm during their service;
- to ensure a smooth transition as veterans return to civilian life in their communities;
- to honor and serve all veterans for the sacrifices they made on behalf of the Nation;
- to contribute to the public health, socioeconomic well being, and history of the Nation.

Just as the history of VA has been evolutionary in nature, we can expect that VA will continue to transform. Today, there are over 25 million living men and women who served in the armed forces. VA currently provides health care, benefits, and services to millions of veterans, as well as eligible survivors and dependents of veterans. As we move further into the new century, we know the needs of veterans and their families will continue to change.

Mission

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

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

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

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

Vision

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

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

Core Values

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

Respect and Commitment

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

Open Communication

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

Excellence in Services, Programs, and People

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

Program Descriptions

VA directly touches the lives of millions of veterans every day through its health care, benefits, and burial programs. With facilities in all 50 states, Puerto Rico, the territories, and the District of Columbia, we provide benefits and services through our 172 medical centers, 137 nursing homes, 43 domiciliaries, 835 outpatient clinics, 206 Vietnam Veteran Outreach Centers (Vet Centers), 57 regional offices, and 120 national cemeteries.

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

Medical Care

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

Medical Education

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

Medical Research

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

Compensation

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

Pension

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

Education

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

Vocational Rehabilitation and Employment

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

Housing

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

Insurance

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

Burial

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

Resource Requirements by Strategic Goal

The following table shows the approximate cost (obligations) of achieving the Department's strategic goals, by program. Because we do not yet have sophisticated financial tools, we cannot precisely state the cost of each goal. The table is included in the 2003 Performance Plan to show the potential for capturing and presenting this information.

Program Account	Total Obligations ($ in millions)	Restore Disabled Veterans	Assure a Smooth Transition	Honor and Serve Veterans	Support National Goals	Enabling Goal
Medical Care	$25,995.2	$12,970.0	$83.1	$12,879.0	$63.0	
Medical Education	$978.9	$528.6			$450.3	
Medical Research	$1,008.0	$216.2			$791.8	
Compensation	$24,002.1	$24,002.1				
Pension	$3,237.9			$3,237.9		
Education	$2,411.7	$237.8	$2,173.9			
Vocational Rehabilitation & Employment	$783.0	$783.0				
Housing	$822.5		$822.5			
Insurance	$2,818.2			$2,818.2		
Burial	$439.2			$359.8	$79.4	
Departmental Management:						
Board of Veterans' Appeals	$61.2	$55.1		$6.1		
Office of Inspector General	$51.2					$51.2
Staff Offices	$558.2					$558.2
Total ($ in millions)	$63,167.3	$38,792.9	$3,079.5	$19,301.1	$1,384.5	$609.3
	100%	**61%**	**5%**	**31%**	**2%**	**1%**

Resource Requirements by Objective

The following table shows the approximate cost (obligations) of achieving the Department's interim objectives, by strategic goal. Because we do not yet have sophisticated financial tools, we cannot precisely state the cost of each objective. The table is included in the 2003 Performance Plan to show the potential for capturing this information.

Interim Objective	Total Obligations ($ in millions)	Restore Disabled Veterans	Assure a Smooth Transition	Honor and Serve Veterans	Support National Goals	Enabling Goal
1.1 Maximize the physical, mental, and social functioning of disabled veterans, including special populations of veterans, and be recognized as a leader in the provision of these specialized services.	$12,970.0	$12,970.0				
1.2 Provide timely and accurate decisions on disability compensation claims, thereby improving the economic status and quality of life of service-disabled veterans.	$20,057.8	$20,057.8				
1.3 Enable service-disabled veterans, through vocational rehabilitation, to become employable, obtain and maintain suitable employment, and achieve independent living with special focus on seriously disabled veterans.	$783.0	$783.0				
1.4 Ensure eligible survivors of service-disabled veterans are able to maintain a minimum (adequate) standard of living and income through compensation, education, and insurance benefits.	$4,237.2	$4,237.2				
2.1 Ease the reentry of new veterans into civilian life by increasing awareness, access to, and use of benefits and services, including readjustment counseling.	$83.1		$83.1			
2.2 Provide timely and accurate decisions on education claims thereby enhancing veterans' and service-members' ability to achieve educational and career goals.	$2,173.9		$2,173.9			
2.3 Improve the ability of veterans to purchase and retain a home by meeting or exceeding lending industry standards for quality and timely service, while minimizing VA loss on foreclosed properties.	$822.5		$822.5			
3.1 Provide consistently reliable, accessible, timely and efficient high quality care through a health care system that maximizes functional status, improves veteran satisfaction, and fosters healthy communities.	$12,879.0			$12,879.0		
3.2 Provide timely and accurate processing of pension claims, thereby ensuring a level of income that brings eligible veterans and their survivors up to a standard of living that assures dignity in their lives.	$3,244.0			$3,244.0		
3.3 Maintain the high level of service to insurance policy holders and their beneficiaries, thereby enhancing the financial security for veterans' families.	$2,818.2			$2,818.2		
3.4 Ensure that the burial needs of veterans and eligible family members are met.	$300.2			$300.2		
3.5 Provide veterans and their families with timely and accurate symbolic expressions of remembrance.	$59.6			$59.6		

Resource Requirements by Objective

Interim Objective	Total Obligations ($ in millions)	Restore Disabled Veterans	Assure a Smooth Transition	Honor and Serve Veterans	Support National Goals	Enabling Goal
4.1 Advance VA medical research and development programs that address veteran's needs, with an emphasis on service-connected injuries and illnesses, while contributing to the Nation's knowledge of disease and disability.	$1,008.0	$216.2			$791.8	
4.2 Maintain sustained partnerships with the medical education community that maximize care to veterans and provide a high level of educational experience for health care providers.	$978.9	$528.6			$450.3	
4.3 Improve the Nations response in the event of a national emergency or natural disaster by providing timely and effective contingency medical support and other services.	$63.0				$63.0	
4.4 Enhance the socioeconomic well-being of the Nation and local communities through veteran's benefits, business assistance programs, and other community initiatives.	<$1.0					<$1.0
4.5 Ensure that national cemeteries are maintained as shrines dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice veterans have made	$79.4				$79.4	
E.1 Improve communications with veterans, employees, and stakeholders about the Department's mission, goals, and current performance and of the benefits and services VA provides.	$15.0					$15.0
E.2 Recruit, develop, and retain a competent, committed and diverse workforce that provides high quality service to veterans and their families	$54.6					$54.6
E.3 Implement a *One VA* information technology framework that supports the integration of information across business lines and that provides a source of consistent, reliable, accurate, and secure information to veterans and their families, employees, and stakeholders	$27.8					$27.8
E.4 Improve the overall governance and performance of VA by applying sound business practices and ensuring accountability	$512.0					$512.0
Total ($ in millions)	**$63,167.3**	**$38,792.9**	**$3,079.5**	**$19,301.1**	**$1,384.5**	**$609.3**

Strategic Goal 1

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

Secretary Priority: *Be recognized as a leader in the provision of specialized services, particularly spinal cord injury, geriatrics, and mental health.*

Secretary Priority: *Provide accurate decisions on compensation and pension rating-related claims within 100 days.*

Secretary Priority: *Focus vocational rehabilitation resources on veterans with serious employment handicaps and independent living services.*

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

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

- Spinal cord injury discharges
- Average days to process rating-related actions on compensation and pension claims
- National accuracy rate for core rating work
- Vocational rehabilitation and employment rehabilitation rate

Provide Specialized Health Care Services

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

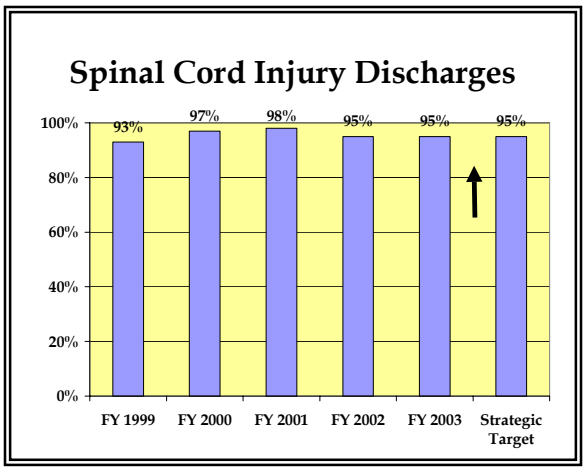
Secretary's Priority: Be recognized as a leader in the provision of specialized services, particularly spinal cord injury, geriatrics, and mental health.

Performance Goal

Maintain at 95 percent the proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings.

Discussion of Current Situation

In 1996, Congress provided a mandate in its Eligibility Reform Legislation (P.L. 104-262) to ensure that we maintain nationwide capacity to deliver specialized care to disabled veterans with spinal cord injuries and diseases, blinded veterans, veterans with amputations and those with severely chronic disabling mental illness. P.L. 104-262 also required the publication of data in an annual report (the "Capacity Report") to Congress demonstrating the VA's compliance with the provisions of this mandate.



The Department has adopted several performance measures to help assess the treatment of veterans with special disabilities. For example, VHA is focused on promoting the health, independence, quality of life, and productivity of individuals with spinal cord injuries (SCI). We view discharge to non-institutional, community living as a positive health outcome. Consequently, one of VHA's primary performance measures is the proportion of discharges from SCI center bed sections to non-institutional settings. The performance goal for FY 2002 is 95 percent.

Means and Strategies

VA is committed to promoting the health, independence, quality of life, and productivity of individuals with spinal cord injury. This is achieved through efficient delivery of medical/surgical care; acute rehabilitation; patient/family education; psychological, social, and vocational care; research; and professional training of residents and students in the care of persons with SCI. Discharge to non-institutional, community living is viewed as a positive outcome.

The purpose of this goal is to monitor the discharge status of SCI patients. Historically, the number of discharges to non-institutional settings has been around 95 percent. Therefore, a 95 percent "floor" target level has been set to assure that VHA continues to address the special needs of this patient population. The actual percentage of 98% in FY 2001 indicates that this special attention has produced positive results. Because of the severity of illness associated with spinal cord injured veterans, this goal will continue to be tracked to ensure that VA's positive record is maintained.

VA utilizes 23 SCI specialty centers that provide the full range of specialty care in interdisciplinary SCI health care. The staff at these centers work with SCI primary care teams throughout the other VA medical centers to facilitate efficient, coordinated, and appropriate delivery of care to veterans. This is referred to as the "hub and spoke" model. SCI clinical practice guidelines have been developed and disseminated, quarterly newsletters shared, and educational opportunities afforded to staff to facilitate communications and quality care for this patient population.

Crosscutting Activities

Achievement of this goal is not directly dependent on other agencies. VHA has established partnerships with stakeholders such as the Paralyzed Veterans of America to meet the needs of SCI patients.

Major Management Challenges

The General Accounting Office (GAO) has identified Treating Veterans with Special Disabilities as a major management challenge. In response to this challenge, a special population clinical coordinator was appointed in November 2000. The FY 2000 Capacity Report was published in May 2001, and established accountability for interpretation of the data for each special disability. Work groups representing each special disability category were created in July 2001.

In regard to Spinal Cord Injury/Disorders (SCI&D) programs since September 30, 2000, significant advances in data gathering and recording processes have substantially improved the validity of capacity data (beds and FTEE). In addition, VHA has issued a policy establishing centralized review of proposed changes in SCI&D programs in the field. This has markedly improved oversight by national program offices and the accuracy of available information. Also, stakeholders, such as the Paralyzed Veterans of America (PVA), have worked closely with VHA to establish this process as a joint VHA/PVA survey.

Data Source and Validation

The origin of data for this performance goal is from the National Patient Care Database (NPCP) at discharge. Non-institutional care setting includes community, foster home, halfway house, boarding house, residential hotel, and

HBHCS. Non-institutional care setting do not include another hospital, nursing home, state home, domiciliary, or penal institution.

The numerator for this goal is inpatients that were discharged from an SCI Bed Section to non-institutional settings. The denominator is patients discharged from an SCI center bed section alive who were not transferred in from institutional care or discharged irregularly.

(For additional information on this performance goal, refer to Medical Programs, Volume 2, Chapter 2.)

Improve the Timeliness and Accuracy of Claims Processing

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

Secretary's Priority: Provide accurate decisions on compensation and pension rating-related claims within 100 days.

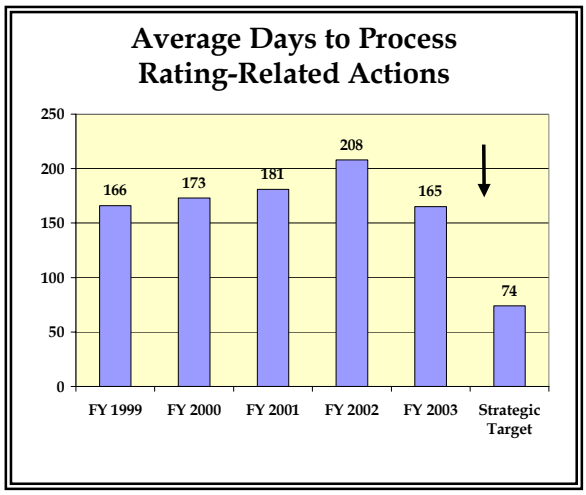
Performance Goals

1. Complete rating-related actions on compensation and pension claims in an average of 165 days. **Note: This number is the average cumulative for the fiscal year. We expect to achieve 100 days processing time during the last quarter.*
2. Attain an 88 percent national accuracy rate for core rating work.

Current Situation Discussion

Timeliness and Quality of Claims Processing

Improving the timeliness and quality of claims processing is a Presidential priority. The Secretary of Veterans Affairs has set a goal to achieve a monthly average of 100 days to process rating-related claims during the last quarter of FY 2003, while continuing to improve quality. This performance plan describes how we will achieve that goal.

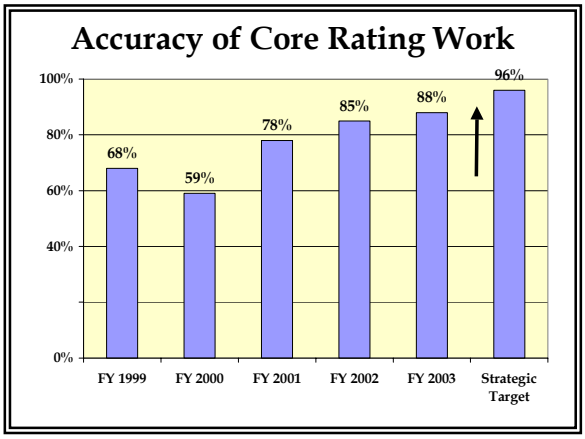


Timeliness of claims processing, especially rating-related actions, continues to be an important issue for the Department. Over the last several years, VA has developed and implemented major initiatives, established cooperative ventures with other agencies, and used technology and training to address this issue. Rating-related actions include original compensation claims, original dependency and indemnity compensation claims, original pension claims, reopened compensation claims, reopened pension claims, routine examinations, and reviews due to hospitalization.

The Secretary launched a major effort to resolve 81,000 of its oldest claims, those that have been pending for more than a year. A key element of that effort involves a special team in Cleveland that will tackle many of these oldest claims over an 18-month period. Its first priority will be the long pending claims of veterans who are 70 years of age and older. The team will then be moving on to claims of other veterans who also have been waiting for a decision for more than

a year. At the same time, VBA will be using the nine Resource Centers, designed to add processing capability to each area of the country, to contribute to the goal of resolving these oldest claims. The team became fully operational in November 2001.

Accuracy has been the Veterans Benefits Administration's number one priority for the past three years. Our Systematic Technical Accuracy Review (STAR) was developed in 1997 and 1998, and implemented in 1999. Starting from a 64% accuracy rate baseline for rating-related workload, there has been significant improvement in accuracy in 2001. The improvement has been achieved not only in the rating-related workload but also for non-rating related and fiduciary workload.



The Department's efforts to reduce workload began to show positive results as the number of pending claims decreased from FY 1998 to FY 2000. We experienced a significant decrease in the appeals workload during this period as well, with the number of pending appeals dropping from 102,834 to 79,561. However, with introduction of new legislation such as the Veterans Claims Assistance Act, additional presumptions granted for diabetes, and issues relating to radiation exposure, we have seen a reverse in both those numbers. At the end of FY 2000, over 330,000 claims were pending claims; however, by the end of December 2001, over 669,000 were pending. The number pending over six months has increased from 85,500 to nearly 162,648.

Appeals Processing

The decision on a claim at a regional office is not necessarily the end of the claims process. If a veteran disagrees with the initial decision, he or she may file a notice of disagreement that starts the appeals process. Although not a key measure, improving appeals resolution time is an important objective of VA. For 2003, our performance goal is to complete appeals in an average of 520 days. Appeals resolution time is the average length of time it takes VA to process an appeal from the date a claimant files a Notice of Disagreement (NOD) until a case is resolved, including resolution at a regional office or a final decision by the Board of Veterans' Appeals (BVA).

Remand rate reduction is a central component of the strategy for reducing appeals resolution time. Remands represent a rework phase of the appellate cycle and typically add two years to the processing time for an appeal and

require additional financial resources. Remands delay not only the individually affected cases, but, because by law the oldest cases must be processed first, processing of newer appeals is delayed when remanded appeals are returned for re-adjudication. One of the primary remand rate reduction strategies is to improve appellate processes through information sharing between BVA and field adjudication staff using regularly scheduled information exchange sessions conducted via interactive video-conference systems**.** A second strategy, developing and refining improved bases of information, encourages improved analysis of trends to identify remand types and reasons.

As a result of ongoing efforts, the remand rate was reduced from 36.3 percent in 1999 to 29.9 percent in 2000. The appeals resolution time dropped from 745 days to 682 days. However, since the enactment in November 2000 of Public Law 106-475 (Veterans Claims Assistance Act of 2000), the remand rate has soared to 48.9 percent. As of December 2001 the remand rate has been reduced to 33 percent. Cooperation with the Board of Veteran Appeals concerning remand development should lead to a significant downward trend for the remand rate in the near future. The recent inception of the law prevents making an educated estimate of how much time will be required to complete the remands or how many days the field development required for an original claim will add to the overall appeals resolution time.

Some improvements in timeliness can be achieved through coordinated efforts undertaken by both BVA and VBA, such as reductions in administrative overhead and other initiatives involving internal procedural changes. Such an approach acknowledges that claims and appeals processing must be viewed as a continuum, rather than as a series of discrete activities. The Department is committed to this approach and has targeted improving appeals resolution time as one of our most important timeliness objectives. Because over 90 percent of VA appellate actions are appeals of compensation benefit decisions, the appeals resolution time measure is aligned with the VA strategic goal and objective for the compensation program.

Means and Strategies

The Department continues striving toward our vision of improved performance in claims processing. Initiatives dedicated to this effort have been both numerous and diverse, but all with one common goal – enhancement of the claims process. As more in-depth analyses of the VBA process are completed, we expect to further streamline our endeavors in order to achieve our strategic target. Our most important initiatives during 2003 include the following:

- **Pension Consolidation --** This initiative includes consolidation of all existing pension programs, death compensation and parent's DIC into three centers. Consolidation through pension centers will begin with two paper-based environments and one imaged environment. Migration to a fully paperless

environment for all sites is planned over five years. A skilled staff solely devoted toward processing one benefit will improve decision quality, minimize the pending time for a pension claim, and expedite the delivery of benefits.

- **Virtual VA --** The Virtual VA Project replaces the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution. It will provide a long-term solution to improving the quality of claims processing for veterans and their dependents through enhanced file management, a reduced dependency on paper, and increased workload management across the business enterprise.
- **Training and Performance Support Systems (TPSS) --** This initiative develops four comprehensive training and performance support systems for the core service delivery positions of the reengineered environment. The four systems are for a) basic rating (RVSR); b) veterans service representatives (VSR); c) journey level rating specialists to include the Decision Review Officers; and d) field examiners. At this time, ten modules have been released to all regional offices.
- **Systematic Individual Performance Assessment (SIPA) --** SIPA complements our national quality assurance program, Systematic Technical Accuracy Review (STAR), and brings performance assessment and accountability to the journey-level individual. Systematic individual performance assessments will bring accountability to the journey-level individual and serve as an internal control mechanism to minimize the potential for fraud, since performance reviews will focus on program and data integrity concerns, proper signatures, and supporting documentation.
- **Compensation and Pension Evaluation Redesign (CAPER) --** As we head into the 21st century we are aware of heightened expectations from customers, rapid change in technology, increasing complexity of decisions, extremely tight labor markets, and a VA workforce which will see significant turnover in the skill-intensive rating veterans service representative (RVSR) position. Current experience documents that the time to fully train an individual for this position can take up to three years. The CAPER team will review all phases of the C&P claims process from the initiation of medical evidence development to the point a rating decision is completed. This project will determine what the optimum exam and other medical evidence gathering processing should be and how they can be integrated to improve the overall disability evaluation process. Furthermore, the team will gather and evaluate medical evidence associated with disability claims and construct a revised model for evaluating disabilities.
- **Benefits Replacement System (Core EP) --** VBA will pursue an incremental strategy as the most effective means to complete the development of the C&P

payment system. The strategy provides for a sequential application development effort, specifically, the incremental development and integration of functional modules or components. The process is divided into three primary areas: 1) Development, Case Management and Tracking; 2) Rating; and 3) Award, Payment and Accounting. This functional division provides opportunities for defining and deploying incremental applications to the new operating environment. Migration from the Benefits Delivery Network (BDN) is achieved in functional components rather than as a total system replacement.

VA has taken steps to offset the impact of legislative and regulatory changes on timeliness and accuracy by implementing countermeasures using available resources. The Under Secretary for Benefits presented the Department's strategies in a satellite broadcast to regional offices in March 2001. As of this time, we have successfully implemented the following measures in FY 2001:

- In March 2001, the Veterans Benefits Administration (VBA) launched its centralized training initiatives to train these new hires. This centralized training is now the standard for training future hires.
- As of December 2001 a total of 1,298 Veterans Service Representatives (VSRs) and Rating VSRs have been hired. All have gone through the Challenge 2001 training program.
- VBA reached an agreement with the Board of Veterans Appeals (BVA) concerning remand development. By January 2002, BVA will begin initiating development on cases that would otherwise be remanded back to the field offices.
- Nine Resource Centers were established to focus on specialized claims processing.
- The St. Louis Helpline was expanded and fully operational by February 2001.
- Several national decision notification letter packages prepared in an enhanced Personal Computer Generated Letters (PCGL) were released in April and November 2001.
- A work group has developed national production standards for VBA's decision-making positions. These proposals are being further evaluated.
- The amendment to the Code of Federal Regulations (38 CFR 3.103) allowing VBA's decision-makers to gather evidence by oral communication, from beneficiaries currently on the rolls, was published in the Federal Register on April 20, 2001.
- The Compensation and Pension Records Interchange (CAPRI) application that allows VBA's decision-makers to successfully obtain medical records

from the Veterans Health Administration database was successfully tested in January 2001. This application will be available to all 57 regional offices.

- VBA and VHA signed a memorandum of understanding in February 2001 to establish a Joint medical Examination Improvement Office in Nashville, Tennessee. The mission of this office is to review all aspects of the C&P examination process in order to identify the problems, their root causes and the tools and procedures needed to improve the quality and timeliness of C&P medical examinations.

VBA also expects to successfully implement the following countermeasures in 2002 – 2003:

- Providing field offices relief from doing local STAR reviews. By January 2002, a national STAR office located in Nashville, Tennessee will be fully operational. VBA has selected most of the subject matter experts for this effort. This office will absorb the additional national reviews in order to take into account local reviews that will no longer be conducted by the field offices.
- The centralized processing of pension maintenance workload will begin in January 2002. Initially, the processing will focus on eligibility verification reports. VBA expects that centralized processing will address all pension maintenance workload by the end of FY 2003.
- Virtual VA's imaging technology will be fully tested in FY 2002 at the pension maintenance center in Philadelphia and then deployed to the Milwaukee and St. Paul pension maintenance centers in FY 2003.

Crosscutting Activities

VA has begun several collaborative efforts with DoD to facilitate our goals of improved accuracy, timeliness and customer service. In collaboration with DoD, we are working on an electronic data exchange system as well as a joint VA/DoD examination process at the time of separation from service. When implemented, both measures should facilitate timelier processing of claims, by reducing the wait time required to receive necessary evidence.

External Factors

The effects of the Veterans Claims Assistance Act (VCAA) and diabetes legislation continue to affect efforts to reduce the timeliness of claims processing. VCAA will also adversely impact VA's achievements in accuracy. Pending legislation on radiation exposure could further increase the total number of expected claims, thereby offsetting improvements VA has made in timeliness.

Major Management Challenges

GAO and IG have identified timeliness and accuracy of claims processing as challenges for VA's compensation and pension programs. They report that the timeliness and quality of C&P medical examinations need improvement.

Accuracy of the Claims Process. VA continues to hold the improvement in technical accuracy as its highest priority. A more extensive training program, along with an expanded accuracy review process, have been developed to accomplish the level of accuracy deserved by our external customers.

Claims Processing Timeliness. VA is committed to reducing the time required to process veterans' claims. Technological advancements in our systems as well as joint endeavors with DoD are expected to aid in attaining our goal of 100 days processing time in the summer of 2003.

Timeliness and Quality of Compensation and Pension Medical Examinations. We continue to integrate initiatives such as pre-discharge centers and the VBA/VHA examination project office to improve the examination process.

Data Source and Validation

Claims Processing Timeliness

The timeliness of claims processing is measured using data captured automatically by the Benefits Delivery Network as part of claims processing.

VA has taken several steps to ensure it has accurate and reliable data in its reports. A database of all end product transactions is maintained and analyzed on a weekly basis to identify questionable actions by regional offices. The C&P Service reports quarterly on its findings and calls in cases for review from stations with the highest rates of questionable practices.

National Accuracy Rate

VBA's quality assurance program for compensation claims processing has been revised to separately identify benefit entitlement processing accuracy, decision documentation/notification accuracy, and administrative issues. These changes are consistent with recommendations in this area by the Secretary's Claim Processing Task Force. While all three areas are important, beginning with FY 2002 STAR reviews, regional office claims processing accuracy will be measured and compared based solely on benefit entitlement processing accuracy. These benefit entitlement issues all would be a basis for future revision based on clear and unmistakable error or would result in a BVA remand if not otherwise corrected during the appeal process.

Compensation and Pension Service will regularly monitor the other two areas. Reports will be maintained and the Service will communicate directly with individual regional offices when significant deficiencies are identified in either area. While decision documentation/notification will not be part of VBA's new

core processing measure, quality performance in these areas remain a fundamental legal and professional obligation of every regional office. Notification requirements are clearly defined in 38 USC 5104 and 38 CFR 3.103, while adequate decision documentation has been the subject of a number of CAVC decisions including Gilbert V. Derwinski, 1 vet. App. 49 (1990).

Beginning in FY 2002 C&P Service will expand its review to independently measure regional office accuracy, which will require the review of approximately 10,000 cases annually. The sample size is large enough to ensure a 95 percent confidence level with a sampling error rate of +/- 5 percent for the nation. The regional office sample size will ensure a confidence level of 95 percent with a margin of error range from +/- 6 percent for best performing regional offices to +/- 9 percent for regional offices with the lowest performance rates. The sample size will be increased for the six regional offices with the poorest documented performance in both rating and authorization reducing the margin of error to +/- 6 percent on the subsequent review. The sample will also be increased for the four largest regional offices. Program experts who are independent of field operations management conduct the reviews.

(For additional information on these performance goals, refer to General Operating Expenses, Volume 4, Chapters 2B and 3D.)

Focus Vocational Rehabilitation Resources

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

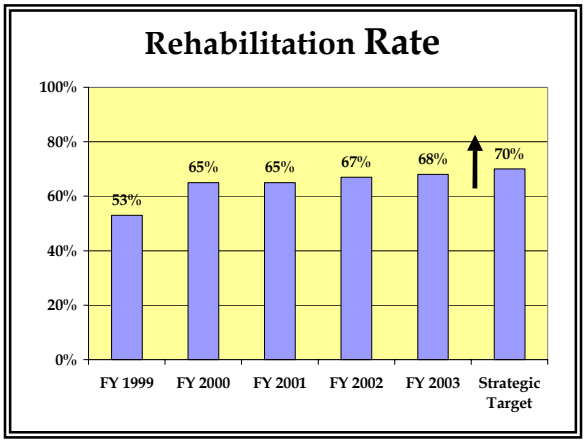
Secretary's Priority: Focus vocational rehabilitation resources on veterans with serious employment handicaps and independent living services.

Performance Goal

At least 68 percent of all veteran participants who exit the vocational rehabilitation program will be rehabilitated.

Current Situation Discussion

For many disabled veterans, the vocational rehabilitation and employment (VR&E) program is the best opportunity they have to establish themselves in suitable employment, or achieve the maximum level of functioning in daily living activities. Many circumstances exist which preclude the completion of the rehabilitation goal, such as worsening of disability, or personal/financial hardship. The VR&E program is committed to helping veterans complete their programs successfully. The objective focuses on this commitment and sets goals for all veteran participants and those participants who meet the additional criteria of a serious employment handicap. The desired outcome is to place service-disabled veterans in suitable employment or facilitate the achievement of independence in daily living, following a program of rehabilitation services.



Improving access to our program will improve our communications capability and help us identify participants' program needs. This will facilitate our on-time case management approach to ensure that our participants will be able to complete their programs and move into suitable employment as quickly and as efficiently as possible.

Our staff will be provided employment services training, in recruitment and placement, job development, and reasonable accommodations. Our legislatively mandated effort to assure that our staff has the type and level of skills needed to provide excellent service will continue.

Our employment specialist strategy includes establishing relationships with employers to match the developing skills of our veteran participants with market demands for current and future job markets.

Means and Strategies

Because the Employment Specialist (ES) pilot program was a success, the VR&E program through succession planning is changing the skill mix of its staff from vocational rehabilitation specialist to employment specialist.

With employment specialists and case managers working outside the normal structured working environment, each individual will be supplied with a laptop and other equipment, as found necessary. These positions will require flexibility in work schedules and the ability to access systems during irregular work hours whether in the office or at other locations in order to best meet the veterans' needs.

Access is focusing on improving the channels of communication between the veterans and the case managers by the use of various methods of information technology and providing the case managers with the tools to perform their jobs regardless of their location. Tools such as the utilization of laptop computers and personal digital assistants (PDA's) will improve the staff's ability to communicate with the office and VBA and/or VA IT systems for immediate access/retrieval of information when assisting the veteran at any location. The program is expanding the locations and methods for which veterans may contact a program representative (i.e. increased outbased locations, redesign of web site, purchase of required information technology equipment for staff, and partnership with other federal agencies).

VR&E is placing emphasis on the training of employees throughout the program to improve the staff's competency and skill level in support of providing the best possible service to veterans. Training is being offered in several methods including, regional training for all clinical staff, in-house training at each office, and continuous Corporate WINRS training for both the VR&E personnel and finance employees who support the VR&E program.

Corporate WINRS is a recently deployed information management system that will continue to be enhanced with improvements that will support the VR&E program and it's ability to service the disabled veterans whenever our expertise and services are needed. As program needs and regulations change or systems that interface with Corporate WINRS are modified, enhancements will continue to be developed in order to comply and provide optimal service for both the veterans and the employees.

A special task force team is being established to conduct a study of the impact and affects the Enhanced Montgomery GI Bill, as well as regulatory and

legislative changes in Compensation and Pension, may have on veteran entitlement to VR&E benefits and services.

Crosscutting Activities

VA partners with the Department of Labor (DOL) and Small Business Administration (SBA) to conduct training on employment assistance and techniques using a new transferable skills inventory.

In 2003, the joint VA/DOL/SBA training will improve the skills for our rehabilitation counselors, employment specialists, and other direct service-delivery staff. This cross-agency training helps build networking and partnering links that can speed the employment process. Employment services training, which includes job-hunting strategies, networking, and employment resources, provided our supervisory staff and employment specialists in prior years has helped us to reduce the amount of time needed for veterans to move into suitable employment. The training has become an integral part of our long-term improvements.

Major Management Challenges

Oversight authorities such as Congress, the General Accounting Office, and the Veterans' Advisory Committee on Rehabilitation have been critical of the effectiveness of the VR&E program. Some of the criticisms highlight valid, unresolved problems within the program, many of which have been, or are being, addressed. Other criticisms can be tied back to problems of customer service and attrition of program participants. The VR&E leadership analyzed these criticisms to identify the fundamental, systemic issues that must be corrected or mitigated to create lasting improvements in the VR&E program. They are summarized into the seven major areas described below:

- **Strengthen focus on employment.** The program has made significant improvement in the placement of disabled veterans in suitable employment. VR&E has implemented an Employment Specialist Pilot program that has assisted in redirecting the program's emphasis to employment. Within the program's succession planning, recruitment that includes the Employment Specialist position will require personnel to obtain more expertise in employment markets and trends, and job placement strategies. Overcoming these shortcomings will require additional tools and training in the latest rehabilitation and employment services techniques.
- **Realign customer perceptions and expectations with the program's intent.** Many veterans, stakeholders, and partners view the VR&E program as an education program, rather than a program geared toward employment. As a result, many veterans have misconceptions when they apply for the program, leading to frustration and high attrition in the application and evaluation phases of the rehabilitation process.

- **Improve monitoring of outcomes and feedback to the program.** VR&E has undertaken a study to try to determine the risk factors of why a significant percentage of program participants eventually drop out of the program. However, until the full implementation of Corporate WINRS and enhancements in phase two are accomplished, we do not have the IT infrastructure to provide the longitudinal data to measure long-term success of participants.
- **Improve IT support for the program.** National veterans data and routine automated tasks will be incorporated into the Corporate WINRS case management and information system. We have completed the migration of the stand-alone systems into the Corporate environment through Phase I of Corporate WINRS, and many of these tasks have been automated. However, some functions will continue to be performed manually until Corporate WINRS is fully automated with all existing or projected new and updated IT systems.
- **Improve access for veterans.** By its very nature, the VR&E program requires a close relationship between VR&E personnel and veterans. This relationship hinges on the veteran having easy access to VA personnel. Establishing flexible access paths will connect veterans with VA personnel. Greater personal interaction and information exchange will reduce frustration and dissatisfaction among veterans and may even encourage more veterans to participate in the program.
- **Foster coalitions with peer organizations and partners.** VR&E has conducted joint training with the DOL and is working on developing training with the SBA. Still, there are locations that have been unable to complete their comprehensive training at the local level. VR&E is developing a relationship with DoD to provide information on how to convert/utilize education and training from military experience in the civilian workforce. Through more effective networking and partnerships, VR&E will enhance its ability to provide veterans with program information and services to help them achieve their goals.
- **Improve business process efficiencies.** The guiding principles and strategies for the future concentrate on improving personal contacts with veterans so they are actively involved throughout their rehabilitation program. Streamlined business processing will reduce the number of handoffs involved with the veteran's claim and will reduce the potential for errors. From the perspectives of veterans, stakeholders, and VR&E personnel, greater continuity of services enhances veterans successful completion of their rehabilitation plans.

Data Source and Validation

Corporate WINRS case management and information system. Accuracy of data related to the veterans' cases are accomplished through the VR&E Quality Assurance Program. The VR&E Quality Assurance process measures work performance at each regional office. A group consisting of field office staff and Central Office personnel conduct quality reviews on each regional office twice a year. At the conclusion of each review, the regional office receives notification of the results, identification of both successes and deficiencies, and instructions of how to submit cases for re-evaluation. When areas of concern are identified, the review results in additional refresher training for VR&E staff, improved accuracy and improved services to better meet the needs of disabled veterans.

(For additional information on this performance goal, refer to General Operating Expenses, Volume 4, Chapter 2E)

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

Secretary Priority: *Provide meaningful readjustment assistance by improving the quality and timeliness of decision-making for education claims through the use of electronic certification.*

Secretary Priority: *Meet community standards for origination and servicing of home loan guaranty benefits, and ensure there are no financial losses incurred on foreclosures.*

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

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

- Montgomery GI Bill (MGIB) usage rate
- Average days to complete original and supplemental education claims
- Foreclosure Avoidance Through Servicing (FATS) ratio

Provide Meaningful Readjustment Assistance

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

Secretary Priority: Provide meaningful readjustment assistance by improving the quality and timeliness of decision-making for education claims through the use of electronic certification.

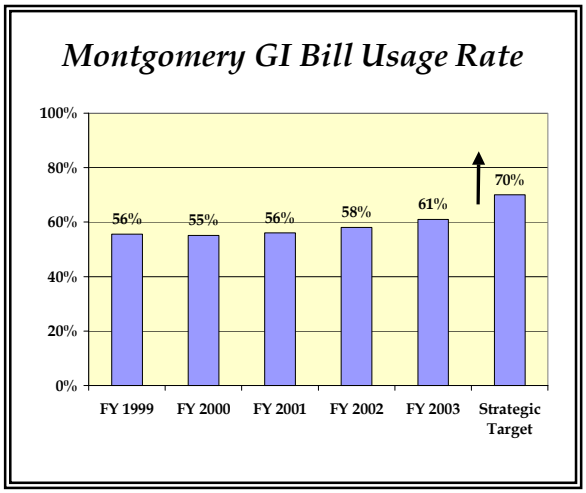
Performance Goals

1. Increase the Montgomery GI Bill (MGIB) usage rate to 61%.
2. Process original and supplemental education claims in 30 and 18 days, respectively.

Discussion of Current Situation

Increase the MGIB Usage Rate

The Montgomery GI Bill (MGIB) is intended to be an incentive that entices this nation's young men and women into military service and a reward for that honorable and faithful service. The extent to which eligible beneficiaries use their earned benefit is but one measure of program success. A greater number of veterans using the MGIB will contribute to a more highly educated and productive national workforce, thus enhancing the nation's competitiveness. Veterans use the benefit to readjust to civilian life and achieve educational and vocational objectives that they might not have attained had they not entered military service. DoD uses the promise of educational benefits under the MGIB as a successful recruiting tool. While MGIB has continued to be a very effective recruiting tool, its value as an earned readjustment benefit has declined over the years.



Several attempts have been made to improve the benefit. For instance, in 1992 Congress enacted legislation to increase the monthly rate of payment each year by the same percent rise in the Consumer Price Index. Training programs approved for benefits in earlier GI Bills (for example, flight training) were added to the vocational and educational programs available under MGIB.

These enhancements occurred without benefit of a full examination of the MGIB program's intent and its success in achieving its stated purposes. The Government Performance and Results Act (GPRA) provided impetus for that full examination in mandating

periodic comprehensive program evaluations. VA's educational assistance programs have received such an examination.

VA contracted for, and received a comprehensive evaluation of the education programs in 2000. The report examined the extent to which the education programs administered by VA have met their statutory intent, the education needs of beneficiaries, and the expectations of stakeholders. It found that by many measures the centerpiece of VA education programs, MGIB, has continued the success established by the GI Bill of Rights. Compared to those who have not taken advantage of MGIB, veterans who further their education under the program have lower unemployment, increased career and education goals, and enjoy higher earnings. In general, the programs show some success in meeting the intended purposes of the legislation while returning $2 to the economy for every $1 in taxpayer funding.

However, the evaluation also found that VA education benefits don't cover all education costs or reflect the increased diversity in available education and training programs. In addition, VA isn't effectively publicizing the availability of its education benefits programs. Recently enacted legislation has raised the VA education benefits rates and has started to address the need for VA benefits to be available for a wider variety of education experiences. Education Service has also embarked on an aggressive outreach program to insure that all potential beneficiaries receive timely information about the VA education programs available to them.

The Administration supported legislation enacted during 2001 that provides veterans meaningful readjustment opportunities by increasing basic monthly benefits and providing more flexibility in the manner in which the benefit is paid. With an adequate basic monthly benefit more veterans will complete programs that in the past they were forced to leave for financial reasons. Flexibility in the manner in which the benefit is paid will permit veterans to pursue programs that are not affordable in the monthly benefit payment format now in existence.

Enhancements to the benefit as advocated by many will increase the usage rate. Increasing the usage rate will have workload and claims processing implications. The challenge for VA is to encourage and support increases in the usage rate while improving the claims processing environment.

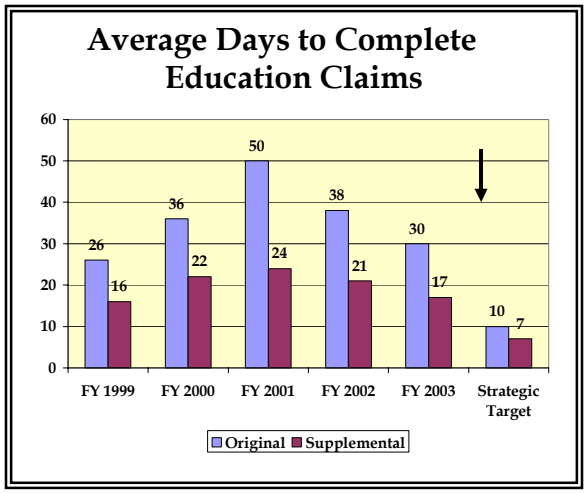
Improve Education Claims Processing

The effectiveness of our education claims processing is measured several ways; chief among them are timeliness (how long it takes to process claims), payment accuracy, and veteran satisfaction. Of these, timeliness, or average days to complete education claims, is a key measure for VA. Claims processing timeliness is directly related to the volume of work received, the resources

available to handle the incoming work, and the efficiency with which that work can be completed.

Cycle time analysis reveals that most claims are held for days awaiting review by a decision-maker. By streamlining work processes and minimizing hold time, dramatic improvements in timeliness are achievable.

Over the past several years, timeliness has deteriorated because available resources did not match the volume of incoming work. In addition, work processes could not be modified to bring that mix of volume and resources into balance. Systems that did not perform at an expected level exacerbated the issue. Future performance improvements have the same dependencies. Workload volume will increase with enhancements to the benefit. That can be mitigated with additional resources and efficient processing systems.



Improved payment accuracy in processing comes from several sources. Systems improvements normally reduce human calculation and some key stroking errors. Training interventions also lead to quality improvements. On the other hand, new hires tend to make more errors in processing until they have gained experience through training and repetition of work actions.

A customer satisfaction rating provides a measure of how beneficiaries rate our service. A customer satisfaction survey instrument was developed several years ago to solicit this feedback. This annual survey allows the scientifically valid measurement of aspects of customer service identified in focus groups with veterans. The survey gauges the satisfaction of veterans and beneficiaries who have received education benefits. Results allow VBA to track and analyze trends and improve performance, as necessary. For example, through the survey beneficiaries expressed a desire to speak directly with VA employees who were knowledgeable in education benefits. That resulted in the creation of a toll-free telephone number that allowed calls to be directed to education subject matter experts.

Means and Strategies

Increase the MGIB Usage Rate

VA's Education Service mails a brochure, "Focus on Your Future with the Montgomery GI Bill," to men and women in the Armed Forces. Similar mailings are planned at specific points throughout each individual's military career. This brochure provides a general description of MGIB education benefits. It also has information to help service members, who might already be eligible for MGIB benefits, make a decision to enter training and use their earned benefits.

VA has developed brochures for specific situations also. For example, VA developed a brochure in 2001 to highlight a new education benefit, reimbursement for licensing and certification tests, enacted by Congress. As veterans learn of this new benefit, they can determine whether it affords them opportunities for advancement in the workplace. Additional targeted brochures, as needed, will advise veterans of other opportunities.

Congress plays a key role in this process of increasing the MGIB usage rate. Legislation enacted by the 107th Congress will dramatically affect VA education benefits in 2003 and beyond. Some provisions of this legislation follow:

- The monthly rate of benefits under MGIB will be increased by more than forty-six percent over the next two years.
- Payments can be accelerated (that is, more funds paid in advance) to satisfy a veteran's immediate need for funds for education leading to employment in high technology.
- As a reenlistment incentive, MGIB benefits can be transferred to a family dependent. DoD has authority to offer this benefit to active duty personnel in hard-to-fill military occupational specialties who agree to reenlist after six years of service.

Improve Education Claims Processing

The development and installation of TEES (The Education Expert System) is a major multi-year initiative started in 2000. When fully operational, it will improve timeliness and enhance customer service by automatically processing more claims (up to 90 percent of those received electronically) without human intervention. A small, proof of concept, application has been developed and deployed. Some enrollment information, received electronically from educational institutions, is now processed by a prototype rules-based expert system without human intervention. VBA contracted for and received an assessment of how to successfully process up to 90 percent of all education claims automatically. A capital investment application was then approved and permission granted to proceed with the initiative. Development efforts began in 2001 and will continue through 2007.

While performance suffered in 2000 and continued into 2001, steps have been taken to reverse that trend. For instance, recently hired employees, representing almost 40 percent of all decision makers in April 2001, will become more proficient and contribute significantly to reducing the number of days it is taking to process a claim. In addition, overtime will be used during heavy enrollment periods to increase the volume of claims completed as soon after receipt as possible.

Payment accuracy can be improved by:

- monitoring claims processing results;
- identifying trends that inhibit accurate processing;
- providing the necessary training for personnel to improve their decision making skills.

The hiring and training of additional new staff has created a setback in progress toward our strategic objective of a 97 percent payment accuracy rate. The electronic training initiative being pursued will facilitate uniform and consistent training. As training interventions continue and new hires gain experience, performance in this measure should improve once again.

Feedback from earlier surveys led VBA to implement nationwide toll-free service for education beneficiaries. They now receive toll-free telephone service by dialing 1-888-GIBILL1 (1-888-442-4551). They are first connected to an automated response system that provides:

- general information;
- answers to frequently asked questions;
- recent payment information;
- limited, beneficiary specific, master record information.

Callers can opt to speak to an Education Case Manager at any time during the call if they want personal attention.

Two issues hampered customer service improvements after implementation of toll-free phone service. First, automated responses have not curtailed the number of callers seeking to speak with an Education Case Manager. Second, call volumes have been larger than originally anticipated. As a result, resource requirements were understated resulting in an inordinate number of callers unable to complete their calls. VA examined resource needs. Seasonal employees will supplement permanent staff during peak periods to improve service. To divert some traffic away from telephones, VA is exploring electronic alternatives that provide services and satisfy education beneficiaries. While there has been an education service web site for several years to provide VA related information, plans have been developed to enhance usage of the site. In addition to resolving

inquiries electronically, the site is being expanded to allow for some veteran self-service. The first application, Web Automated Verification of Enrollment (WAVE), is now accepting monthly self-verifications of enrollment with minimal human intervention. Other self-service actions (such as address changes) will be added.

Crosscutting Activities

Increase the MGIB Usage Rate

Increasing the MGIB usage rate requires coordination between VA and other organizations currently disseminating MGIB information, or planning to do so. State Approving Agencies (SAAs) have expressed interest in conducting outreach to separating service members during transition assistance briefings. A few pilots have been initiated already. For example, the Oklahoma State Accrediting Agency participates in transition briefings at Fort Sill and other military installations within the State by providing information on VA's education programs. Feedback indicates that SAA personnel are better able to disseminate more comprehensive education information. Plans to shift more SAA focus to outreach will be developed during 2002 with the goal of having contract language in place for 2003.

VA initiated a training program with Navy to provide their recruiters accurate MGIB information so they can give prospective sailors correct and consistent messages on future VA benefits. The Army has expressed interest in a similar program. Finally, VA supports military base counseling activities by giving education specialists a guide to use in helping service members who want to pursue educational or vocational objectives and may need financial assistance available through MGIB. These outreach and information dissemination initiatives address recommendations made in the program evaluation. VA will review the initiatives for effectiveness and modify or enhance them, as necessary, to ensure the delivery of correct and consistent messages.

Improve Education Claims Processing

Overall processing timeliness is affected to some extent by the quality of the enrollment information received from school officials. Several years ago, VA tested an initiative with selected school certifying officials in the electronic transmission of that enrollment data, VACert, which proved to be successful and was made available to all education institutions. Many began using the application, but others did not. As a result, VA has developed and tested an Internet application, VANetCert, to encourage more electronic submissions. This application will be deployed in 2002. In addition, we will continue improving relationships with institutions through better liaison and assistance.

Education Case Managers rely on accurate enrollment information from school officials to process claims from veterans and other eligible beneficiaries.

Conflicting or confusing information could lead to errors and hinder payment accuracy. We will continue to work with representatives from education and training institutions to assure reliable, accurate enrollment information. For example, in 2001 VBA developed and piloted an on-line training course for new school certifying officials. It was made available to school officials who were new to the job and in need of "just-in-time" training. If proven effective, VBA will develop and install additional on-line training interventions.

External Factors

Increase the MGIB Usage Rate

Historically, the nation's economy has had some impact on education benefit usage. When employment opportunities are scarce, veterans return to school for additional education or training. During times of economic prosperity with abundant employment options, the opposite will often be true.

Improve Education Claims Processing

Generally, factors affecting claims processing are internal. However, a slowing economy that sees more veterans returning to the classroom and applying for benefits will impact VA's ability to improve the claims processing environment.

Major Management Challenges

There are no major management challenges that will affect achievement of the education program performance goals.

Data Source and Validation

MGIB Usage Rate

The MGIB usage rate is calculated by dividing the cumulative number of individuals who began a program of education under the MGIB (taken from VBA's education master record file) by the overall number of potentially eligible veteran beneficiaries (taken from DoD's Defense Manpower Data Center separation records). VA doesn't independently validate the DoD information.

Average Days to Complete Education Claims

Education claims processing timeliness is measured using data captured automatically by the Benefits Delivery Network as a part of claims processing. The Education Service Staff confirms reported data though ongoing quality assurance reviews conducted on a statistically valid sample of cases. Specifically, dates of claim are examined to insure they are reported accurately.

(For additional information about the education program, refer to Benefits Programs, Volume 1, Chapter 1B; and General Operating Expenses, Volume 4, Chapter 2C.)

Meet Community Standards for Home Loan Guaranty Benefits

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

Secretary Priority: Meet community standards for origination and servicing of home loan guaranty benefits, and minimizes financial losses incurred on foreclosures.

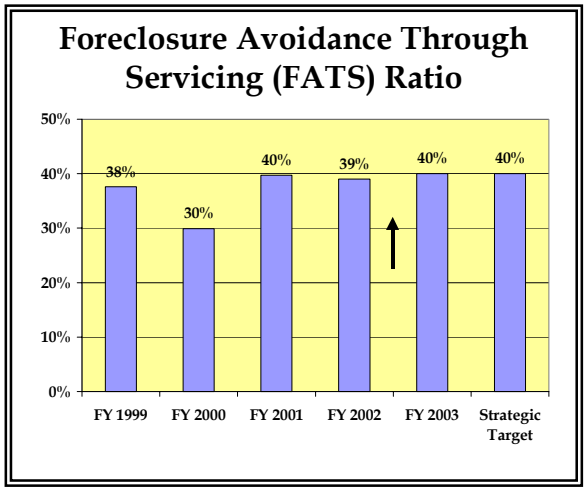
Performance Goal

Improve the Foreclosure Avoidance Through Servicing (FATS) ratio to 40 percent.

Current Situation Discussion

One of VA's critical functions is to assist veterans after they receive their housing benefit. Lenders report to VA when veterans are seriously delinquent (a payment is 90 days in default) on their mortgages. VA's responsibility is to contact the veteran and offer assistance to help the veteran retain his or her home, or resolve the issue at the lowest possible cost to the veteran and VA.

VA measures its success in assisting veterans who are facing foreclosure with the FATS ratio, which measures the extent to which foreclosures would have been greater had VA not pursued alternatives to foreclosure. When VA is able to pursue an alternative to foreclosure, the costs to the government are reduced. Veterans are able either to save their home or avoid damage to their credit rating. There are four alternatives to foreclosure:



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

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

Voluntary conveyance – VA may accept the deed in lieu of foreclosure from the borrower if it is in the best interest of the government.

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

Through 1999, the components of the FATS ratio carried differing weights. Beginning in 2000, each of the four components is weighted equally. We did not recalculate the 1998 and 1999 ratios. Targets and the strategic goal have been revised accordingly.

Means and Strategies

Some veterans, like other homeowners, experience financial difficulties that may cause them to default on their home loan. When this occurs, VA strives to help veterans retain their homes through loan servicing efforts. Besides counseling, VA may intervene directly on behalf of the veteran to work out a repayment plan. In limited circumstances, VA may buy the loan from the holder and the veteran will make future payments directly to VA.

The program emphasis is on developing and implementing information technology solutions to provide more timely service to our customers at a reduced cost. Important benchmarks are the quality and efficiency of service provided by private entities, because they set the level of expectations for all real estate transactions.

VA relies heavily on the lending industry to deliver the home loan benefit. Ultimately, the level of veteran satisfaction is directly dependent on how well VA can meet the expectations of lenders, builders, real estate brokers, and appraisers. This means adapting the delivery of our services to industry practices and making timely changes as technology generates involvements in the loan origination process. Current plans call for major enhancements in the following areas: loan funding fee replacement, automated determination of eligibility, electronic data interchange (EDI) of appraisal data, loan applications, default reporting, and foreclosure processing.

Crosscutting Activities

Achievement of this performance goal is not directly dependent on other agencies.

Major Management Challenges

Restructuring, Service Loss Mitigation, and training have improved delinquent Loan Servicing. However, there is a recognized need to fully review VA's supplemental servicing process. In FY 2002 the Loan Guaranty Program plans a thorough redesign effort to reengineer, standardize and document work process and procedures involved in supplemental servicing and activities related to the lender's primary servicing efforts. This will include the specific information technology requirements needed to support redesigned process.

Data Source and Validation

Data to calculate the FATS Ratio is extracted from the Loan Service and Claims (LS&C) System, which is the system used to manage defaults and foreclosures of VA guaranteed loans.

(For additional information on these performance goals, refer to General Operating Expenses, Volume 4, Chapter 2D)

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

Secretary Priority: *Provide high-quality health care that meets or exceeds community standards.*
Secretary Priority: *Provide access to primary care appointments and specialty care appointments within 30 days, and ensure patients are seen within 20 minutes of their scheduled appointment.*
Secretary Priority: *Ensure access to high-quality health care for veterans with service-connected conditions and veterans who are poor.*
Secretary Priority: *Maintain the high level of service to insurance policy holders and their beneficiaries.*
Secretary Priority: *Ensure the burial needs of veterans and their eligible family members are met.*
Secretary Priority: *Ensure graves in national cemeteries are marked in a timely manner.*

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

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

- Chronic Disease Care Index II
- Prevention Index II
- Patient Safety - bar code medication administration
- Patient satisfaction with health care service
- Waiting times for appointments and treatments
- Cost and efficiency for the health care system
- Average days to process insurance disbursements
- Percent of veterans served by a burial option
- Quality of service provided by national cemeteries
- Timeliness of marking graves in national cemeteries

Provide High Quality Health Care

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

Secretary Priority: Provide high-quality health care that meets or exceeds community standards.

Performance Goals

1. Improve performance on the Chronic Disease Care Index II to 79 percent.
2. Maintain performance on the Prevention Index II at 80 percent.
3. Ensure all facilities have a contingency plan for the loss of the electronic ability of the Bar Code Medication Administration (BCMA) process.
4. Increase to 68 and 69 percent, respectively, the proportion of inpatients and outpatients rating VA health care service as "very good" or "excellent."
5. Decrease the percent of Veterans Service Standard problems reported per patient in the areas of patient education and visit coordination.
6. Increase the Balanced Scorecard: Quality-Access-Satisfaction-Cost to 102 percent.

Current Situation Discussion

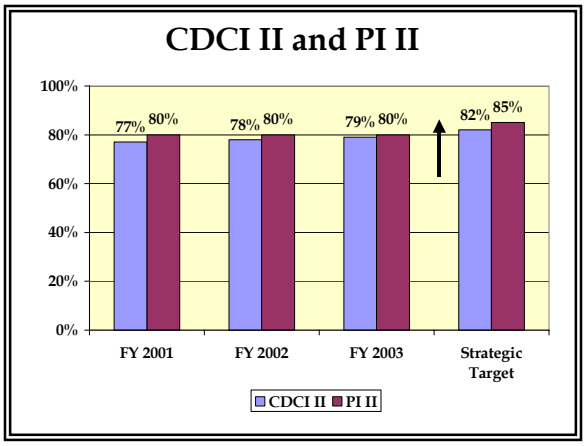
VHA's strategy to achieve these goals addresses VA's priority of high quality medical care, access to that care, and timeliness of health care services. VHA assures that its policies are carried out through a strategic management framework that relies on performance goals and a performance measurement program that monitors progress and promotes accountability. The management framework is comprised of the Domains of Quality: quality, patient satisfaction, functional status, access, cost efficiency and building healthy communities.

VA provides a continuum of patient-centered health care that includes health care for special populations of veterans. While providing care to veterans who use the system, VHA also works to ensure that the health care system meets the special needs of disabled and lower-income veterans. It is a fundamental policy of VA that those veterans who come to us for their health needs will receive the highest quality of health care available.

Chronic Disease Care Index II (CDCI II) and Prevention Index II (PI II)

The CDCI II is one of two primary quality of care measures used by VA. Investment in effective chronic disease management results in improved health outcomes for veterans. The multiple CDCI II is comprised of the evidence and outcomes-based measures for high-prevalence and high-risk diseases that have significant impact on overall health status.

VHA's PI II, the second major quality of care composite measure, spotlights and summarizes VHA's performance on a variety of evidence-based measures for high quality preventive health care.

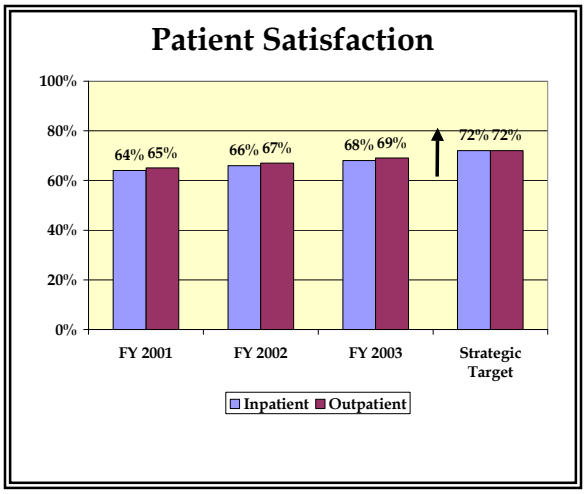


The chronic disease care and prevention indices were recently redefined and updated after several years of increasingly higher performance. The changes add new challenges in the areas of health promotion and disease prevention – areas in which VA is considered an industry leader when compared to the private sector.

Patient Safety

VHA has adopted patient safety procedures in VA facilities. In FY 2002, VA will evaluate a major patient safety process. VHA's National Center for Patient Safety (NCPS) will collect contingency plans from each VHA facility for coping with loss of the electronic medication administration procedure called Bar Code Medication Administration (BCMA) system. The contingency plans will be based on the Healthcare Failure Modes and Effects Analysis (HFMEA), and NCPS will assess the adequacy of each plan to provide viable workarounds to potential BCMA system failures. Plans are due to the NCPS by 8/31/02. Data will be reported by NCPS to the Office of Quality and Performance by 9/31/02 for inclusion in FY 2002 performance results. Establishing a contingency plan at each facility will also meet the new JCAHO requirement for "proactive risk assessment" of a process critical to patient safety.

It is expected that VHA will meet target for this measure in FY 2002 due to the critical need for contingency plans for BMCA. It is expected that another measure will be established based on trend analysis of data from root cause analyses generated at the medical centers.

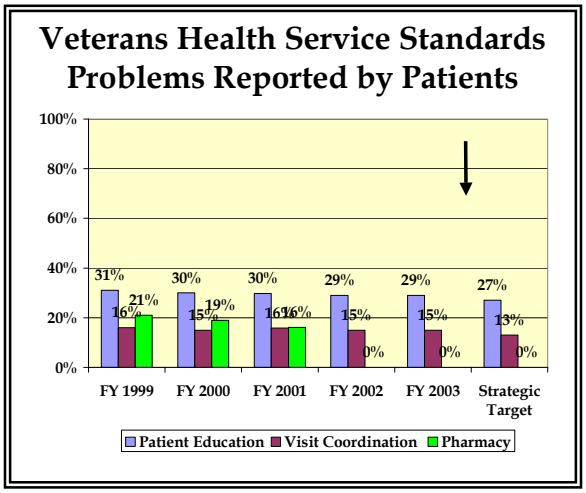


VHA's National Center for Patient Safety (NCPS), winner of the 2001 Innovations in American Government Award, was created to take the lead in integrating patient safety efforts and innovations, and to develop and nurture a culture of

safety throughout VHA. NCPS's primary goal is nationwide reduction and prevention of harm caused by adverse events. In 2001, in addition to providing training in support of the new patient safety orientation video and training module for all new VHA employees.

Patient Satisfaction

VA relies heavily on periodic feedback from veterans, obtained through surveys, as to the level of their satisfaction with service. VA's Performance Analysis Center for Excellence (PACE) conducts national satisfaction surveys that allow VHA to better understand and meet patient expectations. The surveys target the dimensions of care that concern veterans the most. Surveys are sent to patients who have received care in a variety of settings, for example, inpatient, outpatient, home-based, and certain special emphasis programs. Veteran satisfaction performance is externally benchmarked to other large organizations. Due to a new survey process, the FY 2002 measures for patient education and visit coordination are changed. The pharmacy measure was dropped because the goals related to it were satisfactorily accomplished.



Balanced Scorecard

The VHA Balanced Scorecard utilizes four of the same components found in the Quality-Access-Satisfaction (QAS)/Cost Value Index but establishes a percentage goal for cost in the same manner as done for desired outcomes for QAS. These four components of the scorecard are weighted equally to achieve a balanced scorecard value. Each component has a weight of twenty-five percent. The total balanced scorecard value is the sum of the percent goal achievement for each of the components. The balanced

scorecard provides a framework for translating VHA's strategic objectives into performance measurements driven by the key performance measures of quality, access, and satisfaction.

Means and Strategies

Chronic Disease Care Index II

VA ensures the consistent delivery of health care by implementing standard measures for the provision of evidence-based care by focusing on the use of a Chronic Disease Care Index (CDCI). This index is based on the performance of specific processes, provision of certain clinical services, or achievement of certain (proxy) outcomes for which the medical literature has documented evidence of a relationship to good health outcomes.

The CDCI II measures how well VA follows nationally recognized clinical guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, congestive heart failure, major depressive disorder, schizophrenia and tobacco use cessation. A large percentage of veterans have one or more chronic diseases and the improved management of chronic diseases results in improved health outcomes for veterans. The CDCI II has replaced the CDCI. The new measure consists of 23 separate clinical interventions associated with the eight cohorts discussed above, while the previous measure used 13 clinical interventions. The performance target for the CDCI II is estimated from a composite of performance on the 23 separate indicators.

Prevention Index II

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

VA has designed a prevention index that includes several indicators that allow a comparison of VA and private sector health care outcomes. Again, the original Prevention Index has been replaced by the Prevention Index II (PI II). The PI II has added an additional screening indicator for high cholesterol and removed tobacco counseling.

This index charts the outcomes of nine medical interventions that measure how well VA follows national primary-prevention and early-detection

recommendations for several diseases or health factors that significantly determine health outcomes: immunizations for both pneumococcal pneumonia and influenza; screening for tobacco and problem alcohol use; cancer screening for colorectal, breast and cervical cancer; screening for hyperlipidemia; and counseling regarding the risks and benefits of prostate cancer screening. VA provides preventive interventions, which are important for a population of healthy as well as severely ill and disabled veterans. Data contained in the PI II are based on statistically developed random samples that support valid extrapolations of the percentages of patients receiving appropriate medical intervention, whether in the form of immunizations, screening, or counseling. These measures were initially reported for only primary care clinics. Over time, both the implementation and reporting of such measures have been expanded to include related specialty clinics. Through the PI II, VA continues to demonstrate progress in improving systems that support preventive care delivery. For example, the automated medical record system and a system of clinical prompts and reminders facilitate care delivery at the point of patient contact, ensuring that veterans receive appropriate interventions. To effectively implement the PI II, Networks will continue to utilize a variety of strategies including the following:

- implementation of new clinical guidelines and refinement of existing guidelines
- implementation of patient and staff education programs on the importance and benefits of prevention
- continuation of monthly monitoring of local performance using checklists to ensure that preventative activities are accomplished as scheduled for the patients receiving the desired intervention charging primary care teams with responsibility and accountability for local implementation of the PI II.

Patient Safety

VA is committed to continuously improving the culture of patient safety in its health care facilities. An important aspect of this is to develop a good understanding of the causes of safety problems. VA uses root cause analysis (RCA) to accomplish this. RCA is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or "close calls" involving VA patients.

The successful meeting of the RCA performance goals for FY 2001 ensured that VA identifies the root cause of variance in performance in a timely manner.

The future goal in patient safety is to assure that a contingency plan is in place and tested in the event of loss of the electronic ability to use the BCMA system. The plans will be submitted to the NCPS for review.

Patient Satisfaction

VA obtains continual feedback from the veteran user population on their satisfaction with service through surveys, focus groups, complaint handling, direct inquiry, and comment cards. This feedback is used to build a database on what customers expect and provides information that can be used to revise performance goals and identify areas for improvement. Surveys are sent to patients who have received care in a variety of settings.

Networks will continue to implement strategies geared to improving patient satisfaction by access by creating and maintaining community-based outpatient clinics (CBOC), opening weekend clinics, employing case managers, building permanent clinic screening teams, and making infrastructure improvements, such as a VISN-wide Guest Services Program. VA seeks input from veterans service organizations to improve access, quality of care, and veteran satisfaction.

These performance goals are intended to measure patient satisfaction with health care services in select areas. The performance data are derived from a number of questions on the Performance Analysis Center for Excellence (PACE) inpatient and ambulatory care satisfaction surveys that will be part of VHA's overall Survey of Health Expectations of Patients (SHEP).

VHA's success in promoting patient satisfaction was recently recognized by the rankings of the 2001 American Customer Satisfaction Index (ACSI). The ACSI is produced through a partnership among the University of Michigan Business School, the American Society for Quality, and the Claes Fornell International (CFI) Group. The index contains numerical rankings of companies, agencies, and economic sectors on a 100-point scale, based on more than 50,000 interviews annually. The 2001 results show that VHA achieved satisfaction rankings that far exceeded private sector hospitals and other government service ratings. VA hospitals achieved a satisfaction rating of 82 for inpatient care. This compares favorably to the rating of 71 for the private sector and the 68 for the Federal Government. VA outpatient pharmacy services achieved a satisfaction rating of 83 percent, which was a full 12 points higher than the comparable private sector retail rating of 71. VA's outpatient satisfaction rating of 79 far exceeded that of all organizations (70.5) and the Federal Government-wide score (68.6)

Balanced Scorecard

The specific means and strategies that will be employed to meet this performance goal are the same as those identified for the specific components comprising these new measures — Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient satisfaction; and waiting times for primary care, specialty care clinics.

Crosscutting Activities

CDCI II and PI II

VHA continues its association with the Agency for Health Care Research and Quality in monitoring and refining CDCI (II) and the PI (II). VA also works with DoD regarding prevention, although the actual areas measured may be different, indicators and identification of at-risk populations are routinely coordinated with the DoD via a process similar to the clinical practice guidelines process.

Patient Safety

VHA continues its association with the DoD in developing and refining the measures that comprise the CDCI and PI II. Although actual areas measured may be different, indicators and identification of at-risk populations are routinely coordinated by the use of co-authored clinical practice guidelines.

Balanced Scorecard

While VA does not rely exclusively on any other organization for support of the performance goals in the balanced scorecard, there are nevertheless a number of crosscutting activities that impact upon our ability to function in a cost-effective manner. For instance, VA collaborates with HHS to develop non-VA benchmarks for bed days of care, which are obtained from a Centers for Medicare and Medicaid Systems database. In addition, VA is able to obtain data on ambulatory procedures from the National Center for Health Statistics. VA also collaborates with the DoD on Joint Contracting for Pharmaceuticals, enhancing VA's Parametric Automated Cost Engineering System, partnering on real property assets, and acquisition and collocation of VA facilities with excess property available through the closure of military bases. VA also participates in joint design and construction projects with the Department of Agriculture, Indian Health Service, Public Health Service, National Park Service, and Merchant Marine Academy.

Other crosscutting activities that impact the balanced scorecard include providing laundry services to state veterans homes and Job Corps programs, collaborating with the General Services Administration in a Government-wide Real Property Information Sharing program on utilization of Government-owned and Government-controlled real property in the Northeastern area of the United States, and acquiring leasehold interests in real property for clinical and administrative purposes within various regions across the country. Also, VA participates with a private sector panel to identify enhanced-use lease initiatives at various VA medical centers for the purpose of obtaining lower cost utilities and energy services, thus making more resources available for direct patient care.

External Factors

There are no external factors impacting on these performance measures.

Major Management Challenges

Patient Safety

VA's Office of Inspector General (OIG) has identified patient safety as one of VA's ten most serious management challenges. OIG's report to Congress dated November 20, 2000, emphasized that VA needs to ensure high quality of veterans' health care and patient safety, and to demonstrate that health care programs are effective. Factors contributing to the problem are the rapid pace of ambulatory care, which increases the likelihood that clinicians will make errors in treating patients, and the absence of a system to accurately identify and correct treatment errors.

VA has responded to all of the OIG's recommendations to improve patient safety and quality management activities. VA's establishment of the National NCPS and national training on the principles of root cause analysis represent an aggressive response to recommendations made by the OIG. The focus that the NCPS has placed on the issue of patient safety and on resolving long-time patient vulnerabilities will go a long way toward making sure that VA patients receive proper care in a safer environment.

Data Source and Validation

Chronic Disease Care Index II (CDCI II) and Prevention Index II (PI II)

Data for the CDCI and PI are collected through medical chart reviews. The sampling methodology relies upon "established" patients who have been seen at least once in one of eight primary care or specialty clinics. The External Peer Review Program (EPRP), a contracted, on-site review of clinical records, is the data source for both Indices. The EPRP contractor evaluates the validity and reliability of abstracted data using accepted statistical methods. Ongoing inter-rater reliability assessments are performed quarterly for each abstractor in the review process. A random sampling protocol is used to select individual patient charts. Abstractors then review the charts to determine if appropriate data are included. The resulting data are aggregated into appropriate indices. A report is produced quarterly that is available to each VISN.

The EPRP serves as a functional component of VHA's quality management program by:

- providing information for use as a part of VHA's continuous quality improvement program
- identifying opportunities for improvement in care

- establishing a database for the analysis and comparison of patterns of care at all levels

The numerator for individual indicators is typically based on the number of patients who received the specified intervention, clinical service, or have achieved (proxy) outcome. The denominator for the calculation is the number of patients who are eligible for the intervention or who have the disease. Data are abstracted on-site monthly.

Patient Safety

The 45-day timeliness measure for root cause analysis (RCA) was developed for use as a companion compliance measure for the national rollout in FY 2001. This measure will not be formally reported beyond FY 2001, and, thus, it appears for the final time in this iteration of the VA Performance Plan. The source for root cause analysis data is the Patient Safety Information System established by the NCPS. The numerator for this measure was the number of root cause analyses conducted within 45 calendar days, or within the allocated extension time. The denominator was all RCAs in the Patient Safety Information System. Future iterations of the performance plan will contain a performance measure that monitors development and testing of Bar Code Administration contingency plans.

Patient Satisfaction

VHA currently follows a longstanding approach to assessing VHA's quality of care along a number of dimensions – patient satisfaction, functional outcomes, veterans' personal health practices and clinical measures--each with separate measures, separate samples of veterans populations, and separate data analyses and reports. While each of these alone provide meaningful and well-reasoned evaluations of a given aspect of care, VHA realized that this approach presented end users with a significant challenge in converting the data across dimensions into actionable information. Starting in FY 2002, therefore, through the Performance Analysis Center for Excellence, VA will administer a new survey called the Survey of Health Expectations of Patients (SHEP) to collect self-reported information on:

- Satisfaction
- Functional outcomes (SF-12V)
- Healthy behaviors (equivalent to Prevention Index)

This provides a mechanism for VHA to collect and analyze data to provide more meaningful and useful information, especially at a cohort level. Upon receipt of the first data from this new process, analysis will be performed to identify opportunities for improvement and subsequent measures will be developed in the area of satisfaction.

The source of data for evaluating performance associated with the overall satisfaction of patients is a question on the Performance Analysis Center for Excellence (PACE) Inpatient and Ambulatory Care Satisfaction Surveys. The PACE satisfaction surveys are conducted using samples of inpatients and outpatients who are asked, among other things, to rate their care on a scale from "poor" to "excellent." The validity and reliability of the findings have been time tested and are based on rigorous survey methodologic principles. The numerator for this measure is those inpatients and outpatients who respond to the survey and who rate their care as "very good" or "excellent." The denominator is the total number of inpatients and outpatients in the sample who responded to the question on overall satisfaction.

Beginning in late 2002, the ambulatory care patient satisfaction survey will be conducted quarterly instead of semi-annually. The inpatient satisfaction survey will be conducted on a semi-annual basis. Results are published in hardcopy and electronic versions for internal VHA use by the Networks. Networks and medical centers will also conduct more frequent evaluations at the local level. These actions will increase facilities' ability to identify strategies to improve patient satisfaction.

The source of data for evaluating performance associated with the problems reported measure is a series of questions about patient education, visit coordination, and pharmacy services on the PACE inpatient and ambulatory care satisfaction surveys. The numerator is the average of the responses that indicate a problem for each item. The denominator is the total number of respondents to these questions in the surveys. A semi-annual report is available for each Network.

Balanced Scorecard

The sources of data for this performance goal is the same as those identified for the specific components comprising the measures— Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient patient satisfaction; waiting times for primary care, specialty clinics; and wait times to see a provider. The cost element is obligations per unique patient in constant dollars.

All four components in the scorecard are of equal weight (each component is 25 percent of total) to achieve a scorecard of performance to goal. Because the cost factor uses 1997 as the base year for improvement, this element can result in a score greater than 25 percent. Consequently, the total score can be greater than 100 percent. We will review and update the methodology for this measure in advance of the next performance plan.

(For additional information about the medical care programs, refer to Medical Programs, Volume 2, Chapter 2.)

Provide Timely Access to Health Care

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

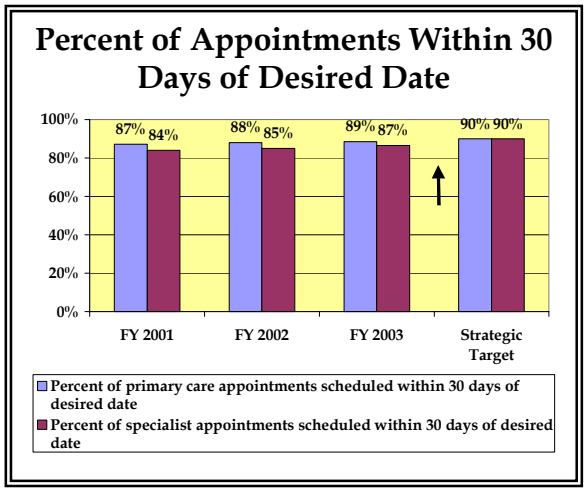
Secretary Priority: Provide access to primary care appointments and specialty care appointments within 30 days of desired date, and ensure patients are seen within 20 minutes of their scheduled appointment.

Performance Goals

1. Increase the percent of primary care appointments scheduled within 30 days of desired date to 89 percent.
2. Increase the percent of specialist appointments scheduled within 30 days of the desired date to 87 percent.
3. Increase the percent of patients who report being seen within 20 minutes of their scheduled appointments at VA health care facilities to 72 percent.

Current Situation Discussion

VA's strategy is to improve access to clinic appointments and timeliness of service. We continue efforts to develop ways to reduce waiting times for appointments in primary care and key specialty clinics in medical centers nationwide. The current measures of appointments seen within 30 days of desired date continues to show improvement. VA has a very strong commitment to decreasing appointment waiting times for the veterans we serve. Further analysis of sub-groups within these measures has resulted in additional monitoring in VHA for new patient and next available appointments.

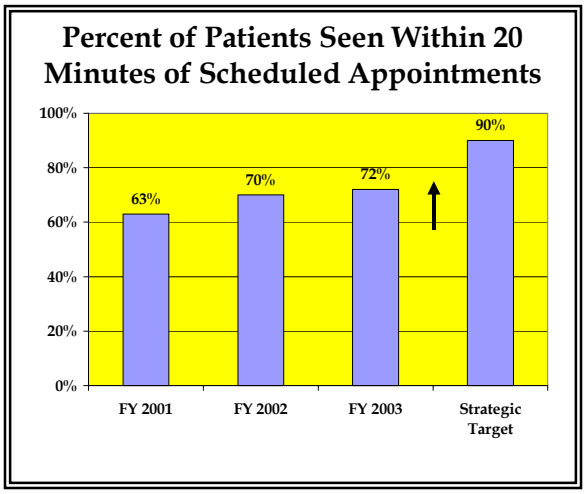


In addition, VHA has a large nationwide initiative to systematically improve clinic appointment processes.

The measure for the goal for timeliness of seeing a provider at the time of an appointment is derived from responses to the outpatient ambulatory survey question in which patients are asked, "How long after the time when your appointment was scheduled to begin did you wait to be seen?" Responses are tabulated to establish the percent of patients who reported waits of 20 minutes or less. Over the past 5 years, steady improvement in this area has been achieved.

Means and Strategies

The purpose of our access goals, which we refer to as the 30-30-20 strategy, is to define expectations for the length of time veterans wait to obtain appointments for non-urgent care, and how long they wait to see a provider for a scheduled appointment after arriving at a VA facility. VA's overall service and access goal is to provide personalized care when and where it is needed, in ways that are creative, innovative, and cost effective. Personalized care means continuity of care is provided and managed, across sites and types of care, through assignment of patients to a provider or team that knows the veteran, understands his or her needs, and coordinates and manages that care. Timely service ensures care is received when it is needed. Providing care in the manner most convenient to the veteran enables us to provide care where it is needed and wanted. The 30-30-20 goals are part of the performance agreements between the Network Directors and the Under Secretary for Health. This helps ensure a consolidated effort across the VA health care system to accomplish these goals.



The clinic waiting time performance measures are defined as the percentage of primary care (or specialty) clinic appointments scheduled within 30 days of desired date. This is the information that is reported externally. However, VHA collects and analyzes other data related to clinic waiting times for management information and decision support. In early 2000, VHA implemented software for measuring the average next available clinic appointment time experienced by patients needing an appointment. The software computes the clinic appointment waiting time by calculating the number of days between the date a next available appointment is requested and the date the appointment is made. This method of measurement is believed to be superior to previous methods, because it measures the actual experience of patients rather than projecting what the experience might be based on appointment availability. A revised version of this software was released January 31, 2001. This version allows a further measuring of appointment waiting times for new patients to primary care. In 2002, VA is exploring mechanisms to quantify the waiting times of newly enrolled patients.

The source of data for the 20-minute waiting time waiting measure is the semi-annual Performance Analysis Center for Excellence (PACE) National Ambulatory Care Satisfaction Survey. The numerator is the number of outpatients who report that they were seen within 20 minutes of their scheduled

appointments. The denominator is the universe of patients who respond to the following question: "How long after the time when your appointment was scheduled to begin did you wait to be seen?"

This is a measure of patients' self-reported responses to the question mentioned above. Therefore, a patient's perception of how long he or she must wait beyond the time of the scheduled appointment (rather than, for example, beyond the time of his or her arrival at the clinic) plays a large role in measuring performance in this area. Performance on this measure is currently reported semi-annually to Network Directors, but will be surveyed and reported on a quarterly basis beginning late in FY 2002.

External Factors

There are no external factors impacting on these performance measures.

Major Management Challenges

The General Accounting Office (GAO) has identified waiting times for appointments and treatments as a major management challenge. GAO states that VA cannot ensure that veterans receive timely care at VA medical facilities. GAO acknowledges that VA has taken steps to improve timeliness and quality of VA-provided care. In response to GAO concerns and those of veterans service organizations, VA has established measures for the time it takes for veterans to get appointments with VA providers and the time veterans spend waiting in provider's offices, and intends to continue monitoring the results closely. As part of its strategy to reduce waiting times, and meet service delivery targets, VA has entered into short-term contracts with consultants to help reduce the backlog of specialty appointments.

Data Source and Validation

VA's strategy is to improve access to clinic appointments and timeliness of service. We continue efforts to develop ways to reduce waiting times for appointments in primary care and key specialty clinics in medical centers nationwide. The current measure of the percent of primary (or specialty) appointments scheduled within 30 days of desired date continues to show improvement. VA has a very strong commitment to decreasing waiting time for appointments for the veterans we serve. Further analysis of sub-groups within these measures has resulted in additional monitoring in VHA for new patient and next available appointments. This same analysis identified a third sub-group where waiting time experience should be measured: new enrollees who have not yet made appointments. Standard enrollment and entry processes are currently under development to differentiate between those enrollees who want appointments from those that do not. A new survey will assist in the identification of the waiting time experience between enrollment and entry into the electronic scheduling system. The triangulation of all three experiences, i.e., waiting times for established patients, new patients once scheduled, and new

patients who have requested appointments, but are not yet scheduled, will allow for more effective and efficient management.

The measure for the goal for timeliness of seeing a provider at the time of an appointment is derived from responses to the ambulatory care satisfaction survey question in which patients are asked, "How long after the time when your appointment was scheduled to begin did you wait to be seen?" Responses are tabulated to establish the percent of patients who reported waits of 20 minutes or less. Over the past 5 years, steady improvement in this area has been achieved.

VA is developing new clinic wait time measures to quantify the wait times of new enrollees. VA is also developing a new survey to assess the experiences of new enrollees in requesting appointments. The data from the new measure, other VHA wait time measures, and the survey will provide more timely and relevant data for decision-making as it relates to the increase in numbers of new enrollees. VA is also recommending the development of standardized entry process for new enrollees. This process will assist in the automated collection of relevant wait time information at the time that the veteran enrolls in the system.

(For additional information about the medical care programs, refer to Medical Programs, Volume 2, Chapter 2.)

Refocus Medical Care on Higher-priority Veterans

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

Secretary Priority: Ensure access to high-quality health care for veterans with service-connected conditions and veterans who are poor.

Performance Goals

The full effect of focusing care on the highest priority veterans is not yet known. VHA is presently evaluating how this focus will impact on the number of veterans who receive care. Appropriate performance goals and measures will be developed when the impacts of focusing on disabled and lower-income veterans are more clearly established.

Current Situation Discussion

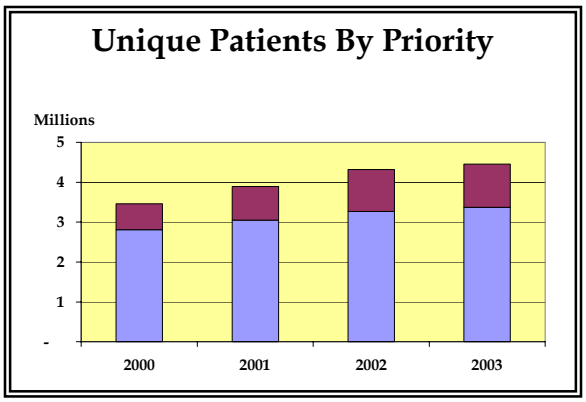
Public Law 104-262, the Veterans' Health Care Eligibility Report Act of 1996, required VA to enroll veterans for medical care in one of seven distinct priority levels. In general, veterans with service-connected disabilities and low incomes are in the highest priority levels for health care while most other veterans are in Priority 7, the lowest priority for care. The following describes how veterans are grouped into priorities:

- Priority 1: Veterans with service-connected conditions rated 50 percent or more disabling.
- Priority 2: Veterans with service-connected conditions rated 30 – 40 percent or more disabling.
- Priority 3: Veterans who are former POWs, who have service-connected conditions rated 10 to 20 percent disabling, who were discharged from active duty for a disability incurred or aggravated in the line of duty, or veterans awarded special eligibility under 38 U.S.C. 1511.
- Priority 4: Veterans who received aid and attendance or housebound benefits or who have been determined by VA to be catastrophically disabled.
- Priority 5: Non service-connected veterans and service-connected veterans rated zero percent disabled whose income are below established dollar thresholds.
- Priority 6: All other veterans who are not required to make co-payments for care, including World War I and Mexican Border veterans, veterans solely seeking care for disorders associated with exposure to a toxic substance, radiation or for disorders associated with service in the Persian Gulf, or compensable zero percent service-connected veterans.

- Priority 7: Non-service connected veterans and zero percent non-compensable service-connected veterans with income above the statutory threshold and who agree to pay specified co-payments related to health care provided to them.

Each year, VA's Secretary must determine what priority levels of veterans are eligible to receive care given the level of available resources provided by Congress. Since 1996, VA's Secretary has declared that all veterans are eligible to receive the full basic benefit package of health care services.

Because of the past and anticipated future increases in the number of Priority 7 veterans who are seeking VA health care, VA cannot continue to provide quality health care, especially to disabled and lower-income veterans, within the current direct appropriations. In order to meet the needs of service-connected and lower-income veterans, many of whom need care in a special population category, VA proposes that Priority 7 veterans cover a larger portion of their VA health care costs by assessing an annual deductible. This annual deductible, in addition to the recent increase in required pharmacy co-payments and decrease in outpatient co-payments, will allow VA's health care system to continue to deliver quality health care and to remain financially sound and sustainable for all veterans.



Means and Strategies

Priority 7 veterans, on average, use $1,890 worth of medical services from VA annually. Under the proposal to establish an annual deductible for Priority 7 veterans, these veterans will be assessed the annual deductible, with an annual ceiling of $1,500, for their inpatient and outpatient care at a rate of 45% of the reasonable charges. The current inpatient and outpatient co-payments would continue to be charged after the $1,500 deductible is paid.

This proposal is not designed to suppress demand. Rather, it is designed to provide Priority 7 veterans with medical and economic choices about their care. While it is expected that Priority 7 veterans will likely continue their enrollments in the VA health care system, some veterans may choose alternative care when faced with paying a deductible. Therefore, demand for health care for Priority 7 veterans should decrease. The reduction of overall net workload expenditures is estimated at $880 million with a revenue increase of $260 million in FY 2003. This reduction in workload expenditures and increase in revenue will help VA maximize appropriated resources to provide care for service-connected and

lower-income veterans (Priorities 1 – 6) and consequently better achieve VA's core mission.

Implementation of this change requires legislation to assess an annual deductible. It is essential that this be in law prior to the start of FY 2003 with sufficient lead-time for the preparation and approval of implementing legislation. All estimates of reduced expenditures and increased revenues assume that legislation will be passed and implementing regulations will be in effect as of October 1, 2002.

Crosscutting Activities

Achievement of this priority is not directly dependent on other agencies.

Major Management Challenges

There are no major management challenges identified that impact achievement of this priority.

Data Source and Validation

Data sources for any performance goals and measures are not yet identified because the goals and measures are still being developed.

(For additional information about the medical care programs, refer to Medical Programs, Volume 2, Chapter 2.)

Maintain High Level of Service to Insurance Policy Holders

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

Secretary Priority: Maintain the high level of service to insurance policy holders and their beneficiaries.

Performance Goal

Timeliness of Insurance Disbursements

Maintain average processing time for insurance disbursements at 3.2 days.

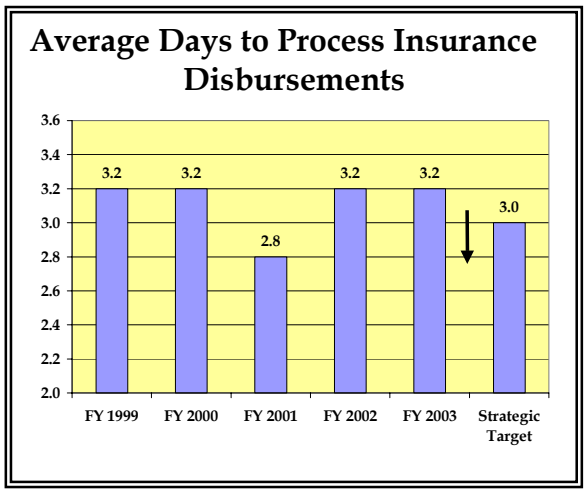
Enhance Insurance Programs

The recommendations of the program evaluation have been reviewed and an implementation plan developed. Performance goals will be developed after VA has approved the recommendations and the implementation plan.

Current Situation Discussion

Timeliness of Insurance Disbursements

Our strategic goal is to improve average processing time to 3 days, which is below the industry average of 3.1 processing days. Disbursements are considered the most important services provided by the insurance program to veterans and beneficiaries. The indicator for this measure is the weighted composite processing days for all three types of disbursements: death claims, loans, and cash surrenders. Weighted composite average processing days means that the volume of end products processed in each category is taken into account in the calculation of the average in order to make it more representative of the group.



We realized a better than expected improvement in average processing days in 2001, due to the installation of the first phase of the paperless processing system. When fully implemented, the paperless processing initiative will provide on-line electronic storage of insurance records and on-line access to those records by technicians. Over the last three years, we have mailed and processed over 1.5 million beneficiary designations of policyholders who have not updated their beneficiaries for many years. This large database of imaged beneficiary designations is allowing us to retire approximately 2.2 million insurance folders. Because of the

need for space in the Philadelphia Regional Office for a new Pension Processing Center, we have accelerated the schedule of the mass retirement of Insurance folders. We are expected to complete the folder retirement in early FY 2002, almost two years ahead of the original schedule.

Because we are retiring our insurance folders ahead of schedule and do not yet have the full imaging capabilities completed, we are using a hybrid system for disbursements consisting of imaged documents associated with temporary insurance folders. This temporary system actually provided faster disbursement processing than what we expected. When we move away from the hybrid system to the paperless processing system we will experience clerical and payroll savings. We expect disbursements to average 3.0 days once the paperless processing system is fully implemented in 2003 and insurance personnel get proficient with the new system.

Enhance Insurance Programs

Public Law 105-368 §303, Assessment of Effectiveness of Insurance and Survivor Benefits Programs for Survivors of Veterans with Service-Connected Disabilities, mandated an objective, third-party study of "Benefits for Survivors of Veterans with Service-Connected Disabilities." The purpose of the study was to determine the extent to which the VA Dependency and Indemnity Compensation (DIC) program and four VA-administered insurance programs -- Service Disabled Veterans Insurance (SDVI), Veterans' Mortgage Life Insurance (VMLI), Veterans' Group Life Insurance (VGLI), and Servicemembers' Group Life Insurance (SGLI) -- meet their statutory intent and the expectations of surviving family members, legislators, program officials, and other stakeholders. The study was expanded to a full program evaluation in order to fulfill the ongoing requirements of Public Law 103-62, the Government Performance and Results Act of 1993.

The study identified key factors in meeting program intent and stakeholder expectations:

- **Available and affordable insurance** - VA life insurance programs should be readily available and affordable to servicemembers and veterans, regardless of whether they are healthy or disabled.
- **Recognition of veteran's sacrifices** – Survivors should perceive that DIC program recognizes the sacrifices made by the servicemembers or veterans during their military service.
- **Adequate level of income support** - Survivors of veterans should have an adequate level of income support following the death of the veteran. The benefit level is the primary concern for DIC program beneficiaries.

The contractor provided suggested outcomes and generic suggestions on outcome measures. These are not dissimilar to the outcomes that the Veterans

Benefits Administration (VBA) had suggested prior to the study. VA will request input from stakeholder groups on suggested changes to outcomes. Outcomes and measures will then be finalized.

Table 1 below presents the highlights of study results that relate to the outcomes and goals suggested by the contractor. In summary, the study findings indicate that several of the expected outcomes are largely fulfilled but there are important exceptions as well, particularly with the comparison of VGLI and SDVI premiums to the private sector.

VA insurance is generally available in terms of comparison to the non-VA sector, regardless of the hazardous nature of certain work in the military or disability status. The availability and affordability of VA insurance for disabled veterans exceed availability and affordability in the private sector. The contractor did find that many SDVI survivors had very little life insurance. However, veterans of SDVI survivors had the opportunity to have enrolled in VGLI upon leaving the service. Hence, the life insurance was available, but the veteran had elected not to participate when they had the opportunity.

SGLI premium rates overall are 58 percent less than the median of private sector premiums, adjusting for age and gender differences between the military work force and the general civilian work force. VGLI premium rates compared unfavorably with a sample of private sector quotes for healthy individuals and in comparisons with military mutual aid associations' rates. Comparable rates for VGLI are considerably higher than the commercial quotes for non-smokers. An important contributing factor is that the private sector quotes do not cover unhealthy individuals while VGLI accepts all separatees regardless of health. SDVI premium rates are significantly higher than comparable rates for healthy individuals in the private sector.

Table 1. Program Outcomes, Goals, and Results

Program and Group Served	Outcomes	Goals	Results
SDVI Program: Veterans with service-connected disabilities	Veterans with service-connected disabilities are provided with the opportunity to obtain life insurance at standard premium rates without regard to their service-connected impairments for a reasonable time period following establishment of a service-connected disability.	For veterans with service-connected disabilities, parity with the options available to healthy individuals of similar ages to purchase reasonable amounts of life insurance in the individual market, within a reasonable time following the disability being established, and with comparable policy features.	SDVI participants had opportunity to obtain VGLI insurance, but many declined it. Half of SDVI beneficiaries receive only $15,000 or less in life insurance payments from all sources. The $10,000 basic coverage provided by SDVI is not adequate. SDVI premium rates are much higher than standard commercial rates for non-smokers.

Program and Group Served	Outcomes	Goals	Results
VMLI Program: Severely disabled veterans with service-connected disabilities who have received a grant for specially adapted housing.	Severely disabled veterans of any age and with service-connected disabilities can purchase mortgage life insurance in amounts consistent with current mortgage loans, and at standard premium rates.	Parity with the average non-disabled American's ability to purchase mortgage life insurance protection at any age in amounts consistent with current limits on mortgage loans and at competitive rates and with comparable policy features.	The $90,000 maximum mortgage protection life insurance under VMLI covers about 75% of the face value of mortgages of VMLI participants. VMLI premium rates are significantly lower than in the private sector for healthy individuals.
SGLI Program: Active Duty Servicemembers and Reservists	Insurance coverage is available to servicemembers and reservists and their family members at comparable costs that meets or exceeds the total life insurance benefit available to employees and their family members in large private sector organizations.	Availability of life insurance Is not affected by hazard. Meets or exceeds life insurance coverage levels for basic, supplemental, and dependent coverage made available by large private sector employers. Costs servicemembers no more than employee premiums available in large private sector organizations. Provides option to convert coverage upon termination.	Current $250,000 SGLI coverage is significantly higher than basic plans provided by private sector employers. Optional supplemental coverage is not available as it often is in the private sector. SGLI survivors in the study population received, on average, about $200,000 in life insurance benefits. Most private sector employers pay for basic coverage. SGLI premium paid by service-member compares favorably to premium costs for group life insurance (including basic and supplemental). Overall, median private sector premiums are 58% higher than SGLI premium. Conversion at termination for basic insurance is superior to conversion feature generally found in the private sector.
VGLI Program: Separated servicemembers and separated reservists	Separating servicemembers and reservists are guaranteed the opportunity to be covered by the same life insurance benefits as they had during active/ reserve service. VGLI costs per $1,000 of coverage, adjusted for health status, are consistent with what they would pay if purchasing equivalent coverage in the private sector.	Provide an option for automatic conversion of SGLI coverage at rates competitive with offerings in the private sector for healthy individuals.	Conversion of SGLI to VGLI is better than most private sector employers. VGLI survivors in the study population received, on average, about $100,000 in life insurance benefits. VGLI cost for the veteran compares unfavorably with a sample of private sector quotes for healthy individuals. Comparisons depend on specific age of individual, but in many cases VGLI rates are more than twice the commercial quotes.

The Program Evaluation of Benefits for Survivors of Veterans with Service-Connected Disabilities is complete and contains several recommendations that

are intended to enhance certain VA insurance programs. The recommendations are summarized below:

Servicemembers' Group Life Insurance (SGLI)

1. Offer a supplemental insurance option
2. Offer dependent's coverage option

Veterans' Group Life Insurance (VGLI)

1. Offer a supplemental insurance option
2. Publicize the conversion features of SGLI
3. Reduce VGLI premium rates to make them more comparable to commercial quotes

Service-Disabled Veterans Insurance (S-DVI)

1. Offer an automatic enrollment in S-DVI
2. Increase the basic coverage maximum to $50,000
3. Reduce S-DVI premium rates

Veterans' Mortgage Life Insurance (VMLI)

1. Remove the terminating at age 70 provision
2. Increase the current coverage maximum to between $150,000 and $200,000
3. Index maximum coverage to new loan origination amounts reported annually by the Federal Financial Institutions Examination Council (FFIEC).
4. Examine methods to increase participation by eligible disabled veterans

Means and Strategies

Timeliness of Insurance Disbursements

The insurance program has undertaken various actions to improve the timeliness of disbursements including special post office boxes, improvements in how we process returned mail and the elimination of data processing delays. We will install the full paperless processing system in 2003 throughout the insurance program. The imaging capabilities from that initiative will reduce the time required for processing disbursements and other services.

Enhance Insurance Programs

Three of the study's recommendations have already been implemented. Public Law 107-14 allows for SGLI dependent's coverage to become effective November 1, 2001. Effective July 9, 2001, VGLI premium rates were reduced,

which makes them more comparable to commercial quotes. Also, a plan was developed to increase VMLI participation by eligible disabled veterans.

An implementation plan was developed for the remaining recommendations which will provide: (1) an assessment of the strengths and weaknesses of the contractor's findings and recommendations (both program and technical), (2) identification of each study recommendation that VA recommends to be accepted and implemented, (3) an action plan for each accepted recommendation including major milestones and resource requirements, (4) recommended legislative proposals, (5) recommended changes to stated program objectives and outcomes, and (6) recommended changes to performance measures (outcome measures, customer satisfaction measures, process measures) and associated performance targets for the future. The implementation plan was completed and presented to the Deputy Secretary of VA in October 2001. The Deputy Secretary agreed with the Insurance Service's findings on all but two Insurance program recommendations. The Deputy Secretary requested additional information on the following two recommendations:

1. Increase basic S-DVI coverage maximum amount from $10,000 to $50,000.
2. Automatically provide S-DVI insurance coverage to any newly eligible veteran who is not enrolled in VGLI.

Crosscutting Activities:

Timeliness of Insurance Disbursements

Achievement of this goal is not directly dependent on other agencies.

Enhance Insurance Programs

Cooperation from the following stakeholders would possibly be required to implement some of the study's recommendations. These stakeholders include, veterans' service organizations, DoD, the individual service branches, Congress, the OMB, the SGLI Advisory Council, and Prudential Insurance Company of America (the parent company of the Office of Servicemembers' Group Life Insurance.)

Major Management Challenges:

There are no major management challenges that will affect achievement of insurance program goals.

Data Source and Validation

Timeliness of Insurance Disbursements

Processing time begins when the veteran's or beneficiary's application or request is received and ends when the Internal Controls Staff approves the disbursement. Average processing days are a weighted composite for all three types of disbursements, based on the number of end products and timeliness for

each category. The average processing days for death claims is multiplied by the number of death claims processed. The same calculation is done for loans and cash surrenders. The sum of these calculations is divided by the sum of death claims, loans and cash surrenders processed to arrive at the weighted average processing days for disbursements. Data on processing time is collected and stored through the SQC Program and the DOOR system. The Insurance Service is charged with periodically evaluating the SQC program to determine if it is being properly implemented. The composite weighted average processing days measure is calculated by the Insurance Service and is subject to periodic reviews.

Enhance Insurance Programs

Information on the study can be found in the "Program Evaluation of Benefits for Survivors of Veterans with Service-Connected Disabilities", Final Report, Volume I through Volume V, dated May 2001.

(For additional information about the insurance programs, refer to Benefits Programs, Volume 1, Chapter 3, and General Operating Expenses, Volume 4, Chapter 2F.)

Ensure Burial Needs are Met

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

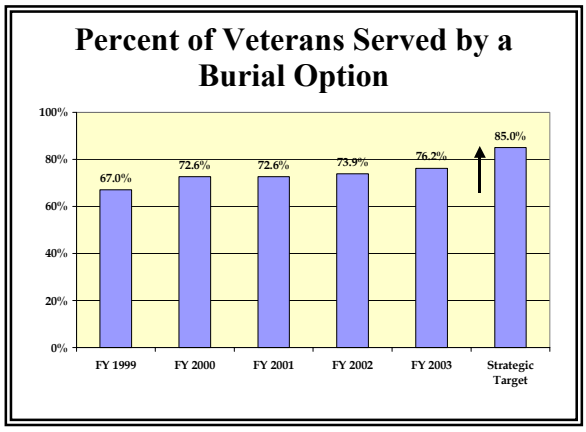
Secretary Priority: Ensure the burial needs of veterans and their eligible family members are met.

Performance Goals

1. Increase the percent of veterans served by a burial option in a national or state veterans cemetery within a reasonable distance (75 miles) of their residence to 76.2 percent by 2003.
2. Increase the percent of respondents who rate the quality of service provided by the national cemeteries as excellent to 96 percent by 2003.

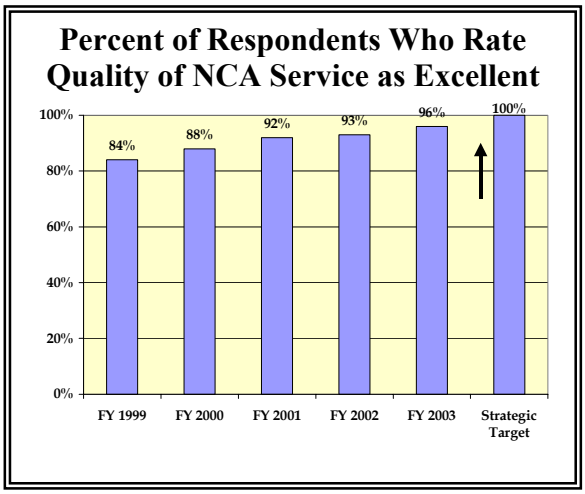
Current Situation Discussion

The mission of the National Cemetery Administration (NCA) is to "honor veterans with a final resting place and lasting memorials that commemorate their service to our Nation." As veteran deaths continue to increase throughout the planning time frame, NCA projects increases in the number of annual interments from 84,822 in 2001 to 90,500 in 2003, an increase of 7 percent. NCA data show that about 80 percent of persons interred in national cemeteries resided within 75 miles of the cemetery at time of death. Effective FY 2000, actual performance and the target levels of performance are based on the new VetPop2000 model developed by the VA Office of the Actuary.



As annual interments and total gravesites used increase, cemeteries deplete their inventory of space and are no longer able to accept casketed or cremated remains of first family members for interment. This reduces the burial options available to veterans. At the end of 2002, of the 120 existing national cemeteries, 61 will contain available, unassigned gravesites for the burial of both casketed and cremated remains; 24 will accept only cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member; and 35 will perform only interments of family members in the same gravesite as a previously deceased family member. By the end of 2003, two national cemeteries will close. Often, when a national cemetery closes, veterans continue to be served by an open national or state veterans cemetery. For example, when Long Island National Cemetery closes in 2002, veterans will continue to be served by Calverton

National Cemetery. A state veterans cemetery recently built in Little Rock, Arkansas, will compensate for the effect of the closure of the Little Rock National Cemetery. By the year 2007, the Barrancas, Natchez, and Woodlawn National Cemeteries will exhaust their current supply of available, unassigned, full-casket gravesites. Efforts are underway to acquire additional land for full-casket interments at Barrancas and Natchez National Cemeteries. Additional land is not currently available to expand Woodlawn National Cemetery. Woodlawn National Cemetery will continue to accept first family member cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member.



VA strives to provide high-quality, courteous, and responsive service in all of its contacts with veterans and their families and friends. These contacts include scheduling the committal service, arranging for and conducting interments, and providing information about the cemetery and the location of specific graves.

Means and Strategies

In order to achieve the performance goal of increasing the percent of veterans served by a burial option in a national or state veterans cemetery, VA will develop additional national cemeteries in unserved areas; expand existing national cemeteries to continue to provide service to meet projected demand, including the development of columbaria and the acquisition of additional land; and develop alternative burial options consistent with veterans' expectations.

Interment operations began at Fort Sill National Cemetery, near Oklahoma City, Oklahoma, in November 2001, providing service to over 165,000 veterans. A new national cemetery in the area of Atlanta, Georgia, will begin interment operations in 2003. NCA is also planning for the development of new national cemeteries to serve veterans in the areas of Detroit, Michigan; Miami, Florida; Pittsburgh, Pennsylvania; and Sacramento, California. When open, these five cemeteries will provide a burial option to nearly two million veterans who are not currently served by a national cemetery within a reasonable distance. These locations were identified in a May 2000 report to Congress as the six areas most in need of a new national cemetery, based on demographic studies.

VA will expand existing national cemeteries by completing phased development projects in order to make additional gravesites or columbaria

available for interments. Phased development in 10-year increments is a part of the routine operation of an open national cemetery. It is the practice of NCA to lay out and subdivide a cemetery by sections or areas so it may be developed sequentially as the need approaches. National cemeteries that will close due to depletion of grave space are identified to determine the feasibility of extending the service period of the cemetery by the acquisition of adjacent or contiguous land, or by the construction of columbaria.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent demographic study to identify those areas of the country where veterans will not have reasonable access to a burial option in a national or state veterans cemetery, and the number of additional cemeteries required to meet veterans' burial needs through 2020. The contractor's report will be provided in the winter of 2002.

To achieve our performance goal to increase the percent of veterans served by a burial option, it is also necessary that state veterans cemeteries be established or expanded to complement VA's system of national cemeteries. NCA administers the State Cemetery Grants Program (SCGP), which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving state veterans cemeteries, including the acquisition of initial operating equipment. These cemeteries may be located by the states in areas where there are no plans for VA to operate and maintain a national cemetery. Forty-seven operating state veterans cemeteries have been established, expanded, or improved using the SCGP. By 2003, states will open 8 new state veterans cemeteries that will provide service to over 270,000 veterans not currently served by a burial option.

In meeting the burial needs of veterans and eligible family members, VA will continue to provide high quality, courteous, and responsive service. We will continue to obtain feedback from veterans, their families, and other cemetery visitors to ascertain how they perceive the quality of service provided. Using a customer satisfaction survey, NCA measures its success in delivering service with courtesy, compassion, and respect. We will also continue to conduct focus groups to collect data on stakeholder expectations and their perceptions related to the quality of service provided by national cemeteries. The information obtained is analyzed to ensure that NCA addresses those issues most important to its customers. This approach provides us with data from the customer's perspective, which are critical to developing our objectives and associated measures.

To increase awareness of benefits and services provided, NCA conducts outreach and education activities for the veteran community and the general public through the use of news releases, articles appearing in veterans service

organization publications, public service announcements, and presentations to schools and community organizations.

To further enhance access to information and improve service to veterans and their families, we will continue to install kiosk information centers at national and state veterans cemeteries to assist visitors in finding the exact gravesite locations of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about the NCA. By 2003, VA plans to install 48 kiosks at national and state veterans cemeteries.

In order to accommodate and better serve its customers, VA developed three hub cemeteries to provide weekend scheduling of the interment in a national cemetery for a specific time in the ensuing week. Each hub cemetery provides this weekend service to families and funeral directors within its geographic area.

Veterans and their families have indicated that they need to know the interment schedule as soon as possible in order to finalize necessary arrangements. To meet this expectation, VA strives to schedule committal services at national cemeteries within two hours of the request. NCA is evaluating an instrument to collect data for timeliness of scheduling the committal service.

Crosscutting Activities

VA partners with the states to provide veterans and their eligible family members with burial options through the State Cemetery Grants Program (SCGP). NCA is also developing a planning model to encourage and help individual states in establishing state veterans cemeteries through the SCGP. Two components of the model, an "applicant information kit" and a "standard pre-design briefing," are now in use. Additional modules, to give applicants more information about costs, size and style of buildings, and other development guidelines, will also be included.

NCA and the State of Missouri co-sponsored the first national conference for directors of state veterans cemeteries. The conference, held in the fall of 2001, provided state cemetery directors with the latest information on best practices in operating federal veterans cemeteries and afforded directors the opportunity to share information and build networks that will result in better service to veterans and their families.

NCA works closely with components of DoD and veterans service organizations to provide military funeral honors at national cemeteries. While VA does not provide military funeral honors, national cemeteries facilitate the provision of funeral honors ceremonies and provide logistical support to funeral

honors teams. Veterans and their families have indicated that the provision of military funeral honors for the deceased veteran is important to them.

VA continues to work with funeral homes and veterans service organizations to find new ways to increase awareness of benefits and services. Funeral directors and members of veterans service organizations participate in regularly conducted focus groups to identify not only what information they need but also the best way to ensure that they receive it.

External Factors

Through the State Cemetery Grants Program, VA has established partnerships with states to provide veterans and their eligible family members with burial options. It is difficult to project future activity for this program because requests for grants are generated from individual states. A state must enact legislation to commit funding to a project that will serve a clearly defined population and require state funds for operations and maintenance in perpetuity.

Veterans and their families may experience feelings of dissatisfaction when their expectations concerning the committal service (including military funeral honors) are not met. Dissatisfaction with services provided by DoD (military funeral honors) or the funeral home can adversely affect the public's perceptions regarding the quality of service provided by the national cemeteries.

Major Management Challenges

There are no major management challenges that will affect achievement of these performance goals.

Data Sources and Validation

NCA determines the percent of veterans served by existing national and state veterans cemeteries within a reasonable distance of their residence by analyzing census data on the veteran population. Arlington National Cemetery, operated by the Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, operated by the Department of the Interior, are included in this analysis. Since FY 2000, actual performance and the target levels of performance have been based on the new VetPop2000 model developed by the Office of the Actuary. VetPop2000 is the authoritative VA estimate and projection of the number and characteristics of veterans. It is the first revision of official estimates and projections since 1993. The new VetPop2000 methodology resulted in significant changes in the nationwide estimate and projection of the demographic characteristics of the veteran population. These changes affected the separate county veteran populations from which NCA determines the percentage of veterans served. Projected openings of new national or state veterans cemeteries and changes in the service delivery status of existing cemeteries are also considered. (Multiple counts of the same veteran population are avoided in cases of service-area overlap.)

VA's Office of Inspector General performed an audit assessing the accuracy of data used to measure the percent of veterans served by the existence of a burial option (national or State cemetery) within a reasonable distance of place of residence. Audit results showed that NCA personnel generally made sound decisions and accurate calculations in determining the percent of veterans served by a burial option. Although inconsistencies in NCA's estimate of the percent of the veteran population served by a burial option were identified, they did not have a material impact and no formal recommendations were made. We have addressed these inconsistencies and the adjustments are included in this performance plan.

From FY 1996 to FY 2000, the source of data used to measure the quality of service provided by national cemeteries was the NCA Visitor Comment Card. For FY 2001 and subsequent years, NCA has developed a new customer satisfaction survey process. The survey is done via mail; the data are collected annually from family members and funeral directors who recently received services from a national cemetery. To ensure sensitivity to the grieving process, NCA allows a minimum of 3 months after an interment before including a respondent in the sample population. The measure for quality of service is the percent of respondents returning the survey who agree that the quality of service received from cemetery staff is excellent.

VA headquarters staff oversees the data collection process to measure the quality of service provided and compiles an annual report at the national level. Regional and cemetery level reports are provided for NCA management's use. The nationwide mail-out survey provides statistically valid performance information at the national and regional levels and at the cemetery level (for cemeteries having at least 400 interments per year).

(For additional information on the burial program, refer to General Operating Expenses, Volume 4, Chapter 4.)

Mark Graves in a Timely Manner

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

Secretary's Priority: Ensure graves in national cemeteries are marked in a timely manner.

Performance Goal

Mark (TBD) percent of graves in national cemeteries within 60 days of interment.

Current Situation Discussion

NCA provides headstones and markers for the graves of eligible persons in national, state, other public, and private cemeteries. The amount of time it takes to mark the grave after an interment is extremely important to veterans and their family members. The headstone or marker is a lasting memorial that serves as a focal point not only for present-day survivors but also for future generations. In addition, it brings a sense of closure to the grieving process to see the grave marked. Delivery of this benefit is not dependent on interment in a national cemetery. In 2001, NCA provided 304,296 headstones and markers for placement in national, state, or private cemeteries. The number of headstones and markers provided is expected to increase to 341,200 in the year 2003.

NCA will continue to provide Presidential Memorial Certificates (PMCs) to families of deceased veterans, recognizing the veteran's contribution and service to the Nation. A PMC conveys to the family of the veteran the gratitude of the Nation for the veteran's service. To convey this gratitude, it is essential that the certificate be accurately inscribed. NCA issued 327,561 Presidential Memorial Certificates in 2001, and expects this number to increase to 335,700 in the year 2003.

Means and Strategies

NCA has developed a new data collection instrument to measure the timeliness of marking graves at national cemeteries. NCA is currently collecting baseline data and validating the accuracy and integrity of the data collected. When this review is complete, performance targets will be established.

NCA has also begun to develop the mechanisms necessary to measure the timeliness of providing headstones or markers for the graves of veterans who are not buried in VA national cemeteries. NCA plans to assess data collection procedures to ensure that data collected to measure timeliness of delivery of headstones and markers are accurate, valid, and verifiable.

The Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, includes a provision that allows VA to furnish an appropriate marker for the

graves of eligible veterans buried in private cemeteries, whose deaths occur on or after December 27, 2001, regardless of whether the grave is already marked with a non-government marker. This authority expires on December 31, 2006. However, not later than February 1, 2006, VA shall report the rate of use of this benefit; an assessment as to the extent to which these markers are being delivered to cemeteries and placed on grave sites consistent with the provisions of law; and a recommendation for extension or repeal of the expiration date.

NCA will improve accuracy and operational processes in order to reduce the number of inaccurate or damaged headstones and markers delivered to the gravesite. Headstones and markers must be replaced when either the Government or the contractor makes errors in the inscription, or if the headstone or marker is damaged during delivery or installation. When headstones and markers must be replaced, it further delays the final portion of the interment process, the placing of the headstone or marker at the gravesite.

NCA will use, to the maximum extent possible, modern information technology to automate its operational processes. On-line ordering using NCA's Automated Monument Application System – Redesign (AMAS-R) and electronic transmission of headstone and marker orders to contractors are improvements that increase the efficiency of the headstone and marker ordering process.

NCA is also increasing its efficiency by encouraging other federal and state veterans cemeteries to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. In 2001, 34 other federal and state veterans cemeteries ordered headstones and markers online.

Crosscutting Activities

NCA provides headstones and markers for national cemeteries administered by the Department of the Army, the Department of the Interior (DOI), and the American Battle Monuments Commission. Arlington National Cemetery, which is administered by the Department of the Army, and Andrew Johnson National Cemetery and Andersonville National Cemetery, which are administered by DOI, order headstones and markers directly through NCA's AMAS-R monument ordering system. NCA also contracts for all niche inscriptions at Arlington National Cemetery.

NCA also provides headstones and markers to state veterans cemeteries. State veterans cemeteries are encouraged to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. NCA also extends its second inscription program to state veterans cemeteries. In this program, the second inscription is added *in situ* (i.e., at the gravesite) to the currently existing headstone following the death and interment of a subsequent family member. In order to participate, state cemeteries must use upright headstones and have the capability to submit requests electronically.

NCA administers the White House program for PMCs. A PMC is an engraved paper certificate, signed by the President, to honor the memory of honorably discharged deceased veterans. Eligible recipients include the deceased veteran's next of kin and loved ones.

External Factors

Headstones and markers are supplied by outside contractors throughout the United States, whose performance greatly affects the quality of service provided to veterans and their families. The timeliness of delivery of headstones and markers is dependent not only on the performance of the manufacturer but also on the performance of the contracted shipping agent. Extremes in weather, such as periods of excessive rain or extended periods of freezing temperatures, that impact on ground conditions can also cause delays in the installation of headstones and markers.

Major Management Challenges

There are no major management challenges that will affect achievement of this performance goal.

Data Source and Validation

Workload data are collected monthly through field station input to the Burial Operations Support System (BOSS) and AMAS-R. The number of headstones and markers ordered also includes markers ordered by the Logistics Division, such as the mass purchase of columbaria niche covers. The total number of PMCs issued, which includes those issued to correct inaccuracies, is reported monthly. Headquarters staff reviews the data for general conformance with previous report periods, and any irregularities are validated through contact with the reporting station.

When headstones or markers are lost, damaged, or incorrectly inscribed, it is important to determine both the cause and the party responsible for the expense of a replacement. NCA developed new codes for ordering replacement headstones or markers; use of these new codes produces reliable and accurate data on replacement actions and provides management with an effective tool for improving the overall business process.

(For additional information about NCA programs, refer to the General Operating Budget, Volume 4, Chapter 4B.)

Strategic Goal 4

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

Secretary Priority: *Focus medical research on military associated issues, particularly rehabilitation, spinal cord injury/paralysis, and biomedical concerns.*

Secretary priority: *Improve the Nation's response in the event of a National emergency or natural disaster by providing timely and effective contingency medical support.*

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

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

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

- Institutional Review Board (IRB) compliance and maintain, as appropriate, Association for the Assessment and Accreditation of Laboratory Animal Care (AAALAC) or Nuclear Regulatory Commission (NRC) accreditation or certification
- Appearance of national cemeteries

Focus Medical Research Programs

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

Secretary Priority: Focus medical research on military associated issues, particularly rehabilitation, spinal cord injury/paralysis, and biomedical concerns.

Performance Goals

Increase to 40 percent the degree of Institutional Review Board (IRB) compliance with National Committee for Quality Assurance (NCQA) accreditation and maintain, as appropriate, Association for the Assessment and Accreditation of Laboratory Animal Care (AAALAC) or Nuclear Regulatory Commission (NRC) accreditation or certification.

Current Situation Discussion

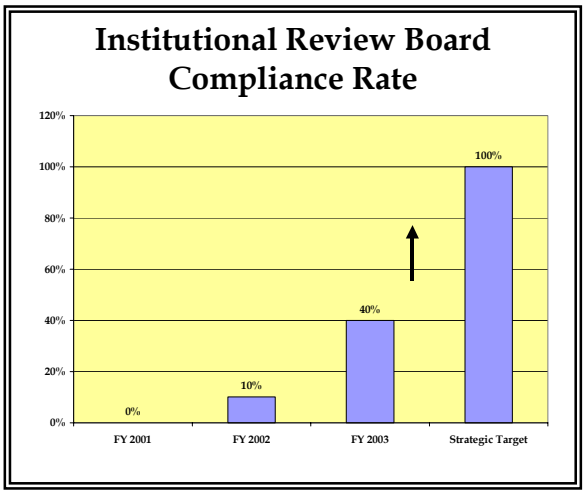
In meeting its mission, the Office of Research and Development (ORD) has capitalized on the unique opportunities provided by the veterans health care system. In response to recommendations from the Research Realignment Advisory Committee, ORD has realigned its priority areas to target more appropriately research projects that address the special needs of veteran patients. The program is also striving to balance research resources among basic and applied research to ensure a complementary role between the discovery of new knowledge and the application of these discoveries into medical practice.

Projects by Designated Research Areas			
Designated Research Area	**2001 Actual**	**2002 Estimate**	**2003 Request**
Aging	470	478	489
Chronic Disease	1,538	1,565	1,603
Mental Illness	169	172	176
Substance Abuse	146	148	152
Sensory Loss	74	75	77
Trauma Related Illness	199	202	207
Health Systems	218	221	227
Special Populations	104	105	108
Military Occupations and Environmental Exposures	137	139	142

VA's research portfolio of more than 2,400 projects has produced numerous discoveries that have improved the quality of health care for veterans and the American public. Virtually all of the VA's research projects are directed toward health conditions relevant to the veteran population. The Designated Research Areas represent areas of particular importance to VHA's veteran patient population.

Significant research results include new or improved treatments, enhanced prosthetic devices, the discovery of genes that play key roles in the development of diseases, and improvements in the delivery of medical care.

For example, VA researchers have identified a promising new treatment for kidney cancer that uses a laboratory-developed analog of a hormone that inhibits the release of growth hormone to reverse cancer growth. VA researchers in Seattle are developing new prosthetic limbs that will reduce patient fatigue and produce greater propulsive forces for walking. Clinician-investigators found that colonoscopy offered significant advantages over sigmoidoscopy in identifying colon cancer or serious precancerous growths. In a major breakthrough for understanding and treating schizophrenia, VA researchers have discovered a gene that plays a major role in schizophrenia and is linked to two physiological defects found in schizophrenics and their family members. Researchers also identified a previously unknown dysfunction in neurons involved in multiple sclerosis (MS). They found that a specific sodium channel, the molecular "battery" that produces electrical impulses in nerve cells, occurs in cells of brains affected by MS but not in those without neurological disease. Their work could revolutionize the treatment of MS.



Means and Strategies

Federal regulations create a system that outlines responsibility for protecting human subjects and is assigned to three groups. Investigators are responsible for conducting research in accordance with these Federal regulations. Institutions are responsible for establishing oversight mechanisms for research, including local committees known as institutional review boards (IRB) that are responsible for reviewing both research proposals and ongoing research. Agencies, including VA, are responsible for ensuring that their IRBs comply with applicable Federal regulations and have sufficient space and staff to accomplish their obligations.

VA requires that each medical center engaged in research with human subjects establish its own IRB or secure the services of an IRB at an affiliated university.

Networks are expected to comply with policies and procedures that prevent and detect activities, practices, or behavior that are not consistent or in compliance with existing regulatory, ethical, or legal requirements. Part of each Network Director's performance evaluation is based on completion or outcome of various compliance measures. Each Director is required to file a quarterly report listing appropriate accreditation agencies for the Network's research programs, including dates of review and conclusions of reviews, and stating whether the Network is scheduled for an NCQA survey (with the date, if so scheduled). Evaluation is based on inclusion of all necessary accreditation agencies, full accreditation by each, and clearly defined plans for any new accreditation that is needed.

VA has also created the Office of Research Compliance and Assurance (ORCA) to advise the Under Secretary for Health on matters affecting the integrity of research protections, to promote the ethical conduct of research, and to investigate allegations of research impropriety.

Crosscutting Activities

Much of the research conducted in VA facilities is subject to the regulations of other Federal agencies as well as to VA's own regulations. For example, human studies funded by pharmaceutical companies and conducted at VA facilities in support of a new drug or device application are subject to Food and Drug Administration (FDA) as well as VA regulations and oversight. Similarly, studies funded by the National Institutes of Health (NIH) and conducted in VA facilities are subject to Department of Health and Human Services (HHS) as well as VA regulations and oversight.

VHA has issued a contract for external accreditation of human subjects programs to the NCQA, an independent, not-for-profit accrediting organization that is nationally renowned for its objective evaluations of health care organizations.

Within VHA, ORCA is responsible for liaison and coordination of enforcement activities with other federal research regulatory agencies, including the FDA and the HHS Office of Human Research Protections. As an example of this collaboration, the FDA has recognized the need to revise its reporting procedures for serious adverse events and has involved ORCA in the development of a clearer set of procedures and guidelines. Also, ORCA officials have met with their counterparts in these agencies and are working collaboratively to develop educational initiatives for investigators and research administrators in the field.

Major Management Challenges

There are no major management challenges that will affect achievement of this performance goal.

Data Source and Validation

The numerator for the target is the number of VA research facilities gaining and maintaining accreditation. The denominator is the number of VA health care facilities conducting research. The source of the data collection is analysis and self-reporting by VA medical centers. A site visit is conducted by NCQA every 3 years at VA facilities to ascertain full accreditation.

(For more information about VA's research program, refer to Medical Programs, Volume 2, Chapter 3.)

Improve Response in Event of National Emergency

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

Secretary Priority: Improve the Nation's response in the event of a National emergency or natural disaster by providing timely and effective contingency medical support.

Performance Goal

In 2003, at least 80 percent of top management officials, other key personnel, and emergency planners receive training or, as applicable, participate in exercises relevant to VA's COOP plan.

Discussion of Current Situation

In response to the events of September 11, 2001 and the subsequent report of the Secretary's Preparedness Review Working Group, the Department will focus on enhancing its capabilities in the area of emergency management. Within this area, the Department is responsible for the following:

- VA contingencies,
- Department of Defense (DoD) contingency support missions,
- Federal Response Plan (FRP),
- National Disaster Medical System,
- Natural and Technological Hazards,
- Homeland Security interagency coordination and support,
- Continuity of Operations Plans (COOP),
- Continuity of Government.

Many of these objectives, while enhancing the Department's internal capabilities and its ability to address VA contingencies, will also improve VA's ability as a federal responder.

Means and Strategies

The first step in achieving this goal will be the establishment of an Office of Operations, Security, and Preparedness. It will play the leading role in ensuring that VA is prepared to handle any emergency situation and will be able to continue its operations and services to veterans and their families. This organization will work with the Administrations to ensure the safety and security of veterans, employees, and visitors at VA facilities. It will ensure continuity of services, while integrating, improving, and increasing VA's operational readiness and ability to support executive law enforcement,

emergency responses, DoD contingency support, Federal Response Plan (FRP), and Homeland Security support missions.

Responsibilities of this new office will include:

- Executing a comprehensive education, training, and exercise program to ensure all personnel are trained in emergency response plans and procedures.
- Managing, directing, and ensuring the immediate readiness and staffing of VA's Readiness Operations Centers.
- Assisting VA's Chief Information Officer to ensure both VA's information technology systems are ready to continue operations during emergencies and that VA's emergency communications system is effective and reliable.
- Coordinating with DoD on the development and sharing of a database to capture casualty and medical treatment data.
- Planning to ensure that designated Primary Receiving Centers can provide the full range of tertiary care for military casualties and meet civilian disaster contingencies.

Crosscutting Activities

VA will be working with FEMA, DoD, the Office of Homeland Security, and HHS in carrying out its responsibilities in responding to national emergencies.

Management Challenges

There are no significant management challenges that would impact achievement of this performance goal.

Data Validation

Performance data are derived from training records. There is no independent validation of the data.

(For additional information about the Office of Operations, Security, and Preparedness, refer to General Operating Expenses, Volume 4, Chapter 3L.)

Maintain National Cemeteries as National Shrines

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

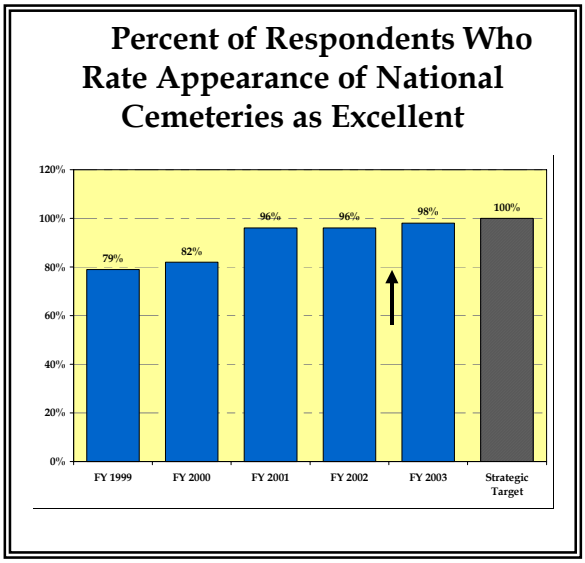
Secretary Priority: Ensure that national cemeteries are maintained as national shrines dedicated to preserving our Nation's history, nurturing patriotism, and honoring the service and sacrifice veterans have made.

Performance Goal

Increase the percent of respondents who rate national cemetery appearance as excellent to 98 percent by 2003.

Current Situation Discussion

NCA will continue to maintain the appearance of national cemeteries as national shrines so that bereaved family members are comforted when they come to the cemetery for the interment, or later to visit the grave(s) of their loved one(s). Our Nation's veterans have earned the appreciation and respect not only of their friends and families but also of the entire country and our allies. National cemeteries are enduring testimonials to that appreciation and should be places to which veterans and their families are drawn for dignified burials and lasting memorials.



Means and Strategies

In order to achieve this objective, NCA must maintain occupied graves and developed acreage in a manner befitting national shrines. Improvements in the appearance of burial grounds and historic structures are necessary for NCA to fulfill this national shrine commitment. In-ground gravesites (casket and cremain) require maintenance to correct ground sinkage and to keep the headstones and markers aligned. Maintenance of columbaria includes cleaning stains from stone surfaces, maintaining the caulking and grouting between the units, and maintaining the surrounding walkways. Cemetery acreage that has been developed into burial areas and other areas that are no longer in a natural state also require regular maintenance.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent study to look at various issues related to the National Shrine Commitment and its focus on cemetery

appearance. A study is underway to identify the one-time repairs needed to ensure a dignified and respectful setting appropriate for each national cemetery. Recommendations to address deferred maintenance issues or preventive steps to minimize future maintenance costs will be identified. The study will also include a report on the feasibility of establishing standards of appearance for national cemeteries equal to the finest cemeteries in the world. Varying characteristics of cemeteries, such as cemetery status (open, cremation only, and closed), as well as geographic and climatic conditions, will be taken into consideration. The contractor's report will be provided in the winter of 2002.

In advance of this report, a total of $10 million is included in the budget to address obvious, long-standing, deferred maintenance deficiencies. This funding for the National Shrine Commitment initiative will primarily be used for raising, realigning, and cleaning headstones and markers and for renovating gravesites.

All national cemeteries are important locations for patriotic and commemorative events. NCA will continue to host ceremonies and memorial services at national cemeteries to honor those who made the supreme sacrifice. To preserve our Nation's history, NCA will continue to conduct educational tours and programs for schools and civic groups.

Crosscutting Activities

NCA will continue its partnerships with various VA and other federal and civic organizations that provide volunteers and other participants to assist in maintaining the appearance of national cemeteries. For example, an Interagency Agreement with the Bureau of Prisons provides for the use of selected prisoners to perform work at national cemeteries. Under a joint venture with VHA, national cemeteries provide therapeutic work opportunities to veterans receiving treatment in the Compensated Work Therapy/Veterans Industries (CWT/VI) program. The national cemeteries are provided a supplemental work force while giving veterans the opportunity to work for pay, regain lost work habits, and learn new work skills.

External Factors

Maintaining the grounds, graves, and grave markers of national cemeteries as national shrines is influenced by many different factors. As time goes by, cemeteries experience a variety of environmental changes that may require extensive maintenance. Extremes in weather, such as excessive rain or drought, can result in or exacerbate sunken graves, sunken markers, soiled markers, inferior turf cover, and weathering of columbaria. For example, the 230-pound upright headstones and the 130-pound flat markers tend to settle over time and must be raised and realigned periodically. The frequency of this need varies depending on soil conditions and climate.

Major Management Challenges

There are no major management challenges that will affect achievement of this performance goal.

Data Source and Validation

From FY 1996 to FY 2000, the source of data used to measure the appearance of national cemeteries was the NCA Visitor Comment Card. For FY 2001 and subsequent years, NCA has developed a new customer satisfaction survey process. The survey is done via mail; the data are collected annually from family members and funeral directors who recently received services from a national cemetery. To ensure sensitivity to the grieving process, NCA allows a minimum of 3 months after an interment before including a respondent in the sample population. Using the new survey, NCA continues to collect information from the families of individuals who are interred in national cemeteries and from funeral directors to measure how these customers perceive the appearance of the cemeteries. This information provides a gauge by which to assess maintenance conditions at individual cemeteries as well as the overall system. The information obtained is analyzed to ensure that NCA addresses those issues most important to its customers. This approach provides us with data from the customer's perspective, which are critical to developing our objectives and associated measures. The measure for cemetery appearance is the percent of respondents who agree that the overall appearance of the national cemetery is excellent.

VA headquarters staff oversees the data collection process and provides an annual report at the national level. Regional and cemetery level reports are provided for NCA management's use. The nationwide mail-out survey provides statistically valid performance information at the national and regional levels and at the cemetery level (for cemeteries having at least 400 interments per year).

(For additional information about the burial program, refer to General Operating Expenses, Volume 4, Chapter 4.)

The Enabling Goal

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

Secretary Priority: *Apply sound business principles and ensure accountability for performance standards.*

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

Although no key performance measures are associated with the enabling goal, there are a wide variety of activities under this goal that will enable us to provide high quality service to our veterans:

- Enhancing accountability for performance
- Enterprise Architecture
- Information security program
- Program evaluation
- Budget account restructuring
- Capital asset management

Enhancing Accountability for Performance

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

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Discussion

VA's performance depends on the contributions of each employee. Therefore, VA is working toward developing more effective accountability systems for programs and for individuals to ensure day-to-day activities remain focused on achieving the Department's strategic goals.

For VA to hold programs and individuals accountable for results and to be successful, we must ensure that:

- performance objectives are clearly stated and effective strategies for achieving those objectives are identified;
- progress against those objectives is regularly measured and reported, and variances acted upon;
- performance is used to manage the organization;
- appropriate recognition, rewards, and incentives are used.

At the Departmental level, the focus has been on the development of a planned, systematic approach to address VA's management and performance agenda, consistent with the President's management agenda to ensure greater accountability for performance. To achieve this objective, Department executives approved the implementation of a new strategic management process that establishes a VA Executive Board (VAEB), a Strategic Management Council (SMC), and six strategic management process groups that oversee the planning and operations of VA's major crosscutting management processes. Major policy and management issues will be vetted in an integrated Departmental forum through the VAEB and SMC prior to being forwarded to the Secretary for decision. These changes will result in a fully integrated strategic management process, binding strategic and performance planning, budget formulation, legislative program development, and program/budget execution.

To further clarify and communicate performance objectives, VA has developed the *Department of Veterans Affairs Strategic Plan for Employees*. The Plan was distributed to all employees in the summer of 2001 and is intended to succinctly communicate to all employees the Department's philosophy and strategic framework, including VA's mission, vision, values, strategic goals, objectives, and performance measures and targets. The *VA Strategic Plan for Employees* serves as a tool for managers and employees at all levels to determine

how their work contributes to the accomplishment of the overall mission of the Department. Managers and employees are encouraged to use this document in the development of individual performance plans to enhance accountability for results.

Employee attitudes and behaviors are important drivers of organizational outcomes such as customer satisfaction, quality, and costs. To assess and improve employee satisfaction, VA administers the VA Employee Survey, determining where opportunities for improvement exist, and developing and implementing integrated improvement plans around these opportunities. By surveying, the Department will better understand employee attitudes and will build employer-of-choice and action planning initiatives, accountability, and support for the performance targets in VA's Strategic Plan.

Veterans Health Administration

VHA annually develops a 5-year strategic plan for the provision of care to eligible veterans through coordinated networks of medical facilities operating within prescribed geographic service-delivery areas. Such plans include provision of services for the specialized treatment and rehabilitative needs of disabled and/or poor veterans.

VHA's strategic planning process integrates the Six for 2007 goals, with their associated strategies and strategic targets, into the daily operations of the health care system. The 22 Networks have the Six for 2007 as the framework for their planning activities as well as the structure for their strategic plans. This framework supplements VHA's comprehensive performance management system that aligns VHA's vision and mission with quantifiable goals, defines measures to track progress in meeting those goals, holds management accountable through performance agreements for achieving established strategic targets, advances quality in the context of patient-centered care while maintaining sound resource management.

Much of the information for VA's Performance Report, VA's Strategic Plan, numerous Congressional reports, and VHA performance and program analyses is derived from the annual Network Strategic Plans.

The planning process is overseen by the Strategic Planning Council (SPC), which is comprised of senior VHA leaders from the field and central office. The SPC is responsible for creating VHA's strategic planning framework, providing planning guidance, and ensuring linkage with the requirements in the Government Performance Results Act.

In the fall of FY 2003, following completion of the annual update of goals, strategies and strategic targets, central office staff will prepare the Strategic Planning Guidance for FY 2005 – 2009 to initiate the Network planning cycle. Draft guidance, approved by the SPC, will be shared with both field and central

office organizations to ensure that final guidance reflects leadership's priorities, strategic directions, and field concerns. The Networks will develop plans based on this guidance and on additional direction from the VHA offices responsible for fiscal resources, human resources, information technology, and capital assets.

This planning system enables the networks to address the unique health care needs of the local veteran population. The central office role is to provide guidance. That permits each Network to develop its own strategic plan, budget, and capital plan, all in response to the mission and services associated with the geography, customer segment, business opportunities, operating barriers and other factors specifically present in the Network.

Although they will address similar problems, the plans will be unique to each Network and will provide a vast array of actions designed to accomplish the Six for 2007 goals, strategies, and strategic objectives. Additionally, Networks may expand the scope of their strategies and resulting actions in response to unique local issues that go beyond central office's planning guidance and strategic objectives.

The final plans will be submitted to central office for review and analysis by VHA's Office of Policy and Planning and each of the Chief Officers, then provided to the Under Secretary for Health for final evaluation. Clarifications/revisions will be obtained at this time. The process will conclude with feedback from both central office and the field concerning the planning process and products, strengths and weaknesses, and recommendations for issues to be addressed in the next strategic planning cycle.

The Under Secretary for Health chartered the VHA Workforce Strategy Team and the VHA Steering Committee for Succession Planning. Both groups were chartered at the end of 2000 and assigned to develop plans for a comprehensive strategy for work force recruitment, retention, and development by the middle of FY 2001. Stakeholders reviewed the reports of both groups and work plans for implementation and deployment of the short- and long-term initiatives are being implemented with the majority of succession planning initiatives scheduled for completion in FY 2003.

The VHA Steering Committee for Succession Planning was responsible for the development of a strategic plan that will enhance the quality of the VHA staff and will promote success in their jobs. The final report laid out a plan that:

- Assessed VHA's human resource management programs against Baldrige Criteria and identified improvement actions.
- Assigned responsibility to appropriate task forces and offices to develop, design, implement, modify, and/or eliminate programs to meet Baldrige Criteria utilizing principles of VHA's High Performance Development Model to achieve or lead to achievement of the following goals:

- Facilitate the recruitment and retention of a talented, committed workforce to enable VA to meet the needs of the veteran population in future years.
- Improve the physical and psychosocial work environment of staff as measured by employee surveys through continuous feedback of results and support for improvement.
- Establish for employees and managers an incentive system that promotes outstanding service to veterans through alignment with and accountability for VHA goal attainment.
- Create an environment based on continuous learning and feedback.

The VHA Steering Committee for Succession Planning was charged with overseeing and coordinating the implementation of a succession plan for VHA. The steering committee benchmarked private and public sector organizations, assessed the current and future workforce of VHA, developed strategies and tactics to address the most critical issues, and developed policy and legislative recommendations that would assist in the administration's succession planning efforts. The plan is linked to the High Performance Development Model and include features that address workforce assessment, definition of career tracks, identification of recruitment strategies, comprehensive leadership training, employee satisfaction, identification of inducements, and incentives and staff development activities and ensures that our diversity goals will be met.

A Succession Planning Deployment work group has been established to oversee the implementation of the recommendations of both committees and multiple succession planning related projects are well underway.

Veterans Benefits Administration

VBA has continued to strengthen its use of a balanced scorecard of performance measures. VBA's balanced scorecard contains the major service delivery performance measures: the speed of claims processing, accuracy, customer satisfaction, unit cost, and employee development. These are measures that mean the most to the veterans we serve, our stakeholders and our employees. Scorecards have been developed for each VBA business line (compensation and pension, education, loan guaranty, vocational rehabilitation and employment, and insurance) to track national performance. In addition, scorecards have been developed for each of the Regional Offices (RO) that roll up to the national level, to ensure a consistent "line of sight" throughout the organization.

To support the performance measurement process, VBA has established an automated Balanced Scorecard, available to all employees via the Intranet. In addition to the actual scorecard for each entity, all supporting data are also available from the same Web site, to provide the capability for in-depth analysis,

trending, and performance management. VBA deploys its Balanced Scorecard as its strategic management system and reports results at both the operational and strategic levels.

VBA has integrated balanced scorecard performance into the executive appraisal system. Each Regional Officer Director is assessed on the percentage of accomplishment in achieving balanced scorecard targets. The assessment is based on the combined weighted achievement of national and RO targeted scores.

An element of the VBA strategy for enhancing accountability is the creation of national performance standards for those who process compensation and pension (C&P) claims. For the first time, all claims processors will have the same performance standards. VBA believes that these standards will assure that all offices address workload and performance issues in a similar manner. Closely related to this is the development of the Systematic Individual Performance Assessment (SIPA). This new tool, which will be tested during FY 2003, will improve the quality of the claims processed by focusing on the quality of work being done by each claims processor. SIPA will measure individual quality and identify training needs. Local management will be able to provide necessary training or take appropriate action to improve the quality of VBA's C&P decision-makers. Both of these initiatives enhance individual accountability within VBA.

National Cemetery Administration

The National Cemetery Administration (NCA) employs a strategic planning model that ensures that strategic goals are linked throughout the organization. Strategic goals are consistent at the national, Memorial Service Network, and cemetery levels. Measurable progress toward meeting NCA's strategic objectives is reported on a regular basis and communicated to all top-level managers. In addition, NCA has developed and is using consistent performance standards for all cemetery directors that are linked to NCA's strategic goals. These performance standards address specific accountability in the areas of customer service and stewardship, employee and self-development, and cemetery operations.

Enterprise Architecture

Enabling Goal: Create an environment that fosters the delivery of *One-VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Discussion

The mission of VA's Enterprise Architecture initiative is to develop and implement an evolutionary, high-performance *One-VA* information technology architecture that is aligned with our program/business goals and enables data integration across the enterprise. VA's Enterprise Architecture will enable us to provide an accessible source of consistent, reliable, accurate, useful, and secure information and knowledge to veterans and their families, our workforce, and stakeholders; to support effective delivery of services and benefits, enabling effective decision-making and understanding of our capabilities and accomplishments. The Enterprise Architecture will support VA's overall strategic goals.

Approach

The Office of the VA Chief Information Officer (VA CIO) is the implementing agent of the Secretary's strategic objective to establish an Enterprise Architecture at the *One-VA* level. This initiative is also driven by a congressional mandate for all agency Chief Information Officers to develop, maintain and facilitate an integrated systems architecture, which was established with the passage of the Clinger-Cohen Act in 1996.

The Enterprise Architecture will drive and support VA's mission by:

- enhancing VA's delivery of service to veterans;
- eliminating the development of redundant or duplicated systems across service divisions;
- improving information technology accountability and cost containment;
- ensuring that the developing information technology asset base is built upon widely accepted industry standards and best practices.

The Enterprise Architecture will provide great latitude to VA system planners, in process and product selection, but it will impose a centralized, system life cycle governance process upon all IT development. This governance will integrate with:

- established VA-wide Capital Investment Planning;

- evolving VA Security Management policy;
- emerging VA Configuration Management processes.

The Enterprise Architecture will ensure that VA's IT development is aligned with and measured by its service to veterans and its support of VA business practices.

The development and governance of the enterprise architecture is a living, evolving process, which requires continuous review to measure its effectiveness in meeting stated objectives and to maintain its alignment with VA business and policy requirements.

At the onset, the VA CIO must develop:

- an architectural repository of system models and documentation in the form of a database and a supporting web-enabled application which spans the full scope of all of VA's application and IT support infrastructure;
- a configuration management database for posting, approving, scheduling and controlling changes across all of the VA IT infrastructure;
- a common object definition repository for posting, negotiating, approving and sharing data definitions across all VA application development initiatives, in order to facilitate the development of interoperable systems.

The Office of the VA CIO is also responsible for:

- developing a modeling and analysis methodology for new IT initiatives;
- maintaining an inventory of all existing applications and infrastructure subsystems;
- assisting developers in building and using models within the architecture;
- performing the necessary review and analysis to assure that new initiatives are in compliance with the architecture and are aligned with the mission objectives of VA;
- assisting developers in meeting Strategic Management Council accountability requirements;
- facilitating and hosting interdepartmental review committees for IT governance, IT configuration management and technical standards approval;
- conducting a periodic review and adjustment of the Enterprise Architecture objectives (in the form of a To-Be Architecture) to ensure that they are aligned with VA business objectives.

Implementation

The 2003 budget for the enterprise architecture program, administered by the Office of the VA Chief Information Officer, will be outlined in a formal capital investment initiative for approval by the Strategic Management Council. The current estimate for 2003 is for $11.8 million, which would support 16 FTE at various grade levels, travel, contractual services, supplies and equipment. Since the enterprise architecture is an out-of-cycle initiative, funds must be redirected from administrations and staff offices to support the FY 2002 activities.

Projects/Tasks that are currently underway or under development include the following:

- Developed the One-VA Enterprise Architecture Strategy and Implementation Plan. Plan was unanimously approved.
- Revised the Information Technology Strategic Plan, achieving alignment with Enterprise Architecture.
- Organized the Enterprise Architecture Working Group out of VA National CIO Council participants.
- Organized and developed the Information Technology Board and organized the Enterprise Architecture Committee.
- Began development of the Implementation Plan for the Office of the Chief Architect and a Users Guide for Enterprise Architecture field implementation.
- Developed and obtained approval for the FY 2003 Capital Investment Plan, Staffing Plan, and Budget for the Chief Knowledge Office/Office of the Chief Architect; including the Enterprise Architecture Service and the Database Management Service.
- Began recruitment and staffing for the Office of the Chief Architect.
- Began creation of an Enterprise Architecture Repository, development of Enterprise Architecture models, began a baseline inventory and the development of the Department of Veterans Affairs (VA) As-Is Architecture.
- Began design and development of an Integrated Information Resources Management approval database application in support of the Enterprise Architecture, Capital Investment Process and Program Management Oversight Office review processes and the Information Technology Board and Senior Management Council approval processes.
- The Office of the Chief Architect is also currently participating in major VA initiatives such as the Office of Information and Technology

Continuity of Operations/Continuity of Government planning, Command and Control Planning and Network Redesign.

VA's overall direction and schedule for implementation of the agency-wide enterprise architecture program is reflected in the document: *Enterprise Architecture: Strategy, Governance, & Implementation.* The major milestones are:

	Start		Complete	
Milestones	**Planned**	**Actual**	**Planned**	**Actual**
Submit FY 2003 Budget Request	Aug 01	Aug 01	Aug 01	Aug 01
Establish IT Board and Architect Council	Aug 01	Aug 01	Oct 01	Oct 01
Establish Implementation Team	Sep 01	Sep 01	Dec 01	Dec 01
Establish & Staff Office of Chief Architect	Sep 01		Apr 02	
Create Board of Outside Experts	Sep 01	Jun 02	Oct 01	Sep 02
Develop EA Communications/Marketing Plan	Sep 01	Sep 01	Dec 01	Dec 01
Identify & Submit Request for 2002 Funding Through Redirection	Oct 01	Oct 01	Dec 01	Nov 01

Once implemented, the Enterprise Architecture will be used to review and validate a number of proposed projects that are designed to improve service to veterans. The proposed projects are aimed at providing valid, secure information that is readily available to both veterans and staff. The projects include information security, telephone services, a registration/eligibility system, electronic records, an enterprise veteran index, and a metadata registry.

Some of these projects, such as the registration/eligibility system and the enterprise veteran index, are aimed at eliminating confusing and redundant data, while others, such as the telephone services and electronic records will make it easier to access information. Implementing these projects will require that certain VA information systems successfully integrate or exchange information in a manner that is transparent to VA customers regardless of where the information originates, how it is being transmitted, or how it is managed.

The *One-VA* Enterprise Architecture is a cross-cutting, collaborative process, which is intended to guide the operational, tactical, budget, and capital planning for future information technology initiatives Department-wide, while providing the maximum possible design latitude to the administrations and each project sponsor. Actual implementation of projects in the architecture will be staged over the next 3 to 5 years.

Information Security Program

Strategic Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance.

Discussion

The purpose of the Information Security Program is to provide services to the veteran that: 1) protect the confidentiality, integrity, and availability of their private information; 2) enable the timely, uninterrupted, and trusted nature of services provided; and 3) provide assurance that cost effective cyber security controls are in place to protect automated information systems from financial fraud, waste, and abuse.

Since 1997, when the Office of Inspector General (OIG) found that VA IT security controls constitute a "Material Weakness" under the Federal Manager Financial Integrity Act (FMFIA), scrutiny of VA systems has steadily increased. Both the OIG and the General Accounting Office (GAO) have consistently uncovered security control shortcomings resulting in a series of negative reports and comments concerning VA automated information systems.

The 1997 findings are captured in the 1998 report cited in the table below. The GAO and IG testimony in September 2000, and the GAO report in the same month are essentially "roll-ups" of all the cyber security issues observed or reported between 1997 and September 2000.

On April 4, 2001, hearings were held by the Subcommittee on Oversight and Investigations of the Committee on Veterans Affairs of the U.S. House of Representatives. Congressman Buyer, the Subcommittee Chair, cited a report from the General Accounting Office (GAO) regarding the state of IT security in VA.

Date	Type	Title
23-Sep-98	Report	Information Systems - VA Computer Control Weaknesses Increase Risk of Fraud, Misuse, and Improper Disclosure
08-Jun-99	Report	VA Information Systems - The Austin Automation Center Has Made Progress in Improving Information System Controls
04-Oct-99	Report	Information Systems - The Status of Computer Security at the Department of Veterans Affairs
11-May-00	Testimony	Information Technology - Update on VA Actions to Implement Critical Reforms
30-Jun-00	Letter	Information Security - Software Change Controls at the Department of Veterans Affairs
16-Aug-00	Report	Information Technology - VA Actions Needed to Implement Critical Reforms
08-Sep-00	Report	VA Information Systems - Computer Security Weaknesses Persist at the Veterans Health Administration
21-Sep-00	Testimony	VA Information Technology - Progress Continues Although Vulnerabilities Remain
04-Apr-01	Testimony	VA Information Technology - Important Initiatives Begun, Yet Serious Vulnerabilities Persist

Created on March 25, 2001, with the naming of an Associate Deputy Assistant Secretary (ADAS) for Cyber Security, the Office of Cyber Security (OCS) is assuming the responsibility for turning around a legacy of inattention to security requirements. OCS has an authorized staff of 18 and an operating budget of $17.5 million.

In FY 2002, the three administrations will contribute $21 million from base budgets to the CIO's security program for OCS funding as approved by the Strategic Management Council. For FY 2003, OCS has an authorized staff of 19 and an operating budget of $22.2 million.

Using the central fund will afford VA the opportunity to report that many security efforts are now consistently pursued agency-wide, and in ways that realize significant economies of scale. Emphasis is on security controls that correspond to significant shared risks across the Department. A variety of contracted professional services, hardware, software, and commercial training services have been acquired under the fund to achieve the objectives of the agency-wide security program.

VA is now implementing an enterprise-wide, integrated anti-virus solution that will remove most of the manual intervention that presently plagues rapid distribution of new anti-virus updates to over 150,000 desktops and servers at over 800 locations. Every VA office will be covered under a single and uniform contract and service vehicle for its anti-virus protection.

VA has launched a major contract to develop a certification and accreditation program to bring discipline, formality, and technical excellence to the security planning activities of offices in the design of their systems and applications.

All VA facilities now have access to a single security incident response service to which they may report security incidents and receive advice related to scope, effect, and suggested remedies. National programs in security training and education of computer professional staffs have been launched employing commercial sources of Web-based study curriculums and the satellite bandwidth available through the VA Learning University.

VA fully realizes the value a central security fund gives in allowing the Department to set definite objectives for consistent improvements across all offices. These improvements might otherwise be difficult to achieve due to the variety of viewpoints in program offices and facilities about the importance of security. The fund also achieves efficiencies and increases assurance in controls by performing tasks once and centrally that might otherwise have to be performed repeatedly by multiple program offices or facilities. In the coming year, VA intends to move ahead under this fund with other uniform approaches to intrusion detection technology, public key infrastructure, and other security software solutions.

The VA overall schedule for implementation of the agency-wide cyber security program will remove the identified FMFIA material weaknesses and be compliant with the Government Information Security Reform Act (GISRA) and the Financial Information System Control Audit Manual (FISCAM). The major milestones are as follows:

	Start		**Complete**	
Milestones	**Planned**	**Actual**	**Planned**	**Actual**
Operate entity-wide security awareness program	Dec 99	Dec 99	Mar 00	Mar 00
Complete an entity-wide risk management plan	Dec 99	Dec 99	Aug 00	Jul 00
Institute ISO training program	Mar 00	Mar 00	Dec 00	Dec 00
Develop certification and accreditation program	Jan 00	Jan 00	Jan 01	Jan 01
Revamp security policies into usable framework	Jun 01	Jun 01	Jul 02	
Capital Investment Application submission to the Strategic Management Council	May 01	May 01	Sep 01	Sep 01
GISRA report and corrective action plans to Office of Management and Budget	Jun 01	Jul 01	Sep 01	Sep 01

Program Evaluation

Enabling Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance.

Purpose

Program evaluations are used to assess, develop, and/or update program outcomes, goals, and objectives and to compare actual program results with established goals. Program evaluations assess the accomplishment of general goals and objectives included in the Department's Strategic Plan and contribute to the revision of such goals and objectives. The VA Strategic Plan includes a description of how program evaluations impact the Department's goals and objectives, along with a schedule for future evaluations. Outcome measures identified or enhanced during the conduct of program evaluations are included in annual performance plans and will be used to continually refine the Strategic Plan. VA's goal is to re-evaluate programs on a 10-year cycle.

Program evaluations assess the:

- extent to which program outcome goals are being met and the extent to which current performance affects program outcomes;
- interrelationships between VA programs and other Federal programs to determine how well these programs complement one another;
- needs and requirements of veterans and their dependents in the future to ensure the nature and scope of future benefits and services are aligned with the changing needs and expectations of veterans and their dependents;
- adequacy of outcome measures in determining the extent to which the programs are achieving intended purposes and outcomes.

In addition, program evaluations fill existing data gaps, particularly relating to outcome information that can only be obtained directly from veterans and beneficiaries. These studies also provide an opportunity to objectively and independently analyze VA programs and yield information useful in developing policy positions. Proposals for future benefit packages and improvement in existing programs evolve from the process of evaluating programs.

Methodology

Consistent with legislative intent and 38 CFR §1.15, the Office of Policy and Planning, an organizational entity not responsible for program administration, is responsible for the operational aspects of program evaluation providing an

unbiased, third party perspective. Within VA, most program evaluations are conducted through contracts, which further enhances third-party objectivity. In all cases, the evaluations are managed using a team approach that includes program officials. For each evaluation, an evaluation team develops the statement of work and oversees the execution of the contract. Pre-evaluation planning and post-evaluation discussion of results and related recommendations involve our major stakeholders including OMB, Congressional staff, and veterans service organizations.

Status

The following is a list of program evaluations, by strategic goal:

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

- Prosthetics and Sensory Aids Program (PSAS) (contract awarded in 2001 and scheduled for completion in 2002)
- Blind Rehabilitation (scheduled to begin in 2002)
- Disability Compensation (scheduled to start in 2003)
- Vocational Rehabilitation (scheduled to start in 2004)

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

- Home Loan Program (started in 2002 and planned for completion in 2003)

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

- Cardiac Care Programs (scheduled for completion in 2002)
- Non-Service Connected Pension for Veterans and Survivors, and Parents' Dependency and Indemnity Compensation (contract awarded in 2001 with completion expected in 2003)
- Seriously Mentally Ill and Post Traumatic Stress Disorder (scheduled to begin in 2004)
- Spinal Cord Injury (scheduled to begin in 2003)

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

- Emergency Preparedness (started in 2002)

Budget Account Restructuring

Strategic Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business practices and ensure accountability for performance.

Performance Goal

Implement the new account structure with the 2004 budget.

Discussion

VA and OMB established a joint working group to identify options for restructuring the Department's budget accounts. The joint VA/OMB working group developed four account restructuring options. Using the best features of each of these options, they proposed a new account structure based on identifying the costs associated with nine VA programs: medical care, research, compensation, pension, education, housing, vocational rehabilitation and employment, insurance, and burial. Medical education, which previously was identified as a separate program, will be included as a subset of the medical care program. We have drafted sample appropriations language based on the proposed account structure. OMB is reviewing the language for appropriateness. Among the benefits of budget account restructuring are to:

- more readily determine program costs;
- shift resource debates from inputs to outcomes and results;
- eventually make resource decisions based on programs and their results rather than on other factors;
- improve planning, simplify systems, enhance tracking, and focus on accountability;
- prioritize capital investments against recurring expenditures.

In January 2001, we met with staff from the Senate and House Appropriations Committees to inform them of our proposal and to get their feedback on its utility. They expressed support for the concept of restructuring and simplifying VA's budget accounts. We will continue to work with our stakeholders in addressing specific implementation issues associated with this proposal.

Core Financial and Logistics System (coreFLS) will support budget account restructuring. CoreFLS will replace VA's core accounting system, Financial Management System (FMS), and up to 33 interfacing applications. CoreFLS will

allow the Department to better align its resources with program activities and improve automated analytical and reconciliation tools. As with the new budget account structure, full implementation of coreFLS is scheduled for FY 2004.

Capital Asset Management

The capital investment process was created in June 1997 to foster a Departmental approach to the use of capital funds and to ensure all major capital investment proposals, including high risk and/or mission-critical projects, are based upon sound economic principles and are fully linked to strategic planning, budget, and performance goals. The Department has demonstrated excellent progress in implementing both the principles and practices of performance-based acquisition management. VA is the first civilian agency to develop an agency-wide capital planning process which allows for investment trade-offs, both among and between, categories of assets, i.e., medical and non-medical equipment, information technology, infrastructure, and leases. The VA Capital Investment Panel (VACIP) makes recommendations to the Strategic Management Council (SMC) on capital investments submitted by the major organizations of the Department. The projects are then submitted to the Secretary's Executive Board for final approval. This final listing of projects is integrated into a unified comprehensive VA Capital Plan consistent with the agency's mission, goals, objectives, priorities, and strategies, and submitted in support of the annual budget request.

Each proposal includes a description of the capital investment and how it supports the Department's strategic goals. Proposals were first validated to ensure the application criteria were adequately addressed prior to scoring. Investment proposals were scored and submitted to the SMC and the Secretary's Executive Board for review and approval. Proposals were evaluated based on the following criteria: customer service, return on taxpayer investment, high performing workforce, risk, special emphasis programs, seismic threat, secretarial priorities, and strategic alignment. The special emphasis program criterion addresses Congressional concern regarding the programs of spinal cord rehabilitation, seriously chronically mentally ill, traumatic brain injury, blind rehabilitation, post-traumatic stress disorder, and prosthetics. The acquisition and use of these capital assets will enhance the Department's ability to attain its strategic goals and perform its mission.

For the 2003 review process, a total of 29 proposals were submitted for review, 23 of which were scored. The following projects have been approved and submitted as part of the budget request for 2003.

Palo Alto Building 2 Seismic Correction

Project Description: This project involves the renovation of Building 2 at the Palo Alto VA Medical Center, a 2-story 77,000 Gross Square Feet (GSF)

inpatient building constructed in 1960. Renovations will include seismic corrections to the entire building, correction of patient privacy deficiencies on one nursing unit in C Wing, correction of fire-safety deficiencies in C Wing, and functional improvements on one floor for the Sierra Pacific Network's Mental Illness Research, Education and Clinical Center (MIRECC). Completion of the project will allow occupancy of the building by three 26-bed psychiatric nursing units as well as the MIRECC offices and dry labs.
2003 Budget Request: $14,013,000

Palo Alto Bldg. 4 Seismic Consolidated Research Complex

Project Description: This project will renovate Building 4, a 3-story 75,000 GSF research building constructed in 1960. Renovations will include seismic corrections to the entire building, correction of fire-safety deficiencies throughout the building, and functional laboratory improvements in areas formerly occupied by inpatient psychiatric wards. Building 205, a 72,300 GSF building on the Menlo Park Campus will be demolished. Most research personnel, housed in Building 205 will be relocated to Building 4. This includes members of the Geriatric Research and Education and Clinical Center (GRECC), Health Services Research and Development (HSR&D) and the Cooperative Studies Program. Completion of the project will allow consolidation of a large segment of wet and dry lab research programs within a cluster of only two or three major buildings at the Palo Alto campus.
2003 Budget Request: $21,750,000

Pittsburgh New Cemetery

Project Description: The project will develop approximately 15,000 gravesites for casket interments including 2,500 pre-placed crypts, a 3,000-niche columbarium and 1,000 in-ground sites for cremated remains. This first phase of development of about 80 acres will provide for approximately 10 years of burial, through 2015. In addition to gravesite development, the initial construction is planned to include an entrance area, a flag/assembly area, two committal service shelters, an information center with public restrooms, an administration and maintenance complex, road system, utilities, signage, site furnishings, fencing and landscape plantings.
FY 2003 Budget Request: $16,400,000

- *Excludes C&P costs for crypts ($750,000)*

San Francisco Bldg. 203 Seismic Correction

Project Description: This project will seismically retrofit Building 203, a five-story, 335,000 GSF concrete structure, housing all acute care beds at the San Francisco VA Medical Center in order to meet current VA standards for seismic safety. Existing lateral-force resisting elements will be strengthened, supplemental members added, and non-structural systems and equipment braced. Minor functional improvements for patient privacy, disability access,

and building efficiency will be included. Building 203 is ranked number 1 in the Extremely High-Risk list of the VA-Degenkolb Seismic Study.
2003 Budget Request: $31,000,000

Southern Florida New Cemetery

Project Description: The project will develop approximately 23,000 gravesites for casket interments, 15,000 niches of columbaria and 3,100 in-ground sites for cremated remains. This first phase of 65 acres development will provide burial capacity for approximately 10 years, through 2014. In addition to gravesite development, the initial construction is planned to include an entrance area, a flag/assembly area, four committal service shelters, a public information center with restrooms, an administration and maintenance complex, road system, utilities, signage, site furnishings, fencing and landscape plantings.
2003 Budget Request: $23,300,000

- *Excludes C&P costs for crypts ($6,000,000)*

West Los Angeles Bldg. 500/501Seismic Correction

Project Description: This project involves the seismic retrofit for Building 500 and non-structural seismic corrections to Building 501. Building 500 is comprised of approximately 937,000 GSF and is ranked number seven in the category of Exceptionally High Risk Buildings (EHR) in the seismic study developed by Degenkolb Engineers. The replacement cost for Building 500 has been estimated at $250,000,000.

Greater Los Angeles Healthcare System (GLAHS) including the West Los Angeles VAMC, has the largest and most diverse patient demographics in the entire VA system. Building 500 provides most of the required inpatient beds, critical care beds and inpatient Operating Rooms for the entire GLAHS which includes: Sepulveda Ambulatory Care and Nursing Home, Santa Barbara Ambulatory Care Center, Bakersfield Ambulatory Care Center, Los Angeles Ambulatory Care Center, and over eight community-based outpatient clinics.
2003 Budget Request: $27,200,000

Willamette Cemetery Expansion

Project Description: The project will develop approximately 10,000 columbaria niches. In addition to the new columbarium, the project will include the design and construction of the following improvements to the cemetery site: approximately 4,500 pre-placed crypts; drainage improvements; a new public restroom building, and automated gravesite locator to enable weekend access for visitors.
2003 Budget Request: $8,400,000

- *Excludes C&P costs for crypts ($1,350,000)*

Management Reforms

Management Reforms
Budget and Performance Integration: *Including Compensation and Pension Claims Processing, Hepatitus C, Capital Asst Realignment for Enhanced Services (CARES)*
Strategic Management of Human Capital
Competitive Sourcing
Improving Financial Performance
Expanding Electronic Government
Making Greater Use of Performance-Based Contracts
Expanding On-Line Procurement and E-commerce
Improving Coordination of VA and DoD Programs and Systems
Faith-based/Community

Budget and Performance Integration

The Department of Veterans Affairs has made significant progress in the integration of budget and performance during the past five years. Each year, the budget has presented better, higher quality performance information for all program activities. In our 2002 Performance Plan, we showed resource requirements (obligations) by program, and by strategic goal and objective. Because we do not yet have sophisticated financial tools, we can only approximate the costs at the present time. With this Performance Plan, we take the next step in improving the integration of budget and performance information by focusing on three important programs or activities as pilot projects in performance budgeting:

- Disability compensation claims processing
- Hepatitis C
- Medical care infrastructure reform through CARES

We will use the lessons learned from these three pilots to develop and implement a plan to incorporate performance budgeting principles for all other VA programs.

Compensation and Pension Claims Processing

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

Secretary Priority: Provide accurate decisions on compensation and pension rating-related claims within 100 days.

Performance Goals

1. Complete rating-related actions on compensation and pension claims in an average of 165 days. (*This number is the average cumulative for the fiscal year. We expect to achieve 100 days processing time during the last quarter.)*
2. Attain an 88 percent national accuracy rate for core rating work.

Description

Improving the quality and timeliness of claims processing is a Presidential priority. The Secretary of Veterans Affairs has set a goal of a monthly average of 100 days to process rating-related claims during the last quarter of FY 2003, while continuing to improve quality.

Over the last several years, VA has developed and implemented major initiatives, established cooperative ventures with other agencies, and used technology and training to address this issue. For example, to address the timeliness and claims processing backlog, the Secretary has launched a major

effort to resolve 81,000 of our oldest claims, ones that have been pending for more than a year. A key element of that effort involves a special team in Cleveland that will tackle many of these oldest claims over an 18-month period. Its first priority will be the long pending claims of veterans who are 70 years of age and older. The team will then be moving on to claims of other veterans who also have been waiting for a decision for more than a year. At the same time, VBA will be using the nine Resource Centers, designed to add processing capacity to each area of the country, to contribute to the goal of resolving these oldest claims. The team became fully operational in November 2001.

Accuracy of decision-making is also a top priority. Currently the accuracy rate for rating related workload is 72 percent, while non-rating related work is at 59 percent and fiduciary work is at 66 percent. We will improve timeliness without sacrificing accuracy.

For more information about our claims processing priority, see pages XX-XX.

Resources: $848,767,000

Hepatitis C

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

Secretary Priority: Provide high quality health care that meets or exceeds community standards.

Performance Goals:

1. Increase percent of patients evaluated for risk factors for hepatitis C to 61%.
2. Increase the percentage of all patients tested for hepatitis C subsequent to a positive hepatitis C risk factor screening to 65%.
3. Increase the percent of patients with hepatitis C who have annual assessment of liver function. (Performance goal to be determined.)

Discussion

Hepatitis C is a major public health problem in the United States. The Centers for Disease Control and Prevention estimates that nearly 4 million Americans are infected with the hepatitis C virus, many of whom are unaware that they have been exposed. Approximately 30,000 new infections occur annually. Hepatitis C is a high priority for VA. Since 1998, VA has undertaken a program to identify, screen, test, and treat veterans for hepatitis C.

Since the beginning of 2001, VHA's Office of Public Health and Environmental Hazards has been responsible for coordination of VA's hepatitis C programs. This group has initiated activities including a comprehensive

review of data sources, creating a nationwide data registry, developing an informational brochure in cooperation with the American Liver Foundation, improving communications, fostering research, and taking other actions to enhance VA's capabilities to identify and treat veterans suffering from hepatitis C.

In February 2001, VHA published a directive on the National Hepatitis C Program that outlined VA's comprehensive approach emphasizing clinical care and prevention through testing, counseling, research, and education. Since then, the Public Health Strategic Health Care Group has hired a new National HIV/Hepatitis C Program Director and a National Clinical Coordinator. A Program Specialist for the National HIV/Hepatitis C Program office will soon be hired. Many additional initiatives have been undertaken, including the following:

National Hepatitis C Screening and Testing Program:

- VA has created the largest hepatitis C screening and testing program in the world. In FY 2001, VHA established that a baseline of 51% of patients had been evaluated for risk factors for hepatitis C.
- An Under Secretary for Health Information Letter was issued in June 2001 transmitting updated Hepatitis C Screening and Counseling Guidelines.
- A VA National Video Conference on Hepatitis C Screening and Testing was taped in August and is being broadcast three times nationally.

Hepatitis C Communications:

The Public Health Strategic Health Care Group has established multiple communications links with the field concerning VA hepatitis C programs. These include:

- Formation of a Hepatitis C Technical Advisory Group with 25 members and monthly conference calls.
- Establishment of a Hepatitis C Lead Clinician as a point of contact for hepatitis C care and issues in each VAMC.
- Creation of a Hepatitis C E-mail list of over 800 front-line providers.
- Establishment of a monthly Hepatitis C Hot Line call for front-line providers to use to address any issue or question about VA hepatitis C programs or care.
- Publishing of a regular VA Hepatitis C Newsletter.
- Renovation of VA's Hepatitis C Program website at www.va.gov/hepatitisc.

Hepatitis C Field Based Resource Centers:

Four Hepatitis C Field Based Resource Centers were funded after a rigorous selection process in which twenty sites submitted applications. The goal of this program is to take advantage of field-based expertise to develop products and programs that will improve hepatitis C care in every facility. The centers will be funded beginning on Jan 1, 2002. The four centers will work closely with the central program office and with each other to produce programs and exportable products in the following areas:

- Hepatitis C Patient Education
- Hepatitis C Clinician Training and Skills Building
- Hepatitis C Prevention (primary and secondary) and
- VA Hepatitis C Models of Care and Best Practices

Hepatitis C Registry

The Public Health Strategic Health Care Group is working with the Chief Information Office to create a new National Hepatitis C Registry. This will identify and track all veterans with hepatitis C who use the VA health care system. Once established, the Hepatitis C Registry will allow improved local patient care management, quality improvement analyses and programs, and system-wide program monitoring and management.

Performance Measurement

VHA is aware of the need to establish and monitor goals for quality of care in hepatitis C. The hepatitis C program staff in this office has undertaken the task of implementing a plan that will meet all needs required to (1) provide hepatitis C screening and testing to any veteran who may be at risk; and (2) develop an appropriate hepatitis C risk prevention program. Two critical steps in meeting these goals are a comprehensive review of data sources and identification of areas for improving data collection and management, and a proposal to create a new nationwide electronic registry to improve data management.

Since no comprehensive system was in place to collect information about actual workload and costs associated with hepatitis C care, previous VHA projections about prevalence and treatment rates were based on incomplete data collection and on formulas that relied on untested assumptions. Although the assumptions had been adjudged reasonable and sensible, actual performance appears to have varied considerably from the projections. Although we have established appropriate performance measures and established numerical goals where sufficient baseline data exist, we expect to significantly refine our projections as data collection and management capacity improves

Resources: $111,130,000

Capital Asset Realignment for Enhanced Services (CARES)

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

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Performance Goal

Attain a 30% cumulative reduction in excess capacity as a result of CARES. Total excess capacity will be identified by the CARES initiative.

Description

The CARES program will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets to support the delivery of health care services. Through CARES, VA will optimize care delivery in terms of both quality and access.

In March 1999, the General Accounting Office (GAO) reported that the VHA could significantly reduce the funds used to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets. In response to GAO's report and a subsequent congressional hearing, VHA initiated development of the CARES process.

Once CARES option(s) are finalized, two groups of initiatives will exist: one requiring little or no capital to implement, and a second, which may require significant capital investments. The CARES funds will enable VA to fund advance planning, design development, construction documents, and construction for major, minor and NRM capital initiatives stemming from the CARES recommendations.

A CARES Phase I (VISN 12) decision is anticipated by mid FY 2002, followed by the development of a formal Implementation Plan. Implementation will minimally be a five-year process. Subsequent phases and their associated schedules will be identified during FY 2002.

The efficiencies from CARES may generate significant savings, mostly from operational right sizing. Savings generated by CARES implementation will be reinvested into the provision of direct clinical health care service enhancements (quality, access and services to meet the underserved, unmet needs of eligible veterans). It should be noted that the CARES process would identify potential space for reduction only. It will not reduce the space VA is responsible for maintaining and operating, which can only be accomplished through a variety of investments by both VA and possibly third party investors.

VHA is developing a performance measure to monitor changes taking place in the capital infrastructure during the CARES process. This performance goal focuses on reducing space no longer required by the system.

Resources: $40,000,000

Strategic Management of Human Capital

Enabling Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Performance Goal

The Department will develop workforce planning performance goals and measures as part of its Workforce Plan, to be completed in 2002, and as part of its Restructuring Plan, to be submitted with the 2003 budget.

Discussion

As a result of an anticipated upswing in retirements, VA is facing a potentially major crisis within the next few years to ensure we can maintain a skilled workforce to meet the Department's needs across a variety of programs. For instance, by 2005**:**

- 98 percent of VHA senior executives will be eligible for early out and optional retirement.
- 88 percent of VHA GS-15's and 94 percent of GS-14's will be eligible for early out and optional retirement.
- 53 percent of NCA staff will be eligible for early out and optional retirement.
- Overall, 49 percent of the workforce will be eligible for early out and optional retirement.

Further, rapid changes in technology, an increasingly diverse labor pool, and different work expectations by younger workers are forces that strongly suggest new recruitment and retention practices must be adopted to meet program goals. Without addressing these changes in the workforce, the Department's ability to provide continued care to our nation's veterans is threatened. In order to remain competitive and become an employer of choice, the Department must design and deploy a process that will enable it to systematically consider all factors that bear upon its ability to develop a competent and diverse workforce capable of accomplishing the Department's mission.

To address this issue, VA is establishing a collaborative approach to design and implement a workforce planning strategy that ensures the Department has a competent and diverse workforce to serve veterans and their families, today and in the future. VA has made great strides in developing this workforce planning process since last year. For example, the Department has completed an initial workforce analysis, including demographic data and skill assessments.

Although VA has made substantial progress, additional work is still required. To fully implement an integrated workforce planning process, the Department is undertaking a number of new initiatives:

- Develop a Departmental Workforce and Succession Plan that will articulate VA's corporate vision for workforce planning and identify specific strategies to address the recruitment, retention, and development issues within the Department.
- Explore the use of emerging technologies and marketing techniques to recruit and hire a highly qualified and diverse workforce.
- Implement a workforce data reporting system to give VA leaders and analysts access to valuable information for workforce planning and human capital management purposes.
- Develop a comprehensive, strategic initiative to address workforce planning education for VA leaders.
- Identify an approach to workforce forecasting so managers not only have access to workforce data, but also can make reliable predictions about future behaviors based on past trends.

The overall goal of VA's workforce planning initiative is to create an ongoing process that is integrated with VA's strategic and budget planning cycles. Subsequently, VA can predict future workforce trends, thereby averting potential crises. The following discussion describes the Department's workforce restructuring activities and the workforce planning initiatives being implemented in each of the Administrations.

De-layering Management Levels to Streamline Organizations

VA has made significant strides in reducing and de-layering management levels. The Department continues to lead the Federal Government in its supervisor to employee ratio. As of September 30, 2000, VA's supervisor to employee ratio was 1 to 11.9, while the Government-wide average was approximately 1 to 8. VA's ratio includes over 5,000 Title 38 physicians, nurses, and other health care professionals whose primary duties are to provide direct patient care, but who also have supervisory responsibilities. If Title 38 supervisors are excluded, the ratio of supervisors to employees is 1 to 17.1.

We have also decreased the number of senior executives and reduced grades GS-14/15 as part of the Department's senior level reduction plan. In addition, VA has established team leader/coach positions and developed team approaches to the management of substantive administrative and clinical programs.

In order to further our streamlining activities, VA chartered a task force in February 2001 to develop a 5-year workforce restructuring plan. This group of senior executives from across the Department is working with each VA

organization to develop a plan that will identify opportunities for additional de-layering, streamlining, and restructuring in order to continue VA's efforts to become more citizen-centered. Critical to the success of this effort will be the input and concurrence of the affected VA organizations.

De-layering can only be successful by ensuring that a strong focus remain on providing quality customer service to our Nation's veterans and their families, and being attentive to the concerns of our stakeholders such as Congressional oversight committees, veterans service organizations, and others.

Veterans Health Administration

The Under Secretary for Health chartered two work groups specifically charged with workforce planning: the VHA Workforce Strategy Team and the VHA Steering Committee for Succession Planning. Both groups were chartered at the end of 2000 and assigned to develop plans by the middle of FY 2001. Stakeholders are reviewing the reports of both groups and work plans for implementation and deployment of the short- and long-term initiatives are in development.

The VHA Workforce Strategy Team was responsible for the development of a strategic plan that will enhance the quality of the VHA staff and will promote success in their jobs. The final report laid out a plan that:

- Assessed VHA's human resource management programs against Baldrige Criteria and identified actions that would bring VHA programs into compliance.
- Assigned responsibility to appropriate task forces and offices to develop, design, implement, modify, and/or eliminate programs to meet Baldrige Criteria and achieve or lead to achievement of the following goals:
  - Facilitate the recruitment and retention of a talented, committed workforce to enable VA to meet the needs of the veteran population in future years.
  - Improve the physical and psychosocial work environment of staff as measured by employee surveys.
  - Establish for employees an incentive system that promotes (including managers) outstanding service to veterans and accountability for VHA goal attainment.
  - Create a continuous employee-learning environment, based on VHA's High Performance Development Model.

The VHA Steering Committee for Succession Planning was charged with overseeing and coordinating the implementation of a comprehensive succession plan for VHA. The steering committee benchmarked private and public sector

organizations, assessed the current and future workforce of VHA, developed strategies and tactics to address the most critical issues, and developed policy and legislative recommendations that would assist in the administration's succession planning efforts. The plan is linked to the High Performance Development Model and includes features that address workforce assessment, definition of career tracks, identification of recruitment strategies, comprehensive leadership training, employee satisfaction, identification of inducements, and incentives and staff development activities, and ensures diversity is appropriately considered.

A deployment work group has been established to initiate and monitor the process of implementation of the recommendations of both work groups.

Veterans Benefits Administration

Workforce planning has been a targeted focus of VBA for the past several years. Current initiatives that support this focus include:

- Development and implementation of a Human Resources Information System that is a data analysis tool for field and headquarters managers and analysts. This type of system will ensure one common data source for counts and trends of FTE, and events such as accessions, retirement predictions, etc. It will enable managers to have as much aggregate information about their employees as they do about their workload. Further, it will enable data-based workforce decisions.
- Development and implementation of a leadership competency system, to include valid behavioral statements, to support VBA's development of its leadership cadre at executive, division chief, and first-line levels. The system will form the basis of hiring, advancement, and development strategies for positions responsible for VBA's mission and workforce.
- Ongoing design and implementation of initiatives in business lines and staff offices related to new leadership and technical career paths. These initiatives will be based on future program and field needs and on competencies. Management has chartered several of these initiatives, and program and operations offices have taken initial steps.

National Cemetery Administration

NCA has participated as a pilot organization in the VA Workforce Planning Project. In conjunction with the Office of Human Resources Management, NCA used VA's Workforce Planning Model and successfully established a base profile on workforce needs focusing on the cemetery directors. As a result, NCA has developed a plan to ensure that the organization has a cadre of fully trained and competent cemetery directors ready to lead NCA in the 21st century. NCA's accomplishments and future goals in this area include:

- ***Cemetery Director Intern Program*:** New position descriptions, competencies, training guides, new sites and mentors, on-site training, classroom training, and technical and leadership skill development have all been incorporated into the improved Cemetery Director Intern Program. The intern program vacancy announcement was posted and has closed. In order to ensure a cadre of cemetery directors for the future, NCA accepted applications for the GS-7, GS-9, and GS-11 levels. Over 140 applications were received and NCA selected six interns who began training in January 2002.

  The trainee program will be announced periodically to permit for an established cadre of well-trained and competent individuals to fill positions as others retire or separate.

- ***Specialized Experience:*** NCA's analysis revealed that the definition of specialized experience necessary for qualification as a cemetery director or cemetery director intern was much too restrictive, resulting in a very limited pool of applicants. For example, it did not allow human resource specialists the opportunity to qualify the majority of recently retired military officers. As a result, NCA subject matter experts have modified the definition of specialized experience necessary for qualification as a cemetery director or cemetery director intern. Specifically, direct cemetery management experience was traditionally required in order to qualify for the position. The panel of subject matter experts reviewed the competencies and skills necessary for success and determined that a definition that focuses on leadership and managerial qualifications is a more appropriate indicator of the skills needed for the job. As a result, a candidate must now demonstrate experience in budget, finance, human resources, contracting, supervision, and procurement to qualify.

  This change was implemented approximately two years ago for cemetery director positions. The number and quality of cemetery director candidates have improved dramatically. NCA management believes this is an indication of the quality of candidates received for the Cemetery Director Intern Program, as well.

- ***Future Actions*:** As a result of the success of the workforce planning pilot on the cemetery director positions, NCA will apply the process and lessons learned to other occupations in need of the same attention.

Competitive Sourcing

Enabling Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Performance Goal

Increase the cumulative total of competitive sourcing to 15 percent of commercial activities by the end of 2003.

Discussion

In response to the OMB Directive M-01-15 on competitive sourcing, VA intends to support the administration's goals through a variety of approaches. VA has been actively pursuing several avenues over the last few years to improve both the efficiency and effectiveness of our operations.

OMB has issued guidance to the heads of agencies providing a competitive sourcing performance target for 2002. This performance target requires that agencies complete competitions, or directly convert to performance by the private sector, of not less than 5 percent of their Federal Activities Inventory Reform (FAIR) Act inventories of *commercial* activities performed by federal employees by the end of 2002, and increase that to 15 percent by the end of 2003. Commercial activities are ones that are operated by the Federal Government to provide goods or services that could be obtained from a commercial source in the private sector.

Over each of the past five years, VA as a whole has steadily increased its contractual services spending while decreasing the number of full-time employees within the Department. In addition, VA's 2001 FAIR Act inventory identifies approximately 85 percent of VA's workforce as being engaged in commercial activities. This is by far the highest percentage of a total agency workforce deemed to be commercial within the President's Cabinet.

VA utilizes competitive sourcing and the FAIR Act as part of its basic business management approach, which is predicated on VA's efforts to deliver timely and high-quality service to our Nation's veterans and their families. As part of its normal business operations, VA continuously assesses the demand for benefits and services from veterans and ensures that it has the capabilities to meet these needs. This market-based analysis often results in contracts for medical care and other services in specific geographical areas when it is determined to be more cost effective to obtain the services from the private sector than to hire doctors, nurses, cemetery maintenance workers, and other skill sets.

It should be noted that this approach does not focus on moving a certain arbitrarily established number of jobs from the public sector to the private sector -- but rather, on providing veterans and taxpayers the best value possible.

The Veterans Health Administration (VHA), which represents about 97 percent of VA's total commercial activities, has increased the amount of contract services to $2.6 billion – a 32 percent increase over the last five years. The estimated total VHA contract service expenditures equate to approximately 43,000 full-time employees. One of the key factors contributing to VHA's achievements in outsourcing 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 examines whether it is more cost effective to outsource or to operate each new facility with VA employees. VHA anticipates that continuing this approach will result in competitive sourcing exceeding 5 percent of its commercial activities in 2002.

A similar strategy has been applied when VA opens a new cemetery. The National Cemetery Administration (NCA) currently contracts 26 of 120 national cemeteries for full maintenance. For FY 2002, NCA will contract out an equivalent of 230 FTE in connection with the National Shrine Commitment. This competitive sourcing is an equivalent of approximately 20 percent of commercial activities with NCA.

The Veterans Benefits Administration (VBA) is currently conducting a comprehensive A-76 study that is examining the property management function. This study involves a competitive sourcing of close to 9 percent of VBA's identified commercial activities. VBA will complete this study in 2002.

We are committed to continuing this current approach of strategically identifying opportunities for competitive sourcing. The Deputy Secretary charged the Office of Policy and Planning with establishing and coordinating a working group to develop a more streamlined VA competitive sourcing process. The working group identified areas of opportunity for future competitive sourcing and developed a tracking system to assess progress and outcomes. The working group has also developed a proposed 3-tier 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 in-house. The proposed tracking system will enable VA to document competitive sourcing decisions in support of providing timely and high-quality service to our Nation's veterans and their families.

Improving Financial Performance

Enabling Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Discussion

An important element of the President's management agenda is the improvement of financial performance through reduction of erroneous payments. VA has four programs that make benefits payments of over $2 billion to veterans and their survivors. The compensation, dependency and indemnity compensation, and pension programs are presented together because they are administered collectively. The insurance program is presented separately.

Compensation, Dependency and Indemnity Compensation, and Pension

Performance Goal: Reduce dollar value of overpayments to $290 million.

Erroneous payments under these programs are payments made to ineligible beneficiaries or payments that were made for an incorrect amount. The causes of erroneous payments include procedural or administrative errors during claims processing, or fraud on the part of employees, beneficiaries, or claimants.

Erroneous Payment Data

Approximately 1.5 percent of payments for these programs are erroneous. During 1999, overpayments amounted to $314 million, and increased during 2000 to $417 million of $22 billion of benefits payments. We estimate that overpayments for 2001 will be $333 million and $310 million during 2002. For erroneous payment purposes, VBA does not distinguish among the three programs and does not know specific reasons for erroneous payments.

Assessment and Action Plan

The Office of Inspector General identified five elements to the improper benefits payment challenge: dual compensation of VA beneficiaries (drill pay), incarcerated veterans, payment to deceased beneficiaries, overpayments due to unreported beneficiary income, and risks due to internal control weaknesses.

- *Dual Compensation of VA Beneficiaries (Drill Pay)*: We have been coordinating the receipt of drill pay information with the Defense Manpower Data Center (DMDC) since late 1999. However, the information received by VA was found to be inaccurate. DMDC and Defense Finance and Accounting Service (DFAS) worked together to identify the problems in the reporting. In June of 2001, DMDC indicated that they had been successful in identifying and

correcting the errors; however, they cannot provide accurate data on drill days prior to FY 2001. We expect to begin the matching program again using the FY 2001 information during FY 2002.

- *Incarcerated Veterans*: VA signed a Memorandum of Understanding with the Social Security Administration (SSA) that will allow us to receive their state and local prisoner files for a matching program. Once the data exchange from SSA is secured, the existing procedures used for the Federal Bureau of Prisons (FBOP) will apply. The system to identify and adjust benefits will be identical to the existing system used for FBOP. Both the FBOP and SSA prison matches will continue as ongoing processes.
- *Payment to Deceased Beneficiaries:* As part of the continuing commitment to reducing erroneous payments to deceased beneficiaries, the Compensation and Pension Service (C&P) has taken measures to install safeguards in our payment system. One such precaution provides for a message to be displayed when a date of death over one year is entered into the system. Additionally, in November 1999, a project was installed to provide for termination of master records effective the first of the month of death even if the date of death is more than one year in the past. To address long term concerns regarding this issue, VBA's Data Management Office (DMO) now runs a quarterly match between the Beneficiary Identification and Records Locator System (BIRLS) and the master record to identify those records with a date of death in one system, but not in the other.
- *Benefit Overpayments Due to Unreported Beneficiary Income:* VBA has implemented the following OIG recommendations: (i) completed a recent review of 100 income verification match (IVM) cases as part of our increased program oversight; (ii) eliminated the review of selected pension cases because they result in no benefit overpayment recoveries; (iii) eliminated review of IVM cases with income discrepancy amounts of less than $500 because they result in little or no benefits overpayment recoveries; and (iv) reported the IVM for consideration as an Internal High Priority Area that needs monitoring.

  We are currently working on a project initiation request intended to address the lack of complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA.
- *Overpayment Risks Due to Internal Control Weaknesses:* In the past two years, the Compensation and Pension Service has been developing procedures to augment its internal controls in the area of erroneous payments. We have continued to focus on this area because of recent findings of erroneous and fraudulent payments. We will develop specific measures to pinpoint the amount of overpayments in each program area (Compensation, Pension, DIC)

and determine the nature and causes of the overpayments. With this information, we will then create additional mechanisms to reduce overpayments in these particular areas.

Insurance Programs

Performance Goal: Maintain accuracy of disbursements at 99 percent.

Erroneous Payment Data

The VA has maintained an erroneous payment rate for insurance programs of less than one percent since 1999, and we expect that rate to continue through 2003.

Assessment and Action Plans

Paying the proper policyholder or beneficiary has long been a top priority of the insurance program officials. In 1992, we established an Internal Control Unit, which is the primary control point for all of our processes involving payments to policyholders and beneficiaries. It augments our traditional management controls, such as, internal system edits, supervision, performance reviews and quality control reviews. One of the main functions of this unit is to monitor, review and approve 100 percent of all manual insurance disbursements. Manual insurance payments include insurance awards to beneficiaries, as well as loans and cash surrenders and premium refunds to policyholders. This unit also reviews a variety of computer matching programs and performs random post payment reviews to attest to the accuracy of computer-generated payments, such as annual dividend payments. In addition, the OIG has thoroughly reviewed this area annually for the past several years. The last review by the OIG was performed during 1999; no material weaknesses were reported.

We believe the insurance program has effective safeguards installed, designed to prevent erroneous or fraudulent payments wherever possible. One test of the effectiveness of these safeguards would be the number of erroneous payments made to beneficiaries during fiscal year 2001. In fiscal year 2001, only 144, or .007% of over 2.2 million total payments made, were erroneous.

Expanding Electronic Government

Enabling Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Performance Goal

By the end of 2003, 100% of VA's high-priority transactions and applications will be electronically available.

Discussion

The Office of Information and Technology and the IT Board approved the establishment of two committees to promote the expansion of electronic government. The Electronic VA (EVA) Committee provides the guidance and direction on how VA administrations and staff offices will deploy and use information technology to serve veterans and other key stakeholders. Under the auspices of the EVA, the Electronic Government Subcommittee was established to ensure there is a coordinated view across the Department regarding electronic government-related issues. The Subcommittee will make agency recommendations on future project developments and suggested redesign strategies. The Section 508 Advisory Committee identifies and provides recommendations on Web accessibility and other Electronic and Information Technology (EIT) accessibility issues to ensure reasonable accommodations for individuals with disabilities.

VA is actively working on the development of a corporate enterprise architecture in which all electronic service requirements and initiatives will be incorporated, and has drafted an enterprise-wide plan that provides a strategy for VA's compliance with the Government Paperwork Elimination Act (GPEA) of 1998. The private sector is assisting VA in conducting risk assessments, preparing cost benefit analyses and developing short and long-term risk mitigation plans. This assistance also includes the development of a strategy on how VA will transform its manual information collection process to conform to the requirements of GPEA and VA's overall strategic mission.

The Department's Internet site is a major medium through which VA reaches its millions of customers--veterans and their families--who live across the country and around the world; to that end, VA completed several key milestones.

- In December 2000, VA acquired contractor services to conduct an assessment of its current activities to deal with customers electronically and to provide recommendations on how the Department should implement GPEA.
- In July 2001, a GPEA assessment and implementation plan was distributed for review and comment to those VA officials responsible for forms, records management and business operations. Implementing GPEA within the Department will facilitate the improvement of public access to VA services.
- In March 2001, VA issued a Department-wide directive covering the full range of Internet and web policies and procedures. The directive was developed to guide the deployment and use of Internet technology by VA organizations, employees, contractors, and customers.
- Since January 1999, approximately 350 user certificates and 10 server certificates have been used through VA's Public Key Infrastructure Project. Those certifications are intended for use by VA employees or contractors to provide secure communications and transactions for internal VA business procedures.
- By June 2001, VA completed its evaluation of over 124 web pages to ensure that they were accessible to people with disabilities. VA continues to define areas for improvement to support reasonable access to Electronic and Information Technology (EIT) for people with disabilities.

Some of the existing VA electronic system development projects are the Veterans Health Information System Technology Architecture, Web Automated Verification Enrollment, VA Online Application and VA NET Certification.

Making Greater Use of Performance-based Contracts

Enabling Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance standards.

Performance Goal

Award contracts over $25,000 using performance-based contracting for not less than 30 percent of the total eligible service contracting dollars for FY 2003.

Discussion

This management reform strives to convert service contracts that are awarded and administered using traditional specifications into an acquisition process that utilizes performance-based contracting. The use of performance-based contracts permits the Government to receive an enhanced level of service at a reduction in overall costs. This enhancement occurs as the result of increasing the flexibility of the contractor to perform the work, while reducing the administrative costs of operating such contracts.

VA has made progress in terms of converting existing and new service contracts at both the field station and national contract levels into performance-based contracts. In addition, the Department demonstrates continued support for performance-based contracting by providing ongoing continuing education on this subject to its contracting officers and allied acquisition professionals.

To more fully monitor the Department's level of success in converting to this performance-based contract approach, a cyclical reporting mechanism has been established through the Federal Procurement Data System (FPDS). Through this FPDS process, beginning with 2001, the Department will be able to analyze the types of conversions, the dollars obligated, and the level of conversion to performance-based contracts.

Expanding On-line Procurement and E-commerce

Enabling Goal: Create an environment that fosters the delivery of *One VA* world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Secretary Priority: Apply sound business principles and ensure accountability for performance awards.

Performance Goals

1. Increase the number of Federal Supply Schedule (FSS) contractors' product information available on-line to 300,000 items.
2. Increase the use of EC/EDI by 110 percent over the base year of 1997.
3. Post 100 percent of the synopses for acquisitions valued at over $25,000 for which widespread notice is required and all associated solicitations, unless covered by an exemption in the Federal Acquisition Regulation, on the government-wide point of entry Web site (www.FedBizOpps.com).

Discussion

VA's Office of Acquisition and Materiel Management (OA&MM) has formed an alliance with the General Services Administration (GSA) to maintain product data in GSA's on-line electronic ordering system, *GSA Advantage!* Today, the VA/GSA partnership makes it possible for VA medical centers and other Government agencies to shop and order health care products and services via the Internet. As of July 20, 2001, VA had all 984 FSS contractors listed and 72 FSS contractors have 52,141 line items on-line at the *GSA Advantage!* Web store. Future plans include the addition of more FSS contractors catalogs and a broader selection of items that will make *GSA Advantage!* and FSS a primary source for fulfilling buyers' procurement needs. OA&MM has also developed applications to post contract solicitations on the Web and to generate purchase orders to vendors utilizing the 850 Electronic Data Interchange (EDI) transaction set. OA&MM has initiated evaluations of electronic reverse auction capabilities. During FY 2001, the National Acquisition Center conducted several reverse auctions on items being purchased. There will be additional tests and the results will be evaluated during FY 2002 with policies being written during FY 2002 and 2003.

VA is in the midst of advancing the configuration and testing of an enterprise resource planning (ERP) information solution, which will enhance and enable significant improvements in VA's e-commerce and e-procurement capabilities. This enterprise level financial and logistics information solution is scheduled to be deployed during 2003 and 2004. The deliverables associated with VA's financial and logistics initiative (designated as "coreFLS") will include

deployment of a fully integrated Web-based information solution that will create the opportunity for VA to accommodate a broad based set of on-line procurement and e-commerce applications. In the area of e-contracting, reform will include the expansion and proliferation of processing standards in the development of contract solicitations, contract milestone tracking, electronic solicitation and task order posting, near real-time receipt of electronic offers and proposals from the vendor community, automated contract award, knowledge-based contract management, and the generation and maintenance of electronic vendor and other catalogs. VA on-line procurement and e-commerce initiatives in the e-procurement arena will include expanded interaction and use of electronic shopping malls, portals, data warehousing, and data mining to support procurement and acquisition business analysis, planning, and development. This information solution will also be designed to support strategic, functional, and operational information management at every level of VA. With the development and implementation of this information solution, the realization of a truly dynamic on-line procurement capability that will accommodate, change, and innovate with minimal difficulty is possible.

Improving Coordination of VA and DoD Programs and Systems

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

Secretary Priority: Provide high quality health care that meets or exceeds community standards.

Performance Goal

Increase the number and dollar volume of sharing agreements by 10% over previous year (Baseline=FY 2000) including Non-DOD Agreements by Number, Dollars Purchased, and Dollars Sold and DoD Agreements (including Tricare) by number and revenue.

Discussion

Improving coordination of VA and DoD programs and systems is an important aspect of this performance goal. For example, as part of President Bush's management agenda, the President has directed VA and DoD to better coordinate benefits, services, information, and infrastructure to ensure the highest quality of health care and efficient use of resources. VA is committed to strengthening the cooperative relationship we have with DoD.

Executive leadership from VA and DoD have been meeting for several years to improve and expand sharing. As a result, there are many outstanding examples of national cooperation. We have made progress in the joint development of clinical practice guidelines. The two Departments have taken leadership roles in the promotion of patient safety. We have combined the military's discharge physical with VA's disability compensation examination for those service members applying for VA compensation benefits. We are also pursuing several joint medical technology assessment initiatives.

The VA/DoD Executive Council, co-chaired by VA's Under Secretary for Health and DoD's Assistant Secretary for Health Affairs, was recently reinvigorated. In addition to ongoing collaboration in the areas mentioned above, VA and DoD have initiated new working groups to look at improving cooperation in the areas of financial management, benefits policy, geriatrics, and facility utilization and resource sharing. We will have some of our top clinical and policy experts reviewing our current interaction and recommending changes.

The two Departments have made substantial progress to increase their joint procurement activities. The foundation for this progress was established in December 1999 when VA and DoD agreed to a Memorandum of Agreement (MOA) to combine their purchasing power to eliminate redundancies. As of May 18, 2001, there were 42 joint VA/DoD contracts for pharmaceuticals. The total estimated cost savings during FY 2000 for both

Departments from these contracts was $42.5 million ($30.8 million for VA and $11.7 million for DoD). An additional eight contracts have been awarded with discounts off the lowest VA Federal Supply Schedule (FSS) price ranging from 0.19 percent to 53.75 percent so far during FY 2001.

The next major phase of the MOA implementation is underway. VA and DoD will convert DoD's Distribution and Purchasing Agreements to FSS for medical/surgical products. The Veterans Health Administration's Office of Logistics is working with the VA National Acquisition Center and DoD counterparts to facilitate shared acquisition strategies through product standardization committees.

In May 2001, the President established a task force to improve health care delivery to our Nation's veterans through better coordination between VA and DoD. The mission of the task force is to:

- identify ways to improve benefits and services for DoD military retirees who are also beneficiaries of VA through better coordination of the activities of the two Departments;
- review barriers and challenges that impede VA and DoD coordination, including budgeting processes, timely billing, cost accounting, information technology, and reimbursement;
- identify opportunities for improved resource utilization through partnership to maximize the use of resources and infrastructure.

Faith-Based and Community Initiatives

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

Secretary's Priority: Provide high-quality health care that meets or exceeds community standards.

Performance Goal: The Task Force will develop performance goals and measures for this initiative. Therefore, there is no FY 2003 performance measure at this time.

Discussion: On January 29, 2001, President Bush signed two executive orders establishing Federal offices to promote his faith-based and community organizations initiatives. One of the orders created an Office of Faith-Based and Community Initiatives in the White House to take the lead in enhancing current efforts and promoting the government's efforts to partner with faith-based and community organizations. His second order established a Center for Faith-Based and Community Initiatives in five federal agencies. That order did not include VA; however, the Department established a Task Force to assess current programs and activities, identify barriers and initiate actions to allow full participation by faith-based and community organizations.

The Office of Public and Intergovernmental Affairs (OPIA) has been assigned the oversight and coordination role for this Task Force and the Director, Office of Homeless Veterans Programs, will serve as the Department's point of contact. The Office of Homeless Veterans Programs and the entire VA have a long tradition of working closely with faith-based and community organizations. There are a number of areas where VA programs may provide an opportunity for increased participation by faith-based and community organizations. The Task Force is charged with reviewing each of these programmatic areas.

The VA Task Force will work to:

- Audit our existing policies and practices Department-wide;
- Identify existing barriers to participation by faith-based and other community organizations in providing the delivery of social services;
- Coordinate Department effort to incorporate faith-based organizations in departmental efforts and initiatives;
- Propose initiatives to remove barriers;
- Propose pilot programs to increase participation of faith-based organizations;

Develop and coordinate Department outreach efforts to disseminate information to faith-based organizations with respect to programming changes, contracting opportunities, and other initiatives (including Internet).

Means and Strategies

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

Medical Care

The Veterans Health Administration (VHA) remains committed to promoting the health, independence, quality and dignity of life, and productivity of individuals with spinal cord injury (SCI) and other disabling conditions. This continues to be achieved through effective and efficient delivery of high quality acute rehabilitation, medical/surgical/neurological care, patient/family education and counseling, psychological, social and vocational care, research and professional training of medical residents and students, student nurses, physical and occupational therapists, and others, directly and indirectly involved in the care of SCI and other disabled veterans.

Special attention is accorded veterans with SCI for a number of reasons and because of the severity of illness and disability associated with spinal cord injury, VHA will continue to closely monitor the performance measure described below to ensure VHA continues to be responsive to veterans with SCI and maximize the potential for positive outcomes of care.

VHA improved the overall care of SCI veterans and coordination of their discharge in the following manner:

- In FY 2001, increased staff at SCI Centers (increase FTE 278.8 in FY 2001);
- Distributed and implemented Clinical Practice Guidelines from the Consortium for Spinal Cord Medicine;
- Conducted annual national SCI-Primary Care team training;
- Made improvements in the SCD-Registry to improve coordination of care;
- Achieved CARF (Rehabilitation Accreditation Commission) accreditation for acute SCI&D rehabilitation programs at 19 of 20 SCI Centers;
- Continued identification and translation of best practices in SCI&D by SCI QUERI;
- Expanded direct outreach to patients with SCI&D to increase proportion of influenza and pneumococcal vaccinations;
- Distributed VHI-SCI Continuing Medical Education Project to enhance primary care knowledge of SCI&D issues;
- Improved access to care within patients' communities.

Closely related to restoring the capability of disabled veterans to the greatest extent possible, are VHA's efforts to keep or decrease the rate of delayed prosthetic orders so as to provide veterans with needed orthotic and/or

prosthetic devices in as timely a manner as possible. This was accomplished by continually monitoring VA Medical Center (VAMC) and Veterans Integrated Strategic Networks (VISN) performance on a monthly basis, as outlined in the Network Directors' annual Performance Contract, continued automation and augmentation of the National Prosthetic Patient Database (NPPD) with Computerized Patient Record System (CPRS) and greater implementation of group-buying power or "blanket purchase agreements" of prosthetic devices. The implementation of the NPPD with CPRS provided the means to process prescriptions in a more timely fashion, reducing the number of hardcopy prescriptions while increasing automated functionality. VISNs and VA Medical Centers also authorized a substantial amount of overtime and compensatory time to curtail delays. In addition, the Prosthetic Program nationally realized an overall increase in field-based staffing which provided additional resources necessary to fulfilling prosthetic orders during a time of significant increases in workload. Compared to FY 2000 data, Prosthetic and Sensory Aids Service sustained a 19 percent increase in obligations and a 23 percent increase in the number of orders received in FY 2001 while maintaining a rate of delay below the projected performance level (1percent vs. projected 2 percent).

Severely Mentally ill, including PTSD, recovering Substance Abuse and/or Homeless Veterans are also special populations of veterans for whom VHA is committed to improving care, living arrangements and quality of life. Central to many is the ability to find and keep both a secure or independent living arrangement and a job, once they have substantially completed either an inpatient and/or outpatient treatment program. For some, balancing work and life maintenance activities and responsibilities needs to be interwoven with continuing medical and psychosocial treatment. VHA program effectiveness is a function of the complex array of conditions and psychosocial issues, level of veteran functioning and impediments these veterans must learn to manage to become and remain employed. VHA is continuing to seek ways to improve our service to veterans to increase the probability of their success. VHA is committed to identifying, via outcomes monitoring, the best approaches to treating PTSD patients that result in the best possible health and psychosocial outcomes for this special population subgroup. VHA placed increased emphasis on outcome monitoring in FY 2001 and will continue to do so in FY 2002. Homeless veterans are particularly challenging to identify and work with; however in keeping with the Secretary's stated priority, VHA will continue to seek ways to communicate with these veterans after initial care and treatment to improve the probability that these veterans will continue to be as self-reliant and successful as possible. Domiciliary care and community care/support programs continue to offer needed alternatives to institutional care, once immediate health needs are met.

VHA is also planning to further pursue interagency coordination with VBA and NCA to enhance VA's Vocational Rehabilitation (VR) Program. VHA has

several post-inpatient hospitalization after-care and transitional programs that provide opportunities for recovering and disabled veterans to effectively re-socialize, acquire independent or secure living arrangements and demonstrate positive work skills and habits in protected environments and programs such as Compensated Work Therapy and Incentive Therapy. VHA continues to need volunteers to augment hospital and clinic operations and recovering veterans often are the ideal candidates, whether from within VHA programs, or emanating from VBA's Vocational Rehabilitation program. In turn, as veteran skills and preferences indicate, VHA VR program veterans may find it ideal to work in VBA and NCA.

Compensation and Pension

The Department continues striving toward our vision of improved performance in claims processing. Initiatives dedicated to this effort have been both numerous and diverse, but all with one common goal – enhancement of the claims process. As more in-depth analyses of the VBA process are completed, we expect to further streamline our endeavors in order to achieve our strategic target. Our most important initiatives during 2003 include the following:

- **Pension Consolidation --** This initiative includes consolidation of all existing pension programs, death compensation and parent's DIC into three centers. Consolidation through pension centers will begin with two paper-based environments and one imaged environment. Migration to a fully paperless environment for all sites is planned over five years. A skilled staff solely devoted toward processing one benefit will improve decision quality, minimize the pending time for a pension claim and expedite the delivery of benefits.
- **Virtual VA --** The Virtual VA Project replaces the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a thin client (web-based) solution. It will provide a long-term solution to improving the quality of claims processing for veterans and their dependents through enhanced file management, a reduced dependency on paper, and increased workload management across the business enterprise.
- **Training and Performance Support Systems (TPSS) --** This initiative develops four comprehensive TPSS for the core service delivery positions of the reengineered environment. The four systems are for a) basic rating (RVSR); b) veterans service representatives (VSR); c) journey level rating specialists to include the Decision Review Officers; and d) field examiners. At this time, ten modules have been released to all regional offices.
- **Systematic Individual Performance Assessment (SIPA) --** SIPA complements our national quality assurance program, Systematic Technical

Accuracy Review (STAR), and brings performance assessment and accountability to the journey-level individual. Systematic individual performance assessments will bring accountability to the journey-level individual and serve as an internal control mechanism to minimize the potential for fraud since performance reviews will focus on program and data integrity concerns, proper signatures, and supporting documentation.

- **Compensation and Pension Evaluation Redesign (CAPER) --** As we head into the 21st century we are aware of heightened expectations from customers, rapid change in technology, increasing complexity of decisions, extremely tight labor markets, and a VA workforce which will see significant turn over in the skill-intensive, rating veterans service representative (RVSR) position. Current experience documents that the time to fully train an individual for this position can take up to three years. The CAPER team will review all phases of the C&P claims process from the initiation of medical evidence development to the point a rating decision is completed. This project will determine what the optimum exam and other medical evidence gathering processing should be and how they can be integrated to improve the overall disability evaluation process. Furthermore, the team will gather and evaluate medical evidence associated with disability claims and construct a revised model for evaluating disabilities.
- **Benefits Replacement System (Core EP) --** VBA will pursue an incremental strategy as the most effective means to complete the development of the C&P payment system. The strategy provides for a sequential application development effort, specifically, the incremental development and integration of functional modules or components. The process is divided into three primary areas: 1) Development, Case Management and Tracking; 2) Rating; and 3) Award, Payment and Accounting. This functional division provides opportunities for defining and deploying incremental applications to the new operating environment. Migration from the Benefits Delivery Network (BDN) is achieved in functional components rather than as a total system replacement.

VA has taken steps to offset the impact of legislative and regulatory changes on timeliness and accuracy by implementing countermeasures using available resources. The Under Secretary for Benefits presented the Department's strategies in a satellite broadcast to regional offices in March 2001. As of this time, we have successfully implemented the following measures in FY 2001:

- In March 2001, VBA launched its centralized training initiative, called Challenge, to train these new hires. Challenge is now the standard for training future hires.

- As of December 2001, a total of 1,298 Veterans Service Representatives (VSRs) and Rating VSRs have been hired. All have gone through the Challenge 2001 training program.
- VBA reached an agreement with the Board of Veterans Appeals (BVA) concerning remand development. By January 2002, BVA will begin initiating development on cases that would otherwise be remanded back to the field offices.
- Nine Resource Centers were established to focus on specialized claims processing.
- The St. Louis Helpline was expanded and fully operational by February 2001.
- Several national decision notification letter packages prepared in an enhance Personal Computer Generated Letters (PCGL) were released in April and in November 2001.
- A work group has developed national production standards for VBA's decision-making positions. These proposals are being further evaluated.
- The amendment to the Code of Federal Regulations (38 CFR 3.103) allowing VBA's decision-makers to gather evidence by oral communication, from beneficiaries currently on the rolls, was published in the Federal Register on April 20, 2001.
- The Compensation and Pension Records Interchange (CAPRI) application that allows VBA's decision-makers to successfully obtain medical records from the Veterans Health Administration database was successfully tested in January 2001. This application will be available to all 57 regional offices.
- VBA and VHA signed a memorandum of understanding in February 2001 to establish a Joint medical Examination Improvement Office in Nashville, Tennessee. The mission of this office is to review the C&P examination process in order to identify problems, their root causes and the tools and procedures needed to improve the quality and timeliness of C&P medical examinations.

VBA also expects to successfully implement the following countermeasures in FY 2002 – 2003:

- Providing field offices relief from doing local STAR reviews. By January 2002, a national STAR office located in Nashville, Tennessee will be fully operational. VBA has selected most of the subject matter experts for this effort. This office will absorb the additional national reviews in order to take into account local reviews that will no longer be conducted by the field offices.

- The centralized processing of pension maintenance workload will begin in January 2002. Initially, the processing will focus on eligibility verification reports. VBA expects that centralized processing will address all pension maintenance workload by the end of FY 2003
- Virtual VA's imaging technology will be fully tested in FY 2002 at the pension maintenance center in Philadelphia and then deployed to the Milwaukee and St. Paul pension maintenance centers in FY 2003.
- VBA has been working closely with the DoD on two major initiatives: the exchange of their records through imaging technology and the creation of a joint separation examination and disability evaluation protocol. It is expected that both of these efforts will be ready for testing by the end of FY 2003.

Vocational Rehabilitation and Employment (VR&E)

Because the Employment Specialist (ES) pilot program was a success, the VR&E program through succession planning is changing the skill mix of its staff from vocational rehabilitation specialist to employment specialist.

With employment specialists and case managers working outside the normal structured working environment, each individual will be supplied with a laptop and other equipment, as found necessary. These positions will require flexibility in work schedules and the ability to access systems during irregular work hours, whether in the office or at other locations, in order to best meet the veterans' needs.

Access is focusing on improving the channels of communication between the veterans and the case managers by the use of various methods of information technology and providing the case managers with the tools to perform their jobs regardless of their location. Tools such as the utilization of laptop computers and personal digital assistants (PDA's) will improve the staff's ability to communicate with the office and VBA and/or VA IT systems for immediate access/retrieval of information when assisting the veteran at any location. The program is expanding the locations and methods for which veterans may contact a program representative (i.e., increased outbased locations, redesign of web site, purchase of required information technology equipment for staff, and partnership with other federal agencies).

VR&E is placing emphasis on the training of employees throughout the program to improve the staff's competency and skill level in support of providing the best possible service to veterans. Training is being offered through several methods including regional training for all clinical staff, in-house training at each office, and continuous Corporate WINRS training for both the VR&E personnel and finance employees who support the VR&E program.

Corporate WINRS is a recently deployed information management system that will continue to be enhanced with improvements that will support the

VR&E program and its ability to service the disabled veterans whenever our expertise and services are needed. As program needs and regulations change or systems that interface with Corporate WINRS are modified, enhancements will continue to be developed in order to comply and provide optimal service for both the veterans and the employees.

A special task force team is being established to conduct a study of the impact and effects of the Enhanced Montgomery GI Bill, as well as the impact that regulatory and legislative changes in Compensation and Pension may have on veteran entitlement to VR&E benefits and services.

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

Medical Care

VHA is continuing to pursue, with VBA and DoD, the expansion of opportunities to link up with current military personnel who will be honorably discharged from service within a six-month window, to expedite completion of their medical record and medical evaluation of need for continuing care under VA auspices. A second facet of this initiative is to ensure the timely and secure transfer of military patient records to the facility of choice made by the military personnel being discharged.

Education

VA's Education Service mails a brochure, "Focus on Your Future with the Montgomery GI Bill," to men and women in the Armed Forces. Similar mailings are planned at specific points throughout each individual's military career. This brochure provides a general description of MGIB education benefits. It also has information to help service members, who might already be eligible for MGIB benefits, make a decision to enter training and use their earned benefits.

VA has developed brochures for specific situations, also. For example, VA developed a brochure in 2001 to highlight a new education benefit, reimbursement for licensing and certification tests, enacted by Congress. As veterans learn of this new benefit, they can determine whether it affords them opportunities for advancement in the workplace. Additional targeted brochures, as needed, will advise veterans of other opportunities.

The development and installation of TEES (The Education Expert System) is a major multi-year initiative started in 2000. When fully operational, it will improve timeliness and enhance customer service by automatically processing more claims (up to 90 percent of those received electronically) without human intervention. A small, proof of concept, application has been developed and deployed. Some enrollment information, received electronically from educational institutions, is now processed by a prototype rules-based expert system without human intervention. VBA contracted for and received an assessment of how to

successfully process up to 90 percent of all education claims automatically. A capital investment application was then approved and permission granted to proceed with the initiative. Development efforts began in 2001 and will continue through 2007.

While performance suffered in 2000 and continued into 2001, steps have been taken to reverse that trend. For instance, recently hired employees, representing almost 40 percent of all decision makers in April 2001, will become more proficient and contribute significantly to reducing the number of days it is taking to process a claim. In addition, overtime will be used during heavy enrollment periods to increase the volume of claims completed as soon after receipt as possible.

Payment accuracy can be improved by:

- monitoring claims processing results;
- identifying trends that inhibit accurate processing;
- providing the necessary training for personnel to improve their decision making skills.

The hiring and training of additional new staff has created a setback in progress toward our strategic objective of a 97% payment accuracy rate. The electronic training initiative being pursued will facilitate uniform and consistent training. As training interventions continue and new hires gain experience, performance in this measure should improve once again.

Feedback from earlier surveys led VBA to implement nationwide toll-free service for education beneficiaries. They now receive toll-free telephone service by dialing 1-888-GIBILL1 (1-888-442-4551). They are first connected to an automated response system that provides:

- general information;
- answers to frequently asked questions;
- recent payment information;
- limited, beneficiary specific, master record information.

Callers can opt to speak to an Education Case Manager at any time during the call if they want personal attention.

Two issues hampered customer service improvements after implementation of toll-free phone service. First, automated responses have not curtailed the number of callers seeking to speak with an Education Case Manager. Second, call volumes have been larger than originally anticipated. As a result, resource requirements were understated resulting in an inordinate number of callers unable to complete their calls. VA examined resource needs. Seasonal employees

will supplement permanent staff during peak periods to improve service. To divert some traffic away from telephones, VA is exploring electronic alternatives that provide services and satisfy education beneficiaries. While there has been an education service web site for several years to provide VA related information, plans have been developed to enhance usage of the site. In addition to resolving inquiries electronically, the site is being expanded to allow for some veteran self-service. The first application, Web Automated Verification of Enrollment (WAVE), is now accepting monthly self-verifications of enrollment with minimal human intervention. Other self-service actions (such as address changes) will be added.

Housing

The program emphasis is on developing and implementing information technology solutions to provide more timely service to our customers at a reduced cost. Important benchmarks are the quality and efficiency of service provided by private entities because they set the level of expectations for all real estate transactions.

VA relies heavily on the lending industry to deliver the home loan benefit. Ultimately, the level of veteran satisfaction is directly dependent on how well VA can meet the expectations of lenders, builders, real estate brokers and appraisers. This means adapting the delivery of our services to industry practices and making timely changes as technology generates improvements in the loan origination process. Current plans call for major enhancements in the following areas: loan funding fee collection and reporting, automated determination of eligibility, appraiser assignment and property valuation, and e-commerce appraisals, loan applications, default reporting and foreclosure processing.

Some veterans, like other homeowners, experience financial difficulties that may cause them to default on their home loan. When this occurs, VA strives to help veterans retain their homes through loan servicing efforts. Besides counseling, VA may intervene directly on behalf of the veteran to work out a repayment plan. In limited circumstances, VA may buy the loan from the holder and the veteran will make future payments directly to VA.

To improve VA's ability to effectively assist veterans who are delinquent on their mortgages, VBA needs to implement state-of-the-art information technology designed for this specific purpose. There was a need to automate the default servicing and foreclosure management so that VA staff can direct efforts towards helping veterans avoid foreclosure. An automated system was substantially developed and implemented in order to track the variety of actions taken by VA, lenders, and borrowers during the default period. This system automates routine and redundant activities, improving efficiency and allowing employees to concentrate on supplemental loan servicing. It also allows for an earlier analysis of the appropriateness of the different alternatives to foreclosure.

A redesign effort is planned to update the requirements for and processes involved in the application. These changes will increase the utility of the application, provide more accurate data, and improve customer service and workload management. The benefits of the redesign effort will ultimately cause an increase in the FATS (Foreclosure Avoidance Through Servicing) ratio.

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

Medical Care

VHA's quality of care is ensured through monitoring many aspects of care and implementation of clinical practice guidelines. VHA ensures the consistent delivery of high quality health care by also implementing standard measures for the provision of evidence-based care by focusing on the use of both a Chronic Disease Care Index (version II) and a Prevention Care Index (version II). These indices are based on recommendations for the performance of specific processes, provision of certain clinical services or achievement of (proxy) patient outcomes that are known, through rigorous research and literature reviews, to improve health outcomes.

The CDCI II measures how well VA follows nationally recognized clinical guidelines for the treatment and care of patients with one or more of the following high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, congestive heart failure, major depressive disorder, schizophrenia and tobacco use cessation. A large percentage of veterans have one or more chronic diseases and the improved management of chronic diseases results in improved health outcomes to veterans.

The CDCI II is a composite measure that reflects VHA's compliance with 23 separate clinical interventions associated with the eight diseases/conditions noted above.

The prevention of major illness and disabling conditions -- or even death -- has been demonstrated by VA to be one of the most cost-effective and quality of life-affirming activities of the agency. VA demonstrated it superior rate of immunizing against both influenza and pneumonia in FY 2000 -2001 and, by extrapolation, led the nation in preventing unnecessary death and infirmity from influenza and pneumonia. The majority of preventable diseases can be identified through early and appropriately frequent screening, continual education and counseling aimed a high risk factor identification and behavior modification. Through its education and screening tests, VA urges veterans to become aware of ways in which health can be enhanced, and encourages each person to assume active responsibility to achieve this performance goal. The program goals of preventive medicine are to maintain health and achieve early detection of disease, thereby easing the likelihood and burdens of suffering, costs, and resource availability in chronic disease care.

VA's PI II includes several indicators that allow VA to assess its overall performance in disease prevention. This composite index characterizes how well VA follows national primary-prevention and early-detection recommendations for several diseases or health factors that significantly determine health outcomes: Immunizations for both pneumococcal pneumonia and influenza; screening for tobacco and problem alcohol use; cancer screening for colorectal, breast and cervical cancer; screening for hyperlipidemia; and counseling regarding the risks and benefits of prostate cancer screening.

VA implements effective preventive measures through the following activities:

- Implementation of new and/or refined clinical practice guidelines;
- Education of staff and patients on the importance and benefits of prevention;
- Monthly monitoring of local VISN and VAMC level performance using checklists to ensure prevention activities are accomplished as scheduled for high risk and other patients as needed; and
- Empowerment of primary care teams with responsibility and accountability for local implementation of the PI II.

Patient satisfaction with VA health care service is of paramount importance to VA and is measured in several ways. These data are routinely collected and analyzed. Patient satisfaction survey frequency is scheduled to increase in late FY 2002. VHA will be increasing the frequency of administration of the inpatient satisfaction survey from an annual cycle to a semi-annual cycle. Along with changing the instrument as outlined before, VHA will increase the frequency of administration of the outpatient satisfaction survey from two times per year to four times per year. This increased frequency of survey will give VA Medical Centers the ability to better support progress in improving patients' satisfaction. The Office of Quality and Performance has also developed and deployed a Patient User Local Satisfaction Evaluator (PULSE), a hand-held, touch-screen device that can be used to gather satisfaction data at the point of care, empowering direct care providers and managers to support improvement more directly. PULSE affords VA Medical Centers the ability to administer recurring surveys as often as they choose (e.g., daily). By emphasizing the importance of overall satisfaction and implementing the PULSE, VHA should see improvement in overall patient satisfaction.

Further, older survey processes will be replaced with the Survey of Health Expectations of Patients (SHEP) process. The SHEP process will allow VHA to integrate and analyze clinical performance, functional status, and satisfaction data gathered from various VHA processes. This integration will provide more meaningful information, especially as it relates to cohort analysis.

The FY 2001 satisfaction measures have been categorized as:

- Proportion of veterans with SCI rating VA health care as 'very good' or 'excellent' (only an inpatient survey is available in FY 2001)
- Proportion of all patients rating VA health care as 'very good' or 'excellent' (inpatient and outpatient)
- Percentage of patients who report problems with the Veterans Health Service Standards (VSS) regarding:
    - Patient education
    - Visit coordination
    - Pharmacy services
    - Health care decision-making
- Percentage of patients rating Vet Centers as 'very good' or 'excellent'

With regard to SCI inpatient satisfaction, VHA achieved, in FY 2001, a level of 53 percent against a projected FY 2001 goal of 60 percent. While this was one percentage point better than FY 2000's attainment level, in retrospect, it appears that improving SCI veterans' satisfaction will take more attention and resources and that FY 2002's projected level needs to be more modestly scaled. This appears prudent given VHA's balancing of resources in constrained economic times and dealing with key staffing shortages in the national health care arena. VHA will conduct focused reviews of results and problem scores.

The Overall Quality measure from the Inpatient Veterans Satisfaction Survey (VSS) is a single item question that asks patients to rate the quality of care they received during their most recent hospital discharge from one of six bed sections (i.e., Medicine, Surgery, Psychiatry, Neurology, Spinal Cord Injured, or Rehabilitation Medicine) on a five-point scale from Poor to Excellent. The FY 2001 inpatient satisfaction score ("Percent of patients rating health care service as very good or excellent") was 64%. When evaluated using the traditional private sector methodology of including 'good' as well as 'very good' and 'excellent' the overall inpatient satisfaction rate increases to 82 percent for FY 2001.

Analysis was conducted to determine which Veterans Service Standard(s) and which questions have the highest correlations with Overall Quality. The VSSs that have strong correlations with the Overall Quality rating include Patient Education/Information, Family Involvement, Preferences, and Transition; challenges within any one of these areas can adversely impact a given VISN's performance in the Overall Satisfaction measure itself.

The Overall Quality measure from the Ambulatory Care Veterans Satisfaction Survey is a single item question that asks patients to rate the quality of care they received in the outpatient setting over the past two months on a five-point scale from "Poor" to "Excellent". The FY 2001 Ambulatory Care

satisfaction score on this measure was 65%. When evaluated using the traditional private sector methodology of including 'good' as well as 'very good' and 'excellent', the overall ambulatory care satisfaction rate increases to 90.7% for FY 2001.

The FY 2001 performance on the percent of Veterans Service Standard (VSS) problems reported per patient was only slightly different from FY 2001 scores. For FY 2000, the patient education, visit coordination, and pharmacy performance was 29.8 %, 15.6 %, and 16.1 %. In FY 2001, the performances were 29.8 %, 15.8 %, and 16.1%, respectively.

Note that with this measure, "positive achievement" is defined as having a lower problem score than the targeted level. Dramatically improved "pharmacy" satisfaction (compared to FY 1999 score) is attributed to full implementation of VHA's Consolidated Mail-Out Pharmacies, which can minimize the number of trips by patients to the nearest VAMC or Community Based Outpatient Clinic (CBOC) for prescription refills through utilization of VHA's mail-out system.

The VSS representing Patient Education/Information assesses the percent of problems reported by patients relating to VHA's patient education/information. VHA's patient education/information enterprise requires that healthcare entities have the optimal mix of information technology support, teaching media and effective teachers that can best meet the learning needs of their local patients. Despite these challenges, improvement (decrease in the percent of patients reporting problems) was realized in three of the seven questions from the 2000 survey results. The issues needing focused attention within this VSS are ensuring the patient understands: 1) side effects of medications and, 2) what to do if problems or symptoms re-occur or get worse. It is noteworthy that 17 VISNs improved performance on this standard, illustrating the commitment by VHA to address and improve performance for the Patient Education/Information VSS.

The VSS representing Visit Coordination relates to the communication of test results, follow-up and referral appointments, and whether or not the patient was given information on who to contact for information after the patient's visit. VHA has achieved a high level of success in coordinating follow up and referral appointments, as problem rates in these areas are remarkably low at only 4 percent (i.e., 96 percent success rate). The issues needing focused attention within this VSS, however, include 1) explaining to patients when and how tests results can be obtained and, 2) who to contact with additional questions post visit. The areas of progress noted above reflect active and effective interventions within all levels of VHA; the remaining challenges suggest that local VA Medical Center leaders may not have adequate tools to assess the impact of local improvement efforts.

VHA met the planned performance levels for the two sub-categories under "health care decision making": patient involvement in decision-making (32

percent) and information on condition/treatment (35 percent). The current survey method and sampling procedure was considered problematic and an interdisciplinary VHA group of clinicians, patient care advocates and statistical sampling experts worked throughout FY 2001 to be ready to roll out the Omnibus Survey in the Second Quarter of FY 2002. VHA expects to start compiling and assessing results in the Fourth Quarter of FY 2002 and in ensuing months.

The Readjustment Counseling Service in VHA has taken steps as necessary and appropriate to preserve core program design features. VHA attained a phenomenal satisfaction rate of 99.73 percent against a projected target level of 95 percent for this measure in FY 2001 in the Readjustment Counseling Service's satisfaction survey. The original design features for the Vet Center program included patient-friendly, community-based facilities largely staffed by veteran service providers. Vet Center Team Leaders locally plan the mix of counseling and outreach services to address the specific needs of the local veteran population. Also, priority is given to accommodating services to the needs of high–risk veterans, to include high-combat exposed, physically disabled, women, ethnic minorities, rural and homeless veterans. Vet Center outreach plans, the level of client satisfaction, the proportion of high-risk veterans among the Vet Center's client caseload maintained at representative levels, and the Vet Center's level of physical visibility and ease of access in the community are subject to ongoing inspection during annual Vet Center quality audits. The program ensures rapport with local veterans by maintaining employees with veteran status at approximately 70 percent of the program's more than 940 total staff. In addition, over 60 percent of the staff that provide direct service to veterans are themselves veterans of a combat theatre of operations. Also relevant is the fact that the program has memorialized its core features in its statement of program purpose, mission and service values providing staff with an easily communicated charter containing the program's unique culture.

VA seeks not only the formal survey results, but actively solicits and obtains veteran and family feedback through focus groups, utilization of Management Assistance Councils to VISN leadership, addressing and analyzing complaints, direct inquiry (correspondence) and comment/suggestion cards. By utilizing these and other means to gauge veteran and family satisfaction, VA can effectively modify its practices and improve its performance goals and measuring instruments.

Access and Waiting Times are key to enabling VHA to improve its patients' perceptions of the quality of care and their overall satisfaction with it. VHA established in FY 2000 and continuing into the future, a set of performance goals titled "30-30-20" and "24/7". These refer, respectively, to when a patient can schedule a non-urgent primary care visit (within 30 days) or a specialty care visit (within 30 days), how long they must wait once they arrive to be seen by a

practitioner (20 minutes), and patients being provided with telephone access to a nurse advisor/referral system on a 24 hour/7 days a week basis. VA's set of service and access performance measures are designed to provide personalized care when and where it is needed, within certain parameters, and in ways that are creative, innovative, and cost-effective. Timely service ensures care is received when it is needed. Providing care in the manner most convenient to the veteran enables us to provide care where it is needed and wanted. The 30-30-20 goals remain a part of Network Director's annual performance contracts and although VHA has made significant improvements in waiting time performance, there remains a need to improve access in two main sub-groups: new enrollees and some specialty care areas. Further monitoring and action is being taken in those areas.

Just some of the many initiatives that VA is pursuing to reach these goals, within anticipated budgetary constraints, include:

- Training or retraining existing transferable staff from inpatient to outpatient care;
- Implementing fully the Institute for Health Care Improvement initiatives and other no or low cost process improvements;
- Where appropriate, adding mental health care to existing CBOCs and planning for this care in new ones;
- Assessing the need to add Geriatrics to existing and new CBOCs;
- Increasing the number of contracts for specialists to provide services to veterans;
- Renovating infrastructure in existing facilities to ensure that at least two exam/treatment rooms are available per clinician providing care on a given day;
- Continue to develop transplant-sharing agreements;
- Continue to update and proliferate computer-based technology to be more cost effective and increase access;
- Continue to provide outpatient medication dispensing technology in community-based outpatient clinics and hospital-based clinics.

In addition to the above noted access and waiting time performance measures, VHA also monitors and strives to increase the number of enrolled veterans with access to home and community-based care (H&CBC). VHA increased the number of veterans served from 14,111 in FY 2000 to 16,150 in FY 2001. This represents a 14.4 percent increase over the baseline year's results. This has been due to sustained emphasis communicated to VISNs as a result of the strong continued Congressional interest in Long-term Care program expansion. At the local level, all Networks recognize the need for expanding H&CBC and all

long-term care services based on the demographics of the veteran population who use VA primarily for their health care. VHA will continue to emphasize expanding access to the long-term care continuum in FY 2002. The introduction of In-home Respite Care will also add to the mix of services available under the H&CBC umbrella.

Patient Safety remains of utmost importance to VA. VA is committed to continuously improving the culture and outcomes of patient safety in its health care facilities. VA has utilized Root Cause Analysis (RCA) as a means to understand the origins and circumstances of safety problems. RCA is a process for identifying the basic or contributing causal factors that underlie variations in performance related to adverse events or "close calls" involving VA patients. VHA achieved its planned performance level of 95 percent implementation for this measure and has decided to replace this measure in FY 2002 with one that will measure the development of a contingency plan if lose the electronic ability for Bar Code Medication Administration (BCMA). BCMA reduces the number of medication errors by using a computer readable bar code with each medication administered.

VHA's National Center for Patient Safety reports the following: For 2001, nationally ninety-nine percent (99 percent) of the root cause analysis reports (RCAs) were submitted within forty-five (45) days or by the date of the granted extension. This information reflects RCAs that were started on or after January 1, 2001 and completed by July 31, 2001. It also reflects RCAs that received a high score based upon their severity and probability rating, and were individual as opposed to aggregated RCAs. This period for evaluation was chosen since the process for requesting and receiving extensions was established and fully operational by January 1, 2001. July 31, 2001 was chosen as the cutoff date so that NCPS could provide performance data for FY 2001 in a timely manner and accomplish the following tasks: perform analysis, develop reports, disseminate information to the Networks to confirm the accuracy of the data, and submit final reports.

Means and strategies used to achieve the performance goal including the management efforts that led to the actual level of performance: NCPS provided ongoing training and assistance to front line staff, managers, facility directors, and VHA leadership to support efficiently completing RCAs. NCPS' methods of communication vary from the structured and formal, to the very informal and spontaneous. The NCPS strategy is to continue to actively solicit success stories and then develop these into information that can be acted upon, disseminating this advice through a variety of means. NCPS employs its newsletter, the NCPS website, the monthly conference calls, and stand-alone PowerPoint presentations to reinforce this message. Such efforts have included:

- Project management tools with specific RCA tasks and proposed timelines;

- Shared stories on how various teams have succeeded in completing timely RCAs;
- A review and analysis of the 15 top reasons for requested extensions, and NCPS suggestions for addressing these roadblocks;
- Ongoing training through national and regional locations;
- Open forum on monthly national calls to discuss timeliness issues;
- Regular briefings to VHA and Network leadership on patient safety.

Insurance

In order to fulfill our mission of providing insurance coverage in reasonable amounts at competitive premium rates, Insurance has made several program enhancements to our programs over the past year. As a result of legislation and administrative actions, improvements to the Servicemembers' Group Life Insurance (SGLI) and Veterans' Group Life Insurance (VGLI) programs include increasing the maximum amount of SGLI coverage available to $250,000, extending SGLI coverage to spouses and children, reducing VGLI premium rates and offering Beneficiary Financial Counseling Service (BFCS) to SGLI and VGLI beneficiaries. We capped Service-Disabled Veterans Insurance (S-DVI) term premiums at the age 70-rate and now provide cash values for National Service Life Insurance (NSLI) and Veterans Service Life Insurance (VSLI) age 70-premium term capped policyholders. In addition, we developed outreach initiatives and are beginning to implement increasing participation of eligible veterans in the Veterans Mortgage Life Insurance (VMLI), VGLI and S-DVI programs.

Insurance has taken various steps to recruit, develop, and retain a competent, committed and diverse workforce that provides high-quality service to veterans and their families. To this end, the Insurance program is undertaking a major training initiative named Skills, Knowledge, and Insurance Practices and Procedures Embedded in Systems (SKIPPES) that calls for 13 separate training initiatives to be developed through 2005. SKIPPES will be composed entirely of standardized materials developed by a group of subject matter experts in collaboration with experts in training methodology. This standardization will result in lower error rates, since every technician will be taught the correct processing procedures rather than relying on individual instructor expertise. Employees will gain confidence from their improved performance when using the imbedded tools the system will provide. This will result in more accurate and timely processing of work, thus improving customer satisfaction. As part of succession planning we have utilized the Presidential Management Intern (PMI) program and the Outstanding Scholar Program (OSP) in order to recruit highly skilled, motivated personnel for mid-level staff positions. The PMI program requires a candidate to have completed a master's or doctoral-level degree from

an accredited college or university; it is designed to attract outstanding graduate students from a wide variety of academic disciplines to the federal service. The OSP is open to college graduates who have a grade point average of 3.5 or higher, based on a 4.0 scale, for all completed undergraduate courses, or who have graduated in the upper 10 percent of their class. Insurance has been very successful in attracting and retaining qualified employees through these programs.

Insurance has utilized information technology to improve the service we provide to our policyholders. Our major technology initiative is the Paperless Processing initiative. Paperless Processing is an imaging system that provides electronic storage of insurance records, on-line access to those records and electronic workflow. Part of this initiative consists of a three-year effort to image all 2.1 million insurance beneficiary and option (B&O) forms of record. After all B&O's are imaged, the need for paper folders will be eliminated. This will save $1.2 million a year in folder handling and storage. This initiative will also improve timeliness and quality of service while reducing the cost to policyholders. When fully installed, this system will reduce the time required for processing death claims and providing other vital services, thus improving customer satisfaction. In addition to faster processing, updated B&O forms ensure that more policies are being paid in accordance with the insured's wishes. Old beneficiary information sometimes results in situations where the beneficiary cannot be found, often requiring lengthy adjudication of claims. Another important initiative is the Insurance Self Service. This web site initiative allows policyholders, with the use of a Personal Identification Number (PIN), to view basic policy information online via the Internet at our web site "**www.insurance.va.gov"**. Policyholders have access to their policy description, dividend amount, premium payment status, cash and loan values and the date of their last beneficiary designation. Policyholders can also request a mailed copy of their insurance policy statement via the web site. In future phases of this initiative, policyholders will be able to make certain account changes, such as address and dividend option changes, complete certain electronic applications, and view their beneficiary designation.

Insurance has also improved service to policyholders by streamlining its program. Over the last few years we merged the program into one centralized operation. We consolidated the St. Paul Insurance Center into the Philadelphia Insurance Center, and merged the Systems Development Center into the Insurance Service. Along with the Benefits Delivery Center, co-located in Philadelphia, Insurance is now a 100 percent centralized operation. This centralized operation of headquarters, field operations, information technology and systems delivery along with a nation-wide toll-free service, has helped the Insurance Program become a world-class organization that meets or beats all industry benchmarks at a lower cost than the average industry costs. An example

of this service can be found in the recent study of death claims conducted by the American Customer Satisfaction Index (ACSI) and the University of Michigan. Death claims are considered one of the most important services provided by Insurance. This study of the satisfaction of Insurance beneficiaries gave Insurance a score of 90 (ACSI scores of 90 are excellent) and stated that this is among the very highest ever recorded for either Government or private industry. Insurance also received a score of 90 for reputation, which is an extremely high index for reputation and is in line with the overall satisfaction index. The Insurance Program also was the recipient of the VA's prestigious Robert W. Carey Quality Award in the "Benefits Category" for 2001, for the second year in a row.

The majority (approximately 93%) of the Insurance program's administrative expenses are reimbursed from the Insurance programs. Since 1996, legislation has authorized the payment of Insurance administrative expenses out of excess earnings from the NSLI, VSLI and United States Government Life Insurance (USGLI) programs. Prior to 1996, only three of the eight government life insurance programs (SGLI, VGLI and Veterans Reopened Insurance (VRI)) paid their own costs of administration from premium income and/or fund surplus. This feature was established under each program's originating legislation. Prior to 1996, the cost of administration of the remaining five programs was borne by the Government. Because the program's administrative costs are primarily borne by the policyholder, we make every attempt to keep our expenses low. The Insurance program's administrative costs are significantly lower than comparable commercial insurance company costs. In 2000, the most recent year that data are available, the median cost of administering a policy for commercial insurance companies was $82.75 per policy to perform the functions that were performed by VA at a cost of $17.66 per policy.

Burial – Ensure burial needs are met

In order to achieve the performance goal of increasing the percent of veterans served by a burial option in a national or state veterans cemetery, VA will develop additional national cemeteries in unserved areas; expand existing national cemeteries to continue to provide service to meet projected demand, including the development of columbaria and the acquisition of additional land; and develop alternative burial options consistent with veterans' expectations.

Interment operations began at Fort Sill National Cemetery, near Oklahoma City, Oklahoma, in November 2001, providing service to over 165,000 veterans. A new national cemetery in the area of Atlanta, Georgia, will begin interment operations in 2003. NCA is also planning for the development of new national cemeteries to serve veterans in the areas of Detroit, Michigan; Miami, Florida; Pittsburgh, Pennsylvania; and Sacramento, California. When open, these five cemeteries will provide a burial option to nearly two million veterans who are not currently served. These locations were identified in a May 2000 report to

Congress as the six areas most in need of a new national cemetery, based on demographic studies.

VA will expand existing national cemeteries by completing phased development projects in order to make additional gravesites or columbaria available for interments. Phased development in 10-year increments is a part of the routine operation of an open national cemetery. It is the practice of NCA to lay out and subdivide a cemetery by sections or areas so it may be developed sequentially as the need approaches. National cemeteries that will close due to depletion of grave space are identified to determine the feasibility of extending the service period of the cemetery by the acquisition of adjacent or contiguous land, or by the construction of columbaria.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent demographic study to identify those areas of the country where veterans will not have reasonable access to a burial option in a national or state veterans cemetery, and the number of additional cemeteries required to meet veterans' burial needs through 2020. The contractor's report will be provided in the winter of 2002.

To achieve our performance goal to increase the percent of veterans served by a burial option, it is also necessary that state veterans cemeteries be established or expanded to complement VA's system of national cemeteries. NCA administers the State Cemetery Grants Program (SCGP), which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving state veterans cemeteries, including the acquisition of initial operating equipment. These cemeteries may be located by the states in areas where there are no plans for VA to operate and maintain a national cemetery. Forty-seven operating state veterans cemeteries have been established, expanded, or improved using the SCGP. By 2003, states will open 8 new state veterans cemeteries that will provide service to over 270,000 veterans not currently served by a burial option.

In meeting the burial needs of veterans and eligible family members, VA will continue to provide high quality, courteous, and responsive service. We will continue to obtain feedback from veterans, their families, and other cemetery visitors to ascertain how they perceive the quality of service provided. Using a customer satisfaction survey, NCA measures its success in delivering service with courtesy, compassion, and respect. We will also continue to conduct focus groups to collect data on stakeholder expectations and their perceptions related to the quality of service provided by national cemeteries. The information obtained is analyzed to ensure that NCA addresses those issues most important to its customers. This approach provides us with data from the customer's perspective, which are critical to developing our objectives and associated measures.

To increase awareness of benefits and services provided, NCA conducts outreach and education activities for the veteran community and the general public through the use of news releases, articles appearing in veterans service organization publications, public service announcements, and presentations to schools and community organizations.

To further enhance access to information and improve service to veterans and their families, we will continue to install kiosk information centers at national and state veterans cemeteries to assist visitors in finding the exact gravesite locations of individuals buried there. In addition to providing the visitor with a cemetery map for use in locating the gravesite, the kiosk information center provides such general information as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about the NCA. By 2003, VA plans to install 48 kiosks at national and state veterans cemeteries.

In order to accommodate and better serve its customers, VA developed three hub cemeteries to provide weekend scheduling of the interment in a national cemetery for a specific time in the ensuing week. Each hub cemetery provides this weekend service to families and funeral directors within its geographic area.

Veterans and their families have indicated that they need to know the interment schedule as soon as possible in order to finalize necessary arrangements. To meet this expectation, VA strives to schedule committal services at national cemeteries within two hours of the request. NCA is evaluating an instrument to collect data for timeliness of scheduling the committal service.

Burial – Timeliness of Marking Graves

NCA provides headstones and markers for the graves of eligible persons in national, state, other public, and private cemeteries. The amount of time it takes to mark the grave after an interment is extremely important to veterans and their family members. The headstone or marker is a lasting memorial that serves as a focal point not only for present-day survivors but also for future generations. In addition, it brings a sense of closure to the grieving process to see the grave marked. Delivery of this benefit is not dependent on interment in a national cemetery.

A data collection instrument, using modern information technology, has been developed to measure the timeliness of marking graves at national cemeteries. NCA is currently collecting baseline data and validating the accuracy and integrity of the data collected. When this review is complete, performance targets will be established.

NCA has also begun to develop the mechanisms necessary to measure the timeliness of providing headstones or markers for the graves of veterans who are not buried in VA national cemeteries. NCA plans to assess data collection

procedures to ensure that data collected to measure timeliness of delivery of headstones and markers are accurate, valid, and verifiable.

The Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, includes a provision that allows VA to furnish an appropriate marker for the graves of eligible veterans buried in private cemeteries, whose deaths occur on or after December 27, 2001, regardless of whether the grave is already marked with a non-government marker. This authority expires on December 31, 2006. However, not later than February 1, 2006, VA shall report the rate of use of this benefit; an assessment as to the extent to which these markers are being delivered to cemeteries and placed on grave sites consistent with the provisions of law; and a recommendation for extension or repeal of the expiration date.

NCA will improve accuracy and operational processes in order to reduce the number of inaccurate or damaged headstones and markers delivered to the gravesite. Headstones and markers must be replaced when either the Government or the contractor makes errors in the inscription, or if the headstone or marker is damaged during delivery or installation. When headstones and markers must be replaced, it further delays the final portion of the interment process, the placing of the headstone or marker at the gravesite.

NCA will use, to the maximum extent possible, modern information technology to automate its operational processes. On-line ordering using NCA's Automated Monument Application System – Redesign (AMAS-R) and electronic transmission of headstone and marker orders to contractors are improvements that increase the efficiency of the headstone and marker ordering process.

NCA is also increasing its efficiency by encouraging other federal and state veterans cemeteries to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. In 2001, 34 other federal and state veterans cemeteries ordered headstones and markers online.

Strategic Goal: ***Contribute to the public health, emergency preparedness, socio-economic well being and history of the Nation.***

Medical Research

VA complies with the federal regulations system that outlines the responsibilities for protecting human subjects. Investigators continue to be responsible for conducting research, in accordance with regulations. Institutions continue with oversight mechanisms, including local committees known as institutional review boards (IRB). IRBs are responsible for reviewing both research proposals and ongoing research. Agencies like VA are responsible for ensuring that their IRBs comply with applicable regulations, and that they provide sufficient space and staff to accomplish their obligations. VA requires that each VAMC engaged in research with human subjects, establish its own IRB or secure the services of another IRB at an affiliated university. VHA continues to

operate the Office of Research Compliance and Assurance (ORCA), to advise the Under Secretary for Health on all matters relating to the integrity of research protections, to promote the ethical conduct of research, and to investigate allegations of research impropriety.

Within VHA, Networks must comply fully with regulations and demonstrate such compliance in the following ways:

- Via Network Director monitors, each VISN Director is required to submit a quarterly report listing appropriate accreditation agencies for the Network's research programs, including dates of such review and conclusions of those reviews.
- VISN Directors are also required to report whether the Network is scheduled for an NCQA review and supply the dates of such review as well.
- Part of each Network Director's annual performance evaluation is therefore based on completion or outcome of various research compliance measures. This evaluation is based on including all necessary accreditation agencies' full accreditation and clearly defined plans for any new accreditation that is planned.

The FY 2001 performance goal for NCQA accreditation of VA Human Subjects Protection Programs was not achieved due to three intervening and unforeseen circumstances. VHA expects to meet the FY 2002 NCQA target level now that these issues have been resolved. With regard to other performance achievement, all 80 Veterinary Medical Units within the VA Research Program are accredited by the AAALAC (100 percent of goal) and all VA facilities requiring licensure by the Nuclear Regulatory Commission received it. The NRC is required for all facilities that utilize radioactive materials and/or radiation producing devices for research or clinical purposes. Oversight of these licensing activities is the responsibility of VA's National Health Physics Program (NHPP), a component of the Office of Patient Care Services.

Medical Education

VA has established and continues to evaluate responses to its annual survey assessing medical residents' and their trainees' satisfaction ratings of their clinical training experience. VA conducts extensive education and training programs to enhance the quality of care provided to veterans within the VA health care system. Education and training efforts are accomplished through coordinating programs and activities directly related to the education and training of health professions' students and medical residents by partnering with affiliated academic institutions. Veterans directly benefit from the care provided by supervised students and residents because the academic milieu encourages sharing of new information, research results, techniques and treatment modalities. VA's education and training programs also enhance VA's ability to

recruit and retain the best clinical staff. VA can better meet its educational mission because the results of the satisfaction survey identify key drivers of learner satisfaction that lead to continuous quality-focused improvements.

Burial

In order to achieve our objective, NCA must maintain occupied graves and developed acreage in a manner befitting national shrines. Improvements in the appearance of burial grounds and historic structures are necessary for NCA to fulfill this national shrine commitment. In-ground gravesites (casket and cremain) require maintenance to correct ground sinkage and to keep the headstones and markers aligned. Maintenance of columbaria includes cleaning stains from stone surfaces, maintaining the caulking and grouting between the units, and maintaining the surrounding walkways. Cemetery acreage that has been developed into burial areas and other areas that are no longer in a natural state also require regular maintenance.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directed VA to contract for an independent study to look at various issues related to the National Shrine Commitment and its focus on cemetery appearance. A study is underway to identify the one-time repairs needed to ensure a dignified and respectful setting appropriate for each national cemetery. Recommendations to address deferred maintenance issues or preventive steps to minimize future maintenance costs will be identified. The study will also include a report on the feasibility of establishing standards of appearance for national cemeteries equal to the finest cemeteries in the world. Varying characteristics of cemeteries, such as cemetery status (open, cremation only, and closed), as well as geographic and climatic conditions, will be taken into consideration. The contractor's report will be provided in the winter of 2002.

In advance of this report, a total of $10 million is included in the budget to address obvious, long-standing, deferred maintenance deficiencies. This funding for the National Shrine Commitment initiative will primarily be used for raising, realigning, and cleaning headstones and markers and for renovating gravesites.

All national cemeteries are important locations for patriotic and commemorative events. NCA will continue to host ceremonies and memorial services at national cemeteries to honor those who made the supreme sacrifice. To preserve our Nation's history, NCA will continue to conduct educational tours and programs for schools and civic groups.

Strategic Goal: ***Create an environment that fosters the delivery of One VA world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.***

In FY 2002, the Office of Public Affairs implemented the Department's Communication Plan to effectively build public awareness of, and support for, the mission and programs of the Department. This plan provides the framework within which all VA personnel can effectively communicate key VA messages as an essential part of their mission. VA's communication must bridge internal organizational structures and barriers, as well as send consistent messages through many voices, to internal and external stakeholders, and focus efforts to inform and educate those audiences with messages that help achieve VA goals.

Major Management Challenges

Each year, VA's Office of Inspector General (OIG) and the General Accounting Office (GAO) separately identify what they consider to be the major performance and accountability challenges facing the Department. This section of the Performance Plan presents each of these challenges and outlines what steps VA plans to take to resolve them. The following is an update prepared by VA's OIG summarizing the most serious management problems facing VA, and assessing the Department's progress in addressing these problem areas. Although VA does not have specific quantifiable goals and performance measures for each challenge, the Department does have corrective action plans in various stages of implementation. Where we have performance measures that directly address a challenge, we include the 2003 performance goal. Progress will be monitored until each management challenge has been successfully addressed. (On pages, 162 - 199 the words "we" and "our" refers to the OIG.)

Management Challenges Identified by VA's Office of Inspector General

1. ***Health Care Quality Management and Patient Safety***

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

One example of a particularly difficult and complex undertaking is the need to provide safe, high quality, patient care in an environment that is rapidly evolving from the traditional specialty-based inpatient care to an ambulatory care/outpatient primary care setting. Increasing reliance on treatment in ambulatory care settings can increase opportunities for clinicians to make errors in treating patients and increase the risk of patients receiving uncoordinated care among various outpatient disciplines. While patients are less vulnerable to hospital-acquired pathogens when they receive care in the ambulatory setting, they are increasingly vulnerable to incurring other medical treatment errors and threats to their safety such as missed diagnoses, inappropriate treatments, prescription errors, and failure to follow-up. The health care industry, including the Veterans Health Administration (VHA), needs to identify and correct these kinds of system problems.

A fully functional quality management program should be able to monitor patients' care to ensure their safety and to safeguard, to the extent possible, against the occurrence of inadvertent adverse events, undetected misdiagnoses, failure to treat through uncoordinated care, etc. These types of risk management functions are intended to assure patients that they will be cared for in a manner

that promotes their maximum safety while providing them with optimal medical treatment.

In recent years, VHA has not provided consistent clinical quality management leadership at all levels of the organization. This is due in part to the devolution of management authority from VHA headquarters to the Veterans Integrated Service Network (VISN) and individual VA medical center (VAMC) levels, coupled with resource reductions associated with the Veterans Equitable Resource Allocation model. In 2000, following an OIG review, VHA managers agreed to develop functional descriptions, which would help ensure the consistency of staffing patterns in VAMCs' quality management departments throughout the country. While no two VAMC quality management departments may focus on similar clinical quality issues in the same way, the VHA quality management system may begin to operate in a more consistent manner if the functional guidelines are followed. However, functional and resource disparities continue to impede the Department's ability to identify or measure the extent of possibly widespread unsatisfactory clinical practices, and to devise procedures to correct or eliminate such problems.

VHA's National Center for Patient Safety (NCPS) training on the principles of root-cause analysis, which responded to past OIG recommendations, continues and is well received by VHA employees. NCPS's focus on patient safety and resolving long-standing patient vulnerabilities has helped make VHA medical facilities a safer environment for their patients.

Current Status: Although VHA managers are vigorously addressing the Department's risk management and patient safety procedures in an effort to strengthen patients' confidence while they are under VA care, system issues remain. In addition, concerns exist for the care VA provides veterans in the private sector, e.g., on a contract or fee basis. Patient safety in these settings needs additional quality management attention. For example, patients, their family members, and members of Congress are concerned about patient safety and the quality of care provided in VA contract nursing homes. During our Combined Assessment Program (CAP) reviews[1], we found that VA contract nursing home inspections were not sufficient to ensure that patient safety and quality of care were equal to that provided in VA nursing homes. Also, in January 1994, the OIG issued a report titled *VHA Activities for Assuring Quality Care for Veterans in Community Nursing Homes* (Report No. 4R3-A28-016) that recommended VHA develop standardized community nursing home inspection procedures and criteria for approving homes for participation in the program. VHA has not implemented the OIG recommendations made in the 1994 OIG

[1] Through this program, auditors, investigators, and healthcare inspectors collaborate to assess key operations and programs at VA healthcare systems and VA regional offices on a cyclical basis.

report. In addition, the U.S. General Accounting Office (GAO) issued a report in July 2001 that had similar recommendations. We are reviewing the need for additional OIG oversight of VHA's inspections and patient safety measures for veterans' care in contract nursing homes.

VHA is also responsible for overseeing and evaluating care provided to veterans in State veterans homes. In January 1999, the OIG issued a report titled *Evaluation of VHA's State Veterans Home Inspection Process* (Report No. 9HI-A06-014) that indicated State veterans home inspections frequently did not adhere to VHA guidelines because employees did not understand their responsibilities. VHA has not implemented the OIG recommendation that they expeditiously conclude their revision and update of the State veterans home policies and procedures included in the annual inspection guidance issued to VAMCs.

The OIG conducted a nationwide assessment of VHA's policies and practices for evaluating and managing violent and potentially violent psychiatric patients. Our March 1996 report titled *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients* (Report No. 6HI-A28-038) recommended that VHA managers explore network flagging systems that would ensure employees at all VAMCs are alerted when patients who have a history of violence arrive at a medical center for treatment. VHA concurred that VISN-level/national databases are needed to support information sharing; however, this recommendation has not been implemented.

Another key patient safety and quality management concern is that the credentials and background assessment system for all patient care providers VA uses, whether VA-paid or not, is not consistent. This places veterans at risk if they receive care from a VA contract or part-time provider on a fee basis who may have an adverse clinical practice history unknown to VA or the patient. The OIG remains committed to reviewing the issue of credentials of non-VA providers who treat veterans.

The OIG is focusing on other areas of patient care that are vulnerable to system problems. Specifically, in addition to focusing on patient care and safety issues in VHA contract nursing homes, we are focusing on pain management, clinic waiting times, homemaker/home health services, primary care for patients in the area of mental health, VAMC sanitation and cleanliness, and patient satisfaction, as part of our CAP reviews. We are also reviewing quality and access-to-care issues in VHA's community-based outpatient clinics.

Future Plans from VHA Program Offices: VHA continues to make significant, nationally recognized progress in its national patient safety/risk management initiatives. Concerns still exist in oversight of care provided to veterans in contract nursing homes. VHA is currently making final revisions on a comprehensive draft directive, on Community Nursing Home Evaluation and Monitoring. Plans are also underway to establish annual review protocols and

follow-up training for VA staff that conduct nursing home inspections. Progress is also being made in revitalizing the information system that monitors facility compliance with the annual review of community nursing homes. A new report is also being designed to monitor compliance with the monthly visit standard.

VHA continues to finalize action to address on the one remaining OIG recommendation about the State veterans home inspection process, involving revision and update of the policies and procedures included in the annual inspection guidance issued to VAMCs of jurisdiction. Completion of this task involves multiple associated steps. Guidelines for State nursing home care standards have been drafted into a training document. They are being used to "test" the guideline. The directive for the State Nursing Home Care Program will be based on the final State nursing home care regulation and will have to be reviewed and approved by General Counsel. The final directive for every level of care will be held until all regulations (State Nursing Home Care, State Adult Day Health Care, State Home Domiciliary Care, State Home Hospital Care) are final. At this point, finalization dates for these regulations have not been verified.

VHA continues to finalize a computerized advisory directive to reflect the approach that is being taken to initiate a computerized system of flagging repetitively dangerous patients. An initial directive has been reviewed by the General Counsel, and Mental Health program officials and the Office of Information continue with project design. The final product may be available for implementation in June 2002.

VA's system for credentialing health care providers, VetPro, is fully operational, secure and state-of-the-art. VA's Under Secretary for Health recently received the highest Public Health Service's award, the Surgeon General's Medallion, for his leadership in implementing this system. VetPro is an electronic data bank that ensures health care professionals have appropriate degrees and licenses as well as track records of high-quality and safe patient care. Streamlining of the system will continue.

VA is developing new clinic wait time measures to quantify the wait times of new enrollees. VA is also developing a new survey to assess the experiences of new enrollees in requesting appointments. The data from the new measure, other VHA wait time measures, and the survey will provide more timely and relevant data for decision-making as it relates to the increase in numbers of new enrollees. VA is also recommending the development of standardized entry process for new enrollees. This process will assist in the automated collection of relevant wait time information at the time that the veteran enrolls in the system.

Performance Goals from VHA Program Offices

1. Improve performance on the Chronic Disease Care Index II to 79 percent.
2. Maintain performance on the Prevention Index II at 80 percent.
3. Ensure all facilities have a contingency plan for the loss of the electronic ability of the Bar Code Medication Administration (BCMA) process.
4. Increase the proportion of inpatients and outpatients rating VA health care service as "very good" or "excellent" to 68 and 69 percent, respectively.
5. Increase the percent of primary care appointments scheduled within 30 days of desired date to 89 percent.
6. Increase the percent of specialist appointments scheduled within 30 days of the desired date to 87 percent.
7. Increase the percent of patients who report being seen within 20 minutes of their scheduled appointments at VA health care facilities to 72 percent.
8. Increase the Balanced Scorecard: Quality-Access-Satisfaction-Cost value to 102 percent.

2. ***Resource Allocation***

Challenge Description: In 1997, Congress required VA to address resource inequities nationwide. Public Law 104-204 mandated that VA develop a plan to improve distribution of resources and ensure veterans equitable access to care across the United States. As a result, VA now uses the Veterans' Equitable Resource Allocation (VERA) system.

Prior to FY 1997, VA used three different resource allocation systems.[2] They were designed to improve certain functions of each preceding funding allocation system. VAMCs received and managed their own budgets, and annual incremental increases were based on prior year allocations. Funds allocated through each of these systems were based on historic funding imbalances that perpetuated inequitable allocations of resources and unequal access to care. The inequities that resulted were caused by a shift in the veteran population demographics without an accompanying shift in resource allocations.

VA developed the current VERA system in response to the legislative mandate and began system implementation in FY 1997. VERA is a capitation-based allocation methodology that moves funds among the VISNs based on patient workload. In FY 2001, $17.7 billion (88 percent of medical care resources) was distributed VISNs using the VERA system. The system provides some

[2] The other three were: (a) prior to 1985 -- Incremental Funding, (b) 1984-1985 -- Resource Allocation Model, and (c) 1984-1997 -- Resource Planning and Management model.

incentives for achieving cost efficiencies and serving more veterans. VISNs maintain responsibility for allocating resources among the facilities in their prescribed geographic areas.

In 1986, Congress requested that VA develop the Decision Support System (DSS), an automated information system. The purpose of DSS was to provide accurate tracking of resource expenditures on a near real-time basis allowing managers to make more informed and more proactive decisions. Despite the great potential of DSS, VHA has encountered problems implementing and using it in decision-making.

The OIG published a report titled *Audit of Veterans Health Administration Decision Support System Standardization* (Report No. 9R4-A19-075) in March 1999. This report discussed the fact that despite significant expenditures for the development and implementation of DSS, not all VHA facilities implemented and used DSS in the same way. In addition, the report discussed resistance to DSS on the part of many VHA managers. As a result, data was not homogenous across VHA facilities and programs, and DSS could not be used to provide accurate tracking of resource expenditures nor relied upon for decision-making. In March 2001, the OIG closed the DSS report recommendations after VHA published a directive on DSS.

In July 1999, the OIG issued a report titled *Evaluation of VHA Radiology and Nuclear Medicine Activities* (Report No. 9R4-A02-133) that found staffing disparities existed among medical centers with comparable workloads and most Radiology and Nuclear Medicine Services did not apply staffing guidelines, or there was disparity in the guidelines that were used. We recommended that VHA take action to standardize staffing guidelines for Radiology and Nuclear Medicine Services.

The GAO also issued reports in 1997 and 1998 that found responsibility for generating data and reporting results is fragmented in VA's system. VA managers did not have timely, comparable, and comprehensive information needed to monitor changes in access to care. GAO reported that VA headquarters had not provided criteria or guidance for improving the equity of resource allocations to facilities and that VA did not review Network allocation methods or results to determine whether allocations within each Network were made equitably.

Current Status: The OIG is continuing to assess the Department's allocation of resources. Currently, we are reviewing the management of nurse resources to determine if sufficient staffing resources are allocated and properly distributed to provide optimum patient care.

A review of historical VERA allocation data and results of a recent OIG management review in VISN 8 show that there are problems with the way VERA allocates funds. Over the last 5 years, VERA has resulted in the shifting of

significant amounts of resources to VISNs that were previously under-funded, however resource allocation issues remain unresolved. In August 2001, the OIG issued a report titled *Audit of Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network 8* (Report No. 99-00057-55). The report recommended that the VERA model include priority group 7 veterans (the majority of whom are currently excluded) so that the total numbers of veterans enrolled and treated are appropriately considered in funding decisions.

Our CAP reviews from 1999 through 2001 also identified uneven implementation levels and inconsistent utilization of DSS. CAP reviews have identified numerous examples where there was a need to realign staffing and resources to correct identified resource deficiencies. We concluded from CAP reviews that VHA needs to more aggressively assess changing health care system resource needs and direct VISN resources to those facilities experiencing shortages.

In July 2001, DSS program officials provided information that showed DSS was 96 percent standardized. However, VHA officials continue to encounter difficulty convincing some facility and VISN managers to incorporate DSS into their management processes. As a result, DSS is still not a completely effective management tool for monitoring and analyzing resource allocation at any level in VHA. We found that some facilities had completely implemented DSS and used it to a pronounced degree in decision-making while other facilities ignored DSS, and management at these facilities believed DSS data was unreliable. As a result, resource allocation is considered a significant management challenge in the Department.

VHA has not implemented the OIG recommendation made in the July 1999 report to standardize staffing guidelines for Radiology and Nuclear Medicine Services.

Future Plan from VHA Program Office: VHA has adequately responded to recommendations in the OIG reports on the Decision Support System and the VERA allocation system (*Availability of Health Care Services in Florida/Puerto Rico, VISN* 8) and no further reporting is required. The report has been closed.

Although the proposed directive on Diagnostic Radiology Staffing has been completed, as well as a handbook on Nuclear Medicine and Radiation Safety, the Office of the Assistant Deputy Under Secretary for Health has recommended disapproval of the staffing directive. Deliberations continue and a final decision on the directive has not yet been made.

3. *Compensation and Pension (C&P) Timeliness, Quality, and Inappropriate Benefit Payments*

Challenge Description: **Timeliness and Quality**

For the past quarter century, the Veterans Benefits Administration (VBA) has struggled with timeliness of claims processing; it continues to face a large backlog and takes an unacceptably long time to process claims. As of September 30, 2001, VBA reported a backlog of more than 532,000 cases. In FY 2001, VBA reported that C&P rating-related actions took an average of 181 days to process.

In December 1997, the OIG issued a report titled *Summary Report on VA Claims Processing Issues* (Report No. 8D2-B01-001) that identified opportunities for improving the timeliness and quality of claims processing and veterans' overall satisfaction with VA claims services. In our September 1998 report titled *Audit of Data Integrity for Veterans Claims Processing Performance Measures Used for Reports Required by the Government Performance and Results Act* (Report No. 8R5-B01-147) and our October 1998 report titled *Accuracy of Data Used to Measure Claims Processing Timeliness* (Report No. 9R5-B01-005), we reported that three key C&P timeliness measures lacked integrity and that actual timeliness was well above reported timeliness.

Current Status: The Secretary created a new Claims Processing Task Force in May 2001 to propose measures and actions to increase the efficiency and productivity of VBA operations, shrink the backlog of claims, reduce the time it takes to decide a claim, and improve the validity and acceptability of decisions. A report on the Task Force's findings and recommendations was issued. Two major types of claims – claims that are older than 1 year and claims that are caught in the appeals-remand cycle – troubled the Task Force. As a result, the Task Force recommended creating a Tiger Team empowered to cut red tape in order to resolve claims affecting aging veterans. This initiative is expected to make a major impact on the most difficult claims and should reduce the average processing time. Until VA can redesign the appeals and remand process, the Task Force also recommended to the Secretary that each VA regional office (VARO) establish, as a priority, a specialized team to manage and process appeals and remand actions locally.

The Task Force reported the appeals process today is ill suited to serve veterans or VA, and made several recommendations targeted at improving the timeliness of appeals processing. These include: (i) establish a special team of experienced VBA staff to expedite resolution of C&P cases over a year old, (ii) require the Board of Veterans Appeals to develop and process the current workload of appeals rather than issuing remands, (iii) establish specialized claims processing teams, (iv) improve record recovery from the VA Records Management Center, and (v) maintain or increase competitive outsourcing of medical examinations. In April 2001, the Secretary also directed the Board of

Veterans Appeals to reduce the time veterans have to wait for appellate decisions. VA needs a better system to manage appeals.

Additional actions taken to improve claims processing timeliness include the development of compensation program outcome statements that reflect the views of key stakeholders. Efforts are currently under way to develop outcome performance measures that support each of the outcome statements. Similar efforts are underway for the pension program. New initiatives for FY 2002 include: development of an on-line application system for C&P benefit; expansion of claims development efforts for service persons awaiting discharge; development of the Personnel Information Exchange System to include all military records centers; implementation of paperless technologies to allow the processing of claims in a fully electronic environment; centralized C&P training programs; and changes to regulations to permit oral evidence gathering. Actions are also underway to improve the ongoing quality, timeliness, and cost of VHA C&P medical examinations.

Current Status: The OIG plans to continue conducting CAP reviews at VAROs and plans to summarize program findings in FY 2002.

Future Plans from VBA Program Offices: The Secretary of Veterans Affairs has set a goal of monthly average of 100 days to process rating-related claims during the last quarter of FY 2003, while continuing to improve quality. VA is putting in place several mitigation actions that cumulatively will dramatically improve timeliness by the end of 2003. As an early step, the Department has launched a major effort to resolve 81,000 of our oldest claims, ones that have been pending more than one year. A special team has been established at the Cleveland Regional Office to tackle many of these oldest claims, especially those claims from veterans over age 70.

VA reduced the appeals resolution time by 5 percent during 2001. We will continue to work toward additional reductions in the length of time required to process appeals of claims by reducing the remand rate.

VBA and VHA signed a memorandum of understanding in February 2001 to establish a Joint Examination Improvement Office in Nashville, Tennessee. The mission of this office is to review the C&P examination process in order to identify the tools and procedures needed to improve the quality and timeliness of C&P medical examinations. It is currently functioning and recruitment is underway for all the necessary subject matter experts from both VBA and VHA.

Challenge Description: **Inappropriate Benefit Payments**

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

Payments to Incarcerated Veterans

In February 1999, the OIG published a report titled *Evaluation of Benefit Payments to Incarcerated Veterans* (Report No. 9R3-B01-031). The review found that VBA officials did not implement a systematic approach to identify incarcerated veterans, and adjust their benefits as required by Public Law 96-385. The evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in six states. Results showed that VAROs had not adjusted benefits in over 72 percent of the cases requiring adjustments, resulting in overpayments totaling $2 million. Projecting the sample results nationwide, we estimated that about 13,700 incarcerated veterans had been, or will be, overpaid about $100 million. Additional overpayments totaling about $70 million will be made over the next 4 years to newly incarcerated veterans and dependents, if VBA does not establish a systematic method to identify these incarcerated veterans.

Our July 1986 report titled *Benefit Payments to Incarcerated Veterans (*Report No. 6R3-B01-110) found that controls were not in place to cut off benefits to veterans when they were incarcerated. That report recommended that a systematic approach be applied; however, actions were not taken to implement the recommendations in the 1986 report.

Current Status: VBA has implemented 1 of 4 recommendations from the February 1999 OIG report. The recommendations that VBA: (i) identify and adjust the benefits of incarcerated veterans and dependents, (ii) establish and collect overpayments for released veterans and dependents that did not have their benefits adjusted, and (iii) establish a method to ensure VAROs process identified cases timely, and properly adjust benefits, are unimplemented.

Future Plans from VBA Program Office: VA signed a Memorandum of Understanding with the Social Security Administration (SSA) that will allow us to receive their state and local prisoner files for a matching program. Once the data exchange from SSA is secured, the existing procedures used for the Federal Bureau of Prisons (FBOP) will apply. The system to identify and adjust benefits will be identical to the existing system used for FBOP. Both the FBOP and SSA prison matches will continue as ongoing processes.

Benefit Overpayments Due to Unreported Beneficiary Income

VBA's Income Verification Match (IVM) did not effectively result in required benefit payment adjustments and identification of program fraud, thus IVM remains a significant internal control and financial risk area. Our November 2000 report titled *Audit of Veterans Benefits Administration's Income Verification Match Results* (Report No. 99-00059-1) found that opportunities exist for VBA to: (i) significantly increase the efficiency, effectiveness, and amount of potential overpayments that are recovered, (ii) better ensure program integrity and

identification of program fraud, and (iii) improve delivery of services to beneficiaries.

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

Current Status: VBA has implemented 7 of 8 recommendations from the November 2000 OIG report. The recommendation to complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA remains unimplemented. This recommendation was a repeat recommendation from our 1990 OIG report.

Future Plans from VBA Program Office: VBA agreed to implement the following recommendations: (i) increase program oversight of the results of IVM actions completed; (ii) eliminate the review of selected pension cases because they result in no benefit overpayment recoveries; (iii) eliminate review of IVM cases with income discrepancy amounts of less than $500 because they result in little or no benefit overpayment recoveries; (iv) complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of unmatched records with SSA; (v) ensure that accounts receivable are established to recover IVM-related debts from beneficiaries; (vi) ensure that waivers of beneficiary IVM-related debts are not granted when fraud is identified; (vii) refer potential fraud cases to the OIG based on the established referral process; (viii) report the IVM for consideration as an Internal High Priority Area that needs monitoring.

Disability Compensation Benefits for Active Military Reservists

In May 1997, the OIG conducted a review to determine whether VBA procedures ensure that disability compensation benefits paid to active military reservists are offset from training and drill pay as required by law. The OIG report titled *Review of Veterans Benefits Administration's Procedures to Prevent Dual Compensation* (Report No. 7R1-B01-089) identified that VBA had not offset VA disability compensation to 90 percent of the sampled active military reservists receiving military reserve pay. We estimated that dual compensation payments of $21 million were made between FY 1993 and 1995 and, if the condition was not corrected, annual dual compensation payments, estimated at $8 million, would continue to be made. Dual payments occurred because procedures established between VA and the Department of Defense (DoD) were not effective or were not fully implemented.

Current Status: VBA has not implemented the recommendation to follow up on FY 1993-1996 dual compensation cases to ensure either VBA disability payments are offset or DoD is informed of the need to offset reservists' pay.

Future Plans from VBA Program Office: VA has been coordinating the receipt of drill pay information with the Defense Manpower Data Center (DMDC) since late 1999. However, the information received by VA was found to be inaccurate. DMDC and DFAS worked together to identify the problems in their reporting. In June of 2001, DMDC indicated that they had been successful in identifying and correcting the errors, however, they cannot provide accurate data on drill days prior to FY 2001. We expect to begin the matching program again using the FY 2001 information during FY 2002.

Benefit Overpayment Risks Due to Internal Control Weaknesses

In FY 1999, the Under Secretary for Benefits asked for OIG assistance to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. The request followed the discovery that three VBA employees had embezzled over $1 million by exploiting internal control weaknesses in the C&P program. Our vulnerability assessment identified 18 categories of vulnerability involving numerous technical, procedural, and policy issues. The Under Secretary for Benefits agreed to initiate actions to address the weaknesses identified.

To test the existence of the control weaknesses identified in the vulnerability assessment, we conducted an audit at the VARO in St. Petersburg, FL. That VARO was selected for review because it was one of the Department's largest VAROs, accounting for 6 percent of C&P workload and was the location where 2 of 3 known frauds took place. The July 2000 report titled *Audit of the Compensation and Pension Program's Internal Controls at VA Regional Office St. Petersburg, FL* (Report No. 99-00169-97) confirmed that 16 of 18 categories of vulnerability reported in our vulnerability assessment were present at the VARO.

Current Status: There is an ongoing criminal investigation at the VARO in Atlanta, GA, where an estimated $11 million in fraudulent benefits were processed. At the request of the Secretary, the IG agreed to conduct a review of all one-time C&P payments, valued at $25,000 or more, made since 1995, to determine if the payments were valid. The OIG will also conduct CAP reviews at selected VAROs to assess internal control weaknesses previously identified in our vulnerability assessment along with reviewing other related claims processing issues.

VBA agreed to address the 18 internal control weaknesses identified in the vulnerability assessment and the 15 recommendations identified in the St. Petersburg audit. Implementation action on these recommendations is currently in process.

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

Example Performance Goals from VBA Program Offices:

1. Complete rating-related actions on compensation and pension claims in an average of 165 days. (*This number is the average cumulative for the fiscal year. We expect to achieve 100 days processing time during the last quarter.)*
2. Attain an 88 percent national accuracy rate for core rating work.
3. Reduce the appeals resolution time to 520 days.
4. Reduce dollar value of overpayments to $290 million.

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

Challenge Description: Successful implementation of GPRA, including performance-based budgeting, requires that information be accurate and complete. At the request of the Assistant Secretary for Policy and Planning, we initiated a series of audits to assess the quality of data used to compute the Department's key performance measures. The OIG has completed work on the following six performance measures:[3]

- Average days to complete original disability compensation claims – 34 percent of the records reviewed contained inaccurate or misleading data.
- Average days to complete original disability pension claims – 32 percent of the records reviewed contained inaccurate or misleading data.
- Average days to complete reopened compensation claims – This number of reopened claims was inflated by 18 percent. Of the records reviewed, 53 percent contained inaccurate or misleading data.
- Percent of the veteran population served by the existence of a burial option within a reasonable distance of place of residence – VA could not recreate population projections used to calculate this measurement because essential data no longer existed.
- Foreclosure avoidance through servicing ratio – The OIG was unable to attest to the accuracy of the reported ratio because VBA did not maintain necessary documentation.

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

- Unique Patients – VHA overstated the number of unique patients by 7 percent.

Deficiencies were identified in each performance measure audited. VBA and VHA are taking action to correct the deficiencies.

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

Current Status: The Office of the Assistant Secretary for Management has identified the following management challenges to the successful implementation of GPRA.

- Better alignment of budget accounts with GPRA programs.
- Improvement of financial management systems report structure and timeliness.
- Improvement of cross-cutting activities between VA and DoD.

Audits of three key performance measures -- the VHA prevention index, the VHA chronic disease care index, and the accuracy of the VBA veteran rehabilitation rate -- are in process.

Future Plans provided by VA Program Offices: To date, the OIG has completed audits of six key measures, with several others on the agenda for the near-term. VBA and VHA began taking action to correct the deficiencies identified in the data for which they have responsibility. Specifically in regard to a VHA issue, the Austin Automation Center installed corrective edit checks in the reporting of unique patients to assure full accuracy, and OIG closed the report. Also, edits of the VHA prevention index and chronic dieses care index are in process. Inconsistencies identified in NCA's estimate of the percent of the veteran population served by a burial option within a reasonable distance of place of residence have been corrected.

VA has made progress in implementing GPRA, although additional improvement is needed to ensure stakeholders have useful and accurate performance data. Management officials continue to refine performance measures and procedures for compiling data. Performance data are receiving greater scrutiny within the Department, and procedures are being developed to enhance data validation.

For additional information on data quality, see the Assessment of Data Quality section. Specific methods of validating data for each of the Department's key performance measures are included in the key policy issue discussions.

5. ***Security of Systems and Data***

Challenge Description: VA faces significant challenges in addressing Federal information security program requirements and establishing a comprehensive integrated VA security program while homeland security risks continue to escalate. Information security is critical to ensure the confidentially, integrity, and availability of VA data and the assets required to support the delivery of health care and benefits to the Nation's veterans. VA provides medical services at over 1,150 sites, a benefits delivery network of 57 VAROs, a burial system involving 119 national cemeteries, maintains 3 major data processing centers, and provides other Departmental functions. VA is highly dependent on automated information systems to support its mission to deliver services to our Nation's veterans.

The three VA administrations' stovepipe operations have not adopted standard hardware and software integration, which contributes to security vulnerabilities in the Department. Decentralization of information technology and lack of management oversight at all levels have also contributed to inefficient practices and to weaknesses in safeguarding electronic information and physical security of assets.

Previous OIG audit reports have identified weaknesses in information security throughout VA. With passage of the Government Information Security Reform Act (GISRA) as part of the FY 2000 Defense Authorization bill, the OIG is required to complete an independent assessment of VA's compliance with the Act. Limited information had been developed by VA on existing information security vulnerabilities that could be analyzed to establish a baseline on the adequacy of VA's information security. Therefore, the OIG performed vulnerability assessments and penetration tests of selected segments of the Department's electronic network of operations to identify vulnerabilities that place sensitive data at risk of unauthorized disclosure and use.

Current Status: Our October 2001 report titled *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 00-02797-001) found that weaknesses exist, and as a result, require the continuing designation of information security as a Department material weakness area under the Federal Managers' Financial Integrity Act. VA systems continue to be vulnerable to unauthorized access and misuse of sensitive automated information and data. The Department has started efforts to correct these weaknesses and work toward compliance with the GISRA requirements; however, results of the recently

completed GISRA audit identified significant information security vulnerabilities that continue to place the Department at risk of:

- Denial of service attacks on mission critical systems.
- Disruption of mission critical systems.
- Unauthorized access to and disclosure of data subject to Privacy Act protection and sensitive financial data.

In addition, the following key issues were identified:

- VA has established comprehensive information security policies, procedures, and guidelines, but implementation and compliance have been inconsistent.
- VA has been slow to implement a risk management framework. As a result, VA does not comply with GISRA; Office of Management and Budget (OMB) Circular A-130, Appendix III; and Presidential Decision Directive 63 security requirements.
- Penetration tests verified that VA systems could be exploited to gain access to sensitive veteran benefit and health care information.

Results of our February 2001 consolidated financial statements audit have also continued to identify information security weakness. This report titled *Audit of the Department of Veterans Affairs Consolidated Financial Statements For Fiscal Years 2000 and 1999* (Report No. 00-01702-50) found management oversight and control weaknesses continue to be problems in the security of sensitive information. The newly confirmed Chief Information Officer/Assistant Secretary for Information and Technology has taken an aggressive approach to correcting identified weaknesses and hardening the security of the Department's electronic information.

Future Plans from VA Program Offices: The OIG continued its assessment of ADP controls as part of its audit of VA's 2001 Consolidated Financial Statements. In addition, the OIG recently concluded a nationwide audit of VA's Information Security Program to assess VA's efforts to address information security control weaknesses and establish a comprehensive integrated security management program. The actions necessary to reduce risk to an acceptable level require a long-term, sustained effort. To address the VA-wide ADP security and control issues, VA established a centrally managed security group in 1999 and an information security working group, in which the OIG participates. In October 2000, the Department issued a revised Information Security Management Plan that identified a number of security enhancement actions that are being accelerated to improve enterprise-wide information security. VA's Information Security Budget Program identifies 10 areas that VA plans to address during fiscal years 2000-2005, at an estimated cost of over $114 million.

6. *Federal Financial Management Improvement Act and VA's Consolidated Financial Statements (OF, OI&T)*

Challenge Description: The Chief Financial Officers Act of 1990, Government Management Reform Act (GMRA) of 1994, and implementing OMB Bulletins require that VA's consolidated financial statements (CFS) be audited annually by the OIG or the OIG's representative. The agency CFS and related audit reports are integral to the Government wide CFS prepared by the Department of Treasury and audited by the GAO. VA's FY 2000 CFS reported assets totaling $44 billion, liabilities totaling $576 billion, and net operating costs of $45 billion.

VA achieved unqualified CFS audit opinions in FY 2000 and FY 1999. VA has also demonstrated management commitment to addressing material internal control weaknesses previously reported and made significant improvements in financial management. However, remaining material weaknesses are still considered significant, such as noncompliance with the Federal financial management system requirements of the Federal Financial Management Improvement Act. Corrective actions needed to address noncompliance with system requirements are expected to take several years to complete. The OIG also reported other significant conditions addressing the need for improving application programming and operating system change controls, business continuity and disaster recovery planning, and operational oversight.

Current Status:

Integrated Financial Management System Material Weakness

The material weakness concerning the Department's financial management systems underscores the importance that the Department continue its efforts to acquire and implement a replacement integrated core financial management system. However, achieving the success of an unqualified opinion currently requires a number of manual compilations and extraneous processes that the financial management system should perform. These processes require extraordinary administrative efforts by Department program, financial management, and audit staff. As a result, the risk of materially misstating financial information is high, considering the need to perform extensive manual compilations and extraneous processes. Efforts are still needed to ensure adequate accountability, and reliable, useful, and timely information needs to be available to help Department officials make well-informed decisions and judgments.

The February 2001 OIG CFS report noted continuing difficulties related to the preparation, processing, and analysis of financial information to support the efficient and effective preparation of the VA's CFS. Examples cited by the CFS auditors include:

- General ledgers for some smaller funds are maintained outside the existing core financial management system.
- Unreconciled differences between the general ledgers and the Property Management System subsidiary ledger exist.
- A significant number of manual adjustments were used during the year-end closing process.

Information Technology Security Controls Material Weakness

The OIG reported this condition in the CFS reports for FY 1997, 1998, and 1999 and made recommendations for VA to implement a comprehensive security program that would improve these controls. The CFS auditors noted the following information technology weaknesses:

- Inadequate security plans and security administration.
- Improper access by programming staff.
- Inappropriate access capabilities by application programmers.
- Inadequate review, investigation, and documentation of network access exceptions.
- Physical access to computer rooms storing production hardware by individuals with incompatible duties.
- Inconsistent anti-virus software upgrades at all locations and improper setup to alert administrators to take prompt actions.

The size of VA programs and the large number of systems that generate program and financial information make correction of existing material weaknesses very complex. VA is also dependent on the receipt of funding through OMB and Congress to implement corrective actions. The target date for completing corrective actions on the information technology security control weaknesses is FY 2003 and corrective action on financial management system deficiencies is FY 2004, when implementation of VA's core Financial and Logistics System (coreFLS) project is scheduled for completion.

Future Plans provided by VA Program Offices: The Department is implementing corrective action plans to correct the material internal control weaknesses. VA's leadership team has initiated cross Administration funding and established individual and collective cyber security responsibility and accountability. A new Office of Cyber Security will implement and monitor the correction of this material internal control weakness. In addition, VBA is correcting three noted items in the Housing Credit Assistance accounting program as well as completing crosswalks to the Department's core accounting system.

Performance Goal from VA Program Offices:

Maintain performance of no audit qualifications identified in auditor's opinion on VA's Consolidated Financial Statements.

7. *Debt Management (VBA, VHA, OF)*

Challenge Description: As of March 2001, debts owed to VA totaled over $4 billion. Debts result from home loan guaranties, direct home loans, life insurance loans, medical care cost fund receivables, compensation, pension, and educational benefits overpayments. Over the last 4 years, the OIG has issued reports addressing the Department's debt management activities. We reported that the Department should be more aggressive in collecting debts, improve debt avoidance practices, and streamline and enhance credit management and debt establishment procedures. VA has addressed many of the concerns reported over the last few years. However, our most recent national and CFS audits and CAP reviews continue to identify debt management issues.

There has been a great deal of dialog and sharing of information between the OIG and VA management to assess the current magnitude of the debt management issues. For example, VBA direct home loans is considered a lender of last resort. Consequently, if a borrower defaults on a loan, few resources are available for VA to collect. However, we feel there are other debt management issues that VA can improve. Issues identified by the OIG relate to: accounts receivable follow-up, timely reconciliation, and billing process problems.

In March 1999, we conducted an evaluation of VHA's IVM program to: (i) follow up on the implementation of recommendations made in a March 1996 OIG report, and (ii) determine whether there were opportunities for VHA to conduct the IVM program in a more efficient and cost effective manner. The OIG report titled *Evaluation of VHA's Income Verification Match Program* (Report No. 9R1-G01-054) found that VHA could increase opportunities to enhance Medical Care Cost Fund (MCCF) collections by $14 million, and put resources valued at $4 million to better use, by requiring VISN directors to establish performance monitors for means testing activities and billing and collection of program referrals. Additionally, to further ensure these monetary benefits are achieved, VHA management needed to implement previous recommendations and the VHA Chief Information Officer needed to increase oversight of the Health Eligibility Center (HEC) activities. VHA also needed to expedite action to centralize means testing activities at the HEC.

Current Status: The Department has performed considerable work in the area of the debt referral process with the Department of Treasury. VA has reported it has met or exceeded Department of Treasury goals this year

demonstrating a commitment to improving debt management within the Department.

VHA has not implemented 7 of 13 recommendations from the March 1999 OIG report on VHA's IVM program.

The OIG is currently conducting an audit to determine VHA's success with MCCF and to identify opportunities to enhance MCCF recoveries. Preliminary audit results show that previous reported conditions, including missed billing opportunities, billing backlogs, and minimal follow up on accounts receivable, are still continuing. Also, insurance identification procedures need improvement. Our July 1998 audit found MCCF recoveries could be increased significantly by more actively managing MCCF program activities; however, our follow-up indicates the recommendations were not effectively implemented.

Future Plans from VA Program Offices: VA staff offices and administrations have been working to reduce the number of outstanding debts. During FY 2001, the Department began an analysis of OIG audits performed over the last 5 years pertaining to debt management. As shown below the audit coverage focused on ten categories in three primary areas.

Medical Care Debts

- Billing and collection of medical care co-payments
- Follow-up on outstanding receivables
- Billing procedures
- Monthly reconciliations

In terms of MCCF activities, VHA's revenue office continues to spend considerable time and effort in identifying opportunities to improve the revenue process. The Revenue Improvement Plan (addressing MCCF issues), completed in September 2001, is a comprehensive document that addresses all aspects of the revenue cycle. It includes an overall improvement plan, responsibilities and time frames for completion. All of the recommendations identified by the OIG are addressed in the plan, as are recommendations that were made by reviews conducted by the Financial and Systems Quality Assurance Service (FSQAS). The plan is now under review in the Office of the Secretary.

Income Verification Process

- Increase program oversight
- Eliminate review of selected pension cases with income discrepancies of less than $500
- Assure that waivers of IVM related debts are not granted in fraud cases

- Data verification of beneficiary identifier number to reduce numbers of unmatched

VHA continues to implement the outstanding recommendations from the report on the Income Verification Match program. The Health Eligibility Center (HEC) has established mechanisms to ensure that IVM conversation cases are referred to all sites of care for appropriate billing action. HEC is working with the VISNs to establish performance standards that require staff involved in the means test co-payment billing process to administer IVM referral cases in a timely manner. HEC also has reporting capabilities that will enable staff at the medical facilities and Networks to monitor and track billing and collection activities. A directive is being prepared for distribution to the Networks and facilities that describes the restart of the IVM process, the new reporting procedures, and draft performance standards for field staff involved in revenue activities related to IVM means test co-payment billing. Target date to resume income verification is April 2002. Redesign of the HEC database and implementation of a national Centralized Renewal of Means Test continue to be on an expedited schedule, and are on target for completion by October 2002.

Compensation and Pension (C&P) Program

- Benefit payment errors
- Weak internal controls

Compliance audits will be performed to ensure that corrective action has been fully implemented to address the deficiencies identified above.

As of June 30, 2001, VA referred 93 percent of eligible debt to the Department of the Treasury's Offset Program (TOP). This is 3 percent above Treasury's goal.

After reaching an agreement with Treasury, VA began referring debts for cross servicing in the first quarter of FY 2001. VA referrals to Treasury have been limited to groups of 5,000 accounts per submission due to Treasury's systems limitations. As of June 30, 2001, VA referred 87 percent of eligible debt to Treasury for cross servicing. Over 90 percent of eligible debt will be referred by the end of FY 2001 once all referrals are completed.

8. *Workers' Compensation Costs*

Challenge Description: The Federal Employees' Compensation Act (FECA) authorizes benefit payments to civilian employees of the Federal government for disabilities or deaths resulting from injuries or disease sustained in the performance of their official duties. The benefit payments have two components – salary compensation payments and medical treatment payments for specific disabilities. Benefit payments under FECA are made from the Employees'

Compensation Fund administered by the Department of Labor, Office of Workers' Compensation Program (OWCP).

During the period July 1998 through June 1999, VA's OWCP costs totaled over $137 million for the 15,287 active cases. Wage loss compensation was over $106 million (77 percent) and medical costs were over $31 million (23 percent). VHA accounts for about 95 percent of VA's total OWCP cases and costs.

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

Current Status: The OIG continues to provide technical support and assistance to the Department in their efforts to reduce WCP costs and identify WCP fraud. The OIG identified 82 claims during its FY 99 audit titled *Audit of High-Risk Areas in the Veterans Health Administration's Workers Compensation Program* (Report No. 99-00046-16) that involved potential WCP fraud. Efforts to continue identifying potential program fraud were addressed when the OIG provided two training sessions prior to VHA's one-time review of priority cases identified by automated analysis of VHA's active/open WCP cases. While VHA's reviews did identify cases they believed to be potential fraud, no investigations have been opened on these cases because additional documentation and evidence was needed. The OIG staff discussed these cases with VHA staff; however VHA has not provided the additional information requested.

Additionally, a VA OIG WCP resources Web page (www.va.gov/oig/52/wcp/wcp.htm) was created to allow VA employees to easily find and download WCP products. This Web page contains presentations, reports, and other WCP products, such as the fraud awareness bulletin. It also contains links to VA OIG Office of Investigation press releases on WCP cases.

Future Plans from VA Program Offices: VHA participates actively in the WCP fraud prevention program, and routinely reports cases of potential abuse. Approximately 40-50 cases have already been referred, although it is recognized that not all have met OIG's criteria for actual fraud. We therefore do not agree with OIG's statement that no potential WCP fraud cases have been referred.

9. *Procurement Practices (OA&MM, VHA)*

Challenge Description: The Department spends over $5.1 billion annually for supplies, services, construction, and equipment. VA faces major challenges to

implement a more efficient, effective and coordinated effort that can better ensure the Department's acquisition and delivery efforts to acquire goods and services. A more integrated effort is needed to ensure the benefits of acquiring goods and services outweigh costs. High-level monitoring and oversight need to be recognized as a Department priority, and efforts must continue to maximize the benefits of competition and leverage VA's full buying power. VA must also ensure that adequate levels of medical supplies, equipment, pharmaceuticals, and other supply inventories are on hand to satisfy demand. Inventories above those levels should be avoided so funds that could be used to meet other needs are not tied up in excess inventories.

Historically, procurement actions are at high risk for fraud, waste, abuse, and mismanagement. Vulnerabilities and business losses associated with theft, waste and damage of information technology are known to be significant. Past audits support the need to provide for adequate acquisition planning on a corporate basis and to improve and coordinate national and regional acquisition planning efforts.

Current Status: Recent OIG reviews have identified serious problems with the Department's contracting practices and acquisitions. These reviews have identified the need to improve the Department's procurement practices in areas of acquisition training and oversight, and to better ensure the adequacy and competency of the acquisition workforce. Recent business reviews conducted by the VA Office of Acquisition and Materiel Management (OA&MM) and other audits conducted by the OIG at VA facilities have identified significant problems relating to acquisition planning, training, inventory management, management oversight and contract administration.

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

An OA&MM Task Group was charged with developing an inventory of procurement problems in December 2000. The Group identified problems with noncompliance with acquisition regulations and poor contract administration on individual procurements as being caused by the failure to hire competent procurements officials, inadequate training, undue pressure, and weak or inconsistent procurement policies. Inadequate or non-existent acquisition planning at the local, VISN, and national levels was also identified. The Group provided a number of recommendations to address these problems effectively.

The Group recommended actions that should improve planning, coordination, and accountability at all Department levels.

Also, the OA&MM Group identified continuing problems with inventory management, purchase cards, scarce medical specialist/sharing contracts and information technology purchases as areas needing immediate study and attention. The group suggests that subgroups consisting of representatives of VHA, OA&MM, OIG and other appropriate offices be formed to address these issues. Subgroups are currently working on addressing specific issues.

Future Plans from VA Program Offices: In November 2000, at the request of the Deputy Under Secretary for Health and the Principal Deputy Assistant Secretary for Management, an Acquisition Issues Task Group prepared a detailed analysis of procurement problems in VHA. The IG served as a member of this group. Some recommendations of this group have been completed or partially completed. Others have been put on hold pending the outcome of the Secretary's Procurement Reform Work Group. This work group was formed in July 2001 and was tasked to look into similar procurement issues. This group is about to turn in its final report to the Secretary. Once the recommendations of both Task Groups have been fully implemented, there should be a marked decrease in procurement related problems.

Federal Supply Schedule Purchases

Federal Supply Schedule (FSS) contracts are awarded non-competitively by the National Acquisition Center to multiple vendors for like or similar commercial off-the-shelf products. The Government's negotiation strategy has historically been to obtain most favored customer pricing or better. Since 1993, the OIG has conducted pre-award and post-award reviews to provide contracting officials with insight into each vendor's commercial sales and marketing practices as well as buying practices. These reviews provide contracting officers with information needed to strengthen the Government's pricing position during negotiations. During the past few years, the effectiveness and integrity of the FSS program have deteriorated because FSS is no longer a mandatory source for these commercial products.

As a result of making FSS contracts non-mandatory sources of supply, there has been an increase in open-market purchases by VAMCs, often without attempts by them to either negotiate prices or determine price reasonableness. The term open-market describes the purchase of goods and services that are not on contract. In increasing numbers, vendors have: (i) withdrawn high-volume medical supply items from FSS contracts, (ii) refused to negotiate in good faith, (iii) cancelled contracts, or (iv) not submitted proposals for FSS contracts.

Although these vendors no longer have contracts, they have not lost their VA market share. They continue to sell in large volumes to individual VAMCs and avoid offering most favored customer prices, shielding themselves from pre-and

post-award reviews. In addition, they are able to sell products made in non-designated countries directly to VA facilities that they cannot sell on FSS or other contracts because of the Buy America and Trade Agreements Act requirements. Previous OIG investigations have resulted in $8 million in civil penalties being imposed on violators of the Act.

Current Status: The OIG CAP reviews at VAMCs have identified non-competitive open-market purchases at significantly higher prices than comparable items offered on FSS contracts. Our reviews have also identified conflict of interest issues and proposed sole source contracts that lack adequate business analyses, justifications, or cost/benefit assessments. Many proposals are not being audited as required and may not be receiving legal and technical reviews as required. Management attention is needed to develop clear and useful policies that will ensure fair and reasonable prices, consistency in the use of VA's statutory authority, and proper oversight of such activities.

Inventory Management

The OIG conducted a series of four audits to assess inventory management practices for various categories of supplies. These audits found that excessive inventories were being maintained, unnecessary large quantity purchases are occurring, inventory security and storage deficiencies exist, and controls and accountability over inventories need improvement. A FY 1998 audit of medical supply inventories at five VAMCs found that at any given time the value of VHA-wide excess medical supply inventory was $64 million, 62 percent of the $104 million total inventory. A FY 1999 audit of pharmaceutical inventories at four VAMCs found that about 48 percent of the $2 million inventory was in excess of current operating needs. Another audit in FY 2000 at five VAMCs concluded that 47 percent of the $3 million prosthetic supply inventory was excessive.

The main cause of the excess inventories was that the Generic Inventory Package was not being used or was insufficiently used to manage the inventories. VAMCs relied on informal inventory methods and cushions of excess stock as a substitute for the more structured Generic Inventory Package inventory management system. The successful transition to prime vendor distribution programs for pharmaceuticals and other supplies has helped reduce pharmacy inventories from previous levels. However, inventories continue to exceed current operating needs for pharmaceuticals and many other items.

Current Status: The last of the four OIG audits completed in FY 2001 concluded that 67 percent of the $5 million engineering supply inventory at five VAMCs was excessive. At any given time, the estimated value of the four types of inventories was about $435 million.

CAP reviews continue to identify numerous inventory management problems. In addition, problems associated with prime vendor programs have

identified areas where supplies are being acquired at increased costs and/or waste has occurred.

Future Plans from VHA Program Offices: All inventory management problems noted by the IG are addressed in VHA Handbook 1761.2, issued in October 2000. Implementation of the handbook has been delayed because the National Labor Management Organizations (AFGE and NAGE) have requested a national demand to bargain. In August 2001, VA Central Office signed an understanding with AFGE, effectively allowing all AFGE facilities to proceed with implementation of the handbook. However, discussions are still being conducted with NAGE.

Government Purchase Card Use

OIG audits and reviews at selected VAMCs have identified significant vulnerabilities in the use of Government purchase cards. Purchases have been split to circumvent competition requirements and some goods and services have been acquired at excessive prices and without regard to actual needs. Our reviews of purchase card records, invoices, purchase orders, procurement history files and other related records, also lead us to believe that VHA is purchasing open-market health care items in amounts greater than the 20 percent maximum allowed under Title 38 U.S.C. §8125(b)(3)(A).

Current Status: Of 33 CAP reports issued from March 31, 1999 to April 11, 2001, 22 identified Government purchase card problems such as the lack of timely reconciliations and certifications, inappropriate approving officials, improper purchases, exceeded purchasing limits, and poor internal controls. These conditions are a result of the widespread and essentially unmonitored use of Government purchase cards in conjunction with the decentralization of purchasing authority to VAMCs. If uncontrolled, risk will escalate as purchase card use increases throughout the Department.

Future Plans of VHA Program Offices: The Office of the Chief Financial Officer is finalizing corrective actions pertaining to VHA on the one remaining OIG recommendation: Strengthen controls over the Purchase Card Program by establishing appropriate mechanisms to monitor unreconciled transactions on a VA-wide basis. VHA requirements have been provided to the coreFLS analysts and the contractor, KPMG Consulting, to ensure the new system can provide the reports. It is expected that all required reports will be available by the time the Department begins nationwide implementation scheduled for April 2003. OIG will close the recommendation when further validation of these actions is received from the contractor. This response is currently being solicited by VHA.

Scarce Medical Specialist Contracts

OIG reviews of scarce medical specialist contracts have identified serious concerns about whether contracts are necessary and costs are fair and reasonable.

Reviews have also identified conflict of interest issues and proposed sole source contracts that lack adequate business analyses, justifications, or cost/benefit assessments. Most importantly, the requirement that noncompetitive contracts must be based on cost or pricing data was not enforced. Consequently, VAMCs paid excessive charges on certain contracts. VHA issued guidance and provided training that significantly improved contracting practices. However, we have found that VAMCs have been inappropriately using Intergovernmental Personnel Act assignments and commercial items contracts as a substitute for scarce medical specialist contracts. Use of these purchasing methods, in lieu of contracts, has resulted in higher prices being paid for services than would have been paid using properly negotiated contracts. Management needs to improve oversight to ensure that, when applicable, properly negotiated contracts are used. Furthermore, management needs to develop and/or enforce policies that ensure consistent compliance with VA's statutory authority in order to obtain reasonable prices.

Current Status: During FY 2001, we completed contract reviews of seven health care resource contract proposals involving scarce medical specialists' services. We concluded the contracting officer should negotiate reductions of over $2million to the proposed contract costs.

Future Program Plans for VHA Program Offices: Many of the problems with awarding Scarce Medical Specialist contracts are the result of such contracts being awarded under 38 USC 8183, Enhanced Sharing. Current policy for enhanced sharing does not fully describe how to negotiate and administer these contracts. Previous Scarce Medical Specialist contracting policy was covered in VHA Directive 96-039, which expired in May 2001. A subgroup of the Acquisition Issues Task Group is working on reissuing this directive and providing additional relevant information to help facilities avoid improperly awarding Scarce Medical Specialist contracts.

Controls Over the Fee-Basis Program

We conducted an audit to determine if VHA had established effective internal controls to ensure that payments for fee-basis treatment were appropriate. Fee-basis treatment is inpatient care, outpatient care, or home health care received from non-VA health care providers at VA expense. In June 1997, the OIG issued a report titled *Audit of Internal Controls over the Fee-Basis Program* (Report No. 7R3-A05-099) that found VHA could reduce fee-basis home health care expenditures by at least $1.8 million annually and improve the cost effectiveness of home health services by: (i) establishing guidelines for contracting for such services, and (ii) providing contracting officers with benchmark rates for determining the reasonableness of charges.

Current Status: VHA has not implemented the OIG recommendations in the June 1997 report to establish guidelines for contracting and provide contracting officers with benchmark rates.

Future Plans from VHA Program Offices: VHA has implemented all but one of the recommendations from the June 1997 report. The remaining recommendation deals with establishing guidelines for contracting home health services and providing contracting officers with benchmark rates for determining the reasonableness of charges. VHA's Geriatrics and Extended Care Strategic Health Care Group is finalizing a directive, (*Purchasing Home Care and Hospice Services from Community Agencies for Enrolled Veterans),* and VHA is working with the OIG to implement this final recommendation.

10. ***Human Capital Management (HRA, VBA, VHA)***

Challenge Description: Human Capital Management (HCM) is a major challenge for the Department, resulting from a high number of employees projected to become retirement eligible over the next 5 years. Given the significant size of VA's work force, there are also significant dollar outlays associated with addressing this challenge effectively. GAO has also identified strategic HCM as a Government wide "high risk" area.

Risks associated with not addressing VA's HCM include:

- Patient injury or loss of life.
- Program failure.
- Significantly reduced effectiveness.
- Significantly reduced efficiency.

VHA Nurses

The VA Office of Human Resources Management (HRM) reported in FY 2001 that registered nurses are the largest segment of health care workers within the Department. VA employs approximately 35,000 registered nurses and nurse anesthetists. VAMCs are having difficulty recruiting nurses in specialty fields and some VAMCs find it difficult to recruit and retain licensed practical nurses and nursing assistants. According to HRM, 12 percent of the VA nursing population is eligible to retire. Each year, approximately 4 percent more will be eligible to retire. HRM reports that by 2005, 35 percent of the current nursing workforce will be eligible for retirement.

Recent GAO reports point to the importance Congress has placed on this issue. The following is a list of recent GAO reports and quotes of pertinent statements in those reports:

- January 2001, High Risk Series - "A national nursing shortage could adversely affect VA's efforts to improve patient safety in VA facilities and put veterans at risk."
- May 2001, Nursing Workforce: Recruiting and Retention of Nurses and Nurse Aides Is a Growing Concern - "With the aging of the population, demand for nurse aides is expected to grow dramatically, while the supply of workers who have traditionally filled these jobs will remain virtually unchanged."
- July 2001, Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors - "The large numbers of registered nurses that entered the labor force in the 1970s are now over the age of 40 and are not being replenished by younger registered nurses… Job dissatisfaction has also been identified as a major factor contributing to the current problems of recruiting and retaining nurses… Demand for nurses will continue to grow as the supply dwindles…The future demand for nurses is expected to increase dramatically when the baby boomers reach their 60s, 70s, and beyond..."
- August 2001, Health Workforce: Ensuring Adequate Supply and Distribution Remains Challenging - "While current data on supply and demand for many categories of health workers are limited, available evidence suggests emerging shortages in some fields, for example, among nurses and nurse aides."

Current Status: VHA formed a National Succession Planning Task Force to address VHA's changing work force. According to the Task Force's August 2001 draft report on VHA Succession Planning, "VHA faces a leadership crisis unprecedented in its history. With 98 percent of our senior executives eligible to retire by 2005 and other key clinical and administrative cadres facing similar turnover, it is paramount that we quickly focus on both developing our new leaders as well as replacing key employees throughout our organization."

The Task Force's draft report lists recommendations in seven major categories: (i) benchmarking, (ii) workforce assessment, (iii) employee morale and satisfaction, (iv) short-term steps, (v) progression planning, (vi) legislative initiatives, and, (vii) organizational infrastructure. The report states that attracting, developing, and retaining a well-qualified workforce at all levels of VA's organization is paramount to ensure VA's ability to provide quality care to our veteran population. Recent GAO reports on management challenges cite a shortage of VHA nurses and difficulty in properly training and recruiting VBA Claims Processors as challenges for the Department.

Future Plans by VA Program Offices: National nursing shortages continue to be a priority issue for the entire health care industry. VHA maintains an ongoing, active recruitment process. There is no indication that the quality of care in VA medical centers has been adversely affected by nursing staff limitations.

VBA Claims Processing

The VA Secretary tasked a Claims Processing Task Force in May 2001 to identify the challenges VBA faces with timely and accurate claims processing. The Task Force reported that during the past decade the number of employees in VBA "dropped slightly while workload increased dramatically." The Task Force also reported that VBA reduced the availability of skilled labor for processing claims while diverting experienced staff to implement new processes that were poorly managed.

Although Congress has provided VBA an average increase of 800 employees in each of the last 2 years, VBA does not have an integrated training plan and program. The Task Force reported that VBA's Office of Employment Development and Training is not equipped to develop a comprehensive training plan. The report concludes that VBA has not put together the needed training infrastructure. The report also states that VBA's current hiring pattern is not the result of any strategy and is not integrated with any business plan. The report identifies 13 separate points in their recommendation for a fully integrated training plan and program, which includes the creation of a fully integrated training infrastructure.

Current Status: The OIG has not issued recent national audits on HCM, however we have identified resource shortages in CAP reviews.

Management Challenges Identified by the General Accounting Office

1. Access to Quality Health Care

Performance Goals:

Performance goals for this GAO challenge are the same as for IG challenge number 1 on page 161.

Challenge Description: Over the past several years, VA has undertaken many initiatives to improve veterans' overall access to VA-provided health care, such as shifting its emphasis from inpatient to outpatient primary care and increasing the number of outpatient clinics it operates. VA has also undertaken efforts to improve the quality of care it provides, including the introduction of patient safety initiatives. However, several areas require continued emphasis if VA is to achieve its goals. For example, VA cannot ensure that veterans receive timely care at VA medical facilities, nor can it ensure that it has maintained the capacity to provide veterans who have spinal cord injuries, serious mental illnesses, or other special needs the care that they require, as mandated by Congress. VA must also assess its capacity to provide long-term care for its aging veteran population and respond to emerging health care needs, such as treating veterans for hepatitis C. At the same time, VA is facing a potential shortage of

skilled nurses which, if nationwide projections for the next several years bear out, which could have a significant impact on VA's quality of care initiatives.

Current Status and Future Plans:

Access

VA has taken significant steps to improve veterans' access to health care. Over the past several years, VA has created hundreds of community-based outpatient clinics (CBOC) to provide care to veterans in outpatient settings rather than less efficient inpatient settings.

Waiting Times

In response to concerns about waiting times, VA established strategic targets for the time it takes veterans to get an appointment with a VA provider and the time they spend waiting in a provider's office. The Veterans Health Administration (VHA) has been measuring clinic appointment waiting times beginning in February 2000 using the average waiting time for next available appointment requests. VHA has also provided additional waiting times monitors to provide local managers with other perspectives on waiting time problems. Examples include average waiting time for new patients and average waiting time for established patients. VA continues to enter into short-term contracts with consultants to help reduce the backlog of specialty appointments and improve waiting times.

Quality and Patient Safety

VA has a number of initiatives underway to improve the quality of VA-provided care, including developing or revising systems for detecting and preventing adverse events that could harm patients.

Treating Veterans with Special Disabilities

The Department has adopted several performance measures to help assess the treatment of veterans with special disabilities. For example, VA is focused on promoting the health, independence, quality of life, and productivity of individuals with spinal cord injuries (SCI). We view discharge to non-institutional, community living as a positive health outcome. Consequently, one of our performance measures is the proportion of discharges from SCI center bed sections to non-institutional settings.

Shifting Health Care Needs and Workforce Issues

VA officials estimate that as much as 6.6 percent of its health care enrollees are infected with the hepatitis C virus. This is a rate three times that of the general U.S. population. Over the past 2 years, VA identified health care funding

to screen patients for hepatitis C risk factors, develop treatment protocols, and create a public health awareness campaign. VA projects spending an additional $152 million in 2001. During 2000, the Department screened over 385,000 veterans for hepatitis C. Of this total, about 4,500 patients tested positive and began therapy.

2. Health Care Resource Utilization

Performance Goals:

- Increase dollars derived from alternative revenue generated from health care cost recoveries to $1,489 million.

Challenge Description: To expand care to more veterans and respond to emerging health care needs, VA must continue to aggressively pursue opportunities to use its health care resources—including its appropriation of over $20 billion—more wisely. VA has reduced its per patient costs—one of its key performance measures—by 16 percent, but it could achieve additional efficiencies by realigning capital assets and human capital based on changing demographics and veterans' health care needs. For example, VA needs to further modify its infrastructure to support its increased reliance on outpatient health care services and expand its use of alternative methods for acquiring support services, such as food and laundry. The Department spends as much as one-quarter of its annual health care budget to operate and maintain about 4,700 buildings and 18,000 acres of property. VA also needs to pursue additional opportunities with DoD to determine cost-effective ways to serve both veterans and military personnel, including sharing services and facilities. In addition, VA must ensure that it collects the money it is entitled to from third-party payers for health care services provided to veterans whose conditions are not service-connected.

Current Status and Future Plans:

Asset Restructuring

In response to a recommendation to develop asset-restructuring plans for VA's 106 health care markets to guide planning and management of health care, VA established the Capital Asset Realignment for Enhanced Services (CARES) program. This program calls for assessments of veterans' health care needs in the future and available service delivery options to meet those needs in each health care market. VA has developed specific criteria for making these assessments.

VA began the CARES program in January 2001 in Network 12, which includes the Chicago VA medical centers. Booz-Allen & Hamilton (BAH) was awarded the primary contract to assess veteran health care needs, identify service delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets to support the delivery of health care services. BAH used actuary data from another contractor to project the health

care needs of veterans in VISN 12 through 2010. They studied the location and condition of VA facilities, the cost of different options, the community resources available, accessibility of health care for veterans, other VA missions (for example, research and education), and VA/DoD sharing opportunities.

DoD and VA Cooperation

VA and DoD officials have sought ways to share excess health care resources. Local VA medical centers and military treatment facilities have entered into agreements to exchange inpatient, outpatient, and specialty care services, as well as support services. Some local VA and DoD facilities have entered into joint ventures, pooling resources to build a joint medical facility or capitalize on an existing facility. Local facilities and the National Acquisition Center have also arranged to jointly procure pharmaceuticals, laboratory services, medical supplies, and equipment. In 2000, the two Departments saved an estimated $51 million from jointly awarded national committed-use contracts with suppliers to purchase four percent of their total drug replacements. On a national basis, VA and DoD continue to develop memorandums of agreement to work together on cost effective acquisitions.

For additional information concerning this challenge, see "Improving Coordination of VA and DoD Programs and Services" on page 134.

Third-Party Collections

VA supplements its medical care appropriations with collections from third-party insurers. In 2000, VA collected $387 million from these insurers - $35 million less than the year before. Several factors contributing to this decline are out of VA's control. For example, more veterans are becoming eligible for Medicare, which, by law, cannot pay for VA-provided care. Also, more veterans are enrolling in managed care organizations, from which VA cannot typically collect because it is not a participating provider. In September 1999, VA began billing insurers based on "reasonable charges" for actual care provided, rather than charging rates based on average cost of care. However, reverses in declining third-party collections will not occur until VA implements its improved billing processes.

VA has begun to update its billing and records systems to bring them in line with industry standards. VA has also undertaken several initiatives to address collections weaknesses. Specifically, VA's reasonable charges were designed to be set at the 80th percentile of charges in the market area of each VA facility. We also completed much work on refining our ability to discriminate among hundreds of diagnosis related groups (DRG) and thousands of Current Procedural Terminology (CPT) codes in order to document charges to insurance companies. Adding to the complexity is the fact that insurance companies pay providers differently, depending on the presence or absence of preferred provider agreements and other contractual arrangements. Accordingly, VA is not

yet in a position to routinely verify the appropriateness of insurers' payments when they pay less than what was charged. Efforts to improve VA's ability to do this have been substantial, however, and are ongoing.

3. Compensation and Pension Claims Processing

Performance Goals:

1. Performance goals are the same as IG challenge number 3, (see page 169).

Challenge Description: VA must also continue to seek ways to ensure that veterans are compensated for reduced earning capacity due to disabilities sustained, or aggravated, during military service. VA has had long-standing difficulties in ensuring timely and accurate decisions on veterans' claims for disability compensation. VA has improved its quality assurance system in response to GAO's recommendations, but large and growing backlogs of pending claims and lengthy processing times persist. Moreover, veterans are raising concerns that claims decisions are inconsistent across VA's regional offices. VA has taken steps to improve its information systems, performance measures, training strategies, and processes for reviewing claims accuracy.

However, VA also needs better analyses of its processes in order to target error-prone types of cases and identify processing bottlenecks—as well as determine if its performance goals are realistic. VA also needs to be vigilant in its human capital strategies to ensure that it maintains the necessary expertise to process claims as newly hired employees replace many experienced claims processors over the next 5 years.

Current Status and Future Plans: VA has addressed a number of key management issues. These include implementing new performance measures, modernizing its information technology systems, and developing training. However, many experienced staff are expected to retire and veterans are seeking compensation for more service-connected disabilities per claims. Claims processing is more complex due to increasing procedural and documentation requirements.

VA has taken steps to offset the impact of legislative and regulatory changes on timeliness and accuracy by implementing countermeasures using available resources. The Under Secretary for Benefits presented the Department's strategies in a satellite broadcast to regional offices in March 2001. As of this time, we have successfully implemented the following measures in FY 2001:

- As of June 30, 2001, a total of 932 Veterans Service Representatives (VSRs) and Rating VSRs have been hired.

- In March 2001, the Veterans Benefits Administration (VBA) launched its centralized training initiatives to train these new hires. This centralized training is now the standard for training future hires.
- VBA reached an agreement with the Board of Veterans Appeals (BVA) concerning remand development. By January, 2002, BVA will begin initiating development on cases that would otherwise be remanded back to the field offices.
- Nine Resource Centers were established to focus on specialized claims processing.
- The St. Louis Helpline was expanded and fully operational by February 2001.
- Several decision notification letter packages prepared in an enhanced PCGL were released in April and November 2001. A work group has developed national production standards for VBA's decision-making positions. These proposals are being further evaluated.
- The amendment to the Code of Federal Regulations (38 CFR 3.103) allowing VBA's decision-makers to gather evidence by oral communication was published in the Federal Register on April 20, 2001.
- The Compensation and Pension Records Interchange (CAPRI) application that allows VBA's decision-makers to successfully obtain medical records from the Veterans Health Administration database was successfully tested in January 2001. This application will be available to all regional offices by the end of this fiscal year.
- VBA and VHA signed a memorandum of understanding in February 2001 to establish a Joint Examination Improvement Office in Nashville, Tennessee. The mission of this office is to review the C&P examination process in order to identify the tools and procedures needed to improve the quality and timeliness of C&P examinations. It is currently functioning and recruitment is underway for all the necessary subject matter experts from both VBA and VHA.

4. Management Capacity

Challenge Description: VA has more work to do to become a high-performing organization and increase veterans' satisfaction with its services. It must revise its budgetary structure and develop long-term, agency-wide strategies for ensuring an appropriate information technology (IT) infrastructure and sound financial management. If its budgetary structure linked funding to performance goals, rather than program operations, VA and the Congress would be better positioned to determine the Department's funding needs. VA's IT strategy, which aims to provide veterans and their families coordinated services,

must be successfully executed to ensure that VA can produce reliable performance and workload data and safeguard financial, health care, and benefits payment information. Similar to most other major agencies, VA's financial management strategies must ensure that its systems produce reliable cost data and address material internal control weaknesses and Federal Financial Management Improvement Act requirements.

Current Status and Future Plans

Performance-based Budgeting

VA and OMB staff jointly developed a proposal to restructure the Department's budget accounts. The goal of this account restructuring effort is to facilitate charging each program's budget accounts for all of the significant resources used to operate the program and produce its outputs and outcomes. The benefits of budget account restructuring are: (1) to more readily identify program costs; (2) to shift resource debates from inputs to outcomes and results; (3) to eventually make resource decisions based on programs and their results rather than other factors; (4) to improve planning, simplify systems, enhance tracking, and focus on accountability.

VA's Administrations and staff offices have endorsed this proposal. While OMB approves of the concept, we are still discussing many of the details of the new structure with them. In addition, we have started consultation sessions with our appropriations committees. Both the Senate and House appropriations committee staffs agree with the basic thrust and goals of the account restructuring proposal. We will continue to work with our major stakeholders on specific implementation issues.

Information Technology

GAO has identified seven challenges for VA to strengthen the leadership and management of its IT initiatives. These challenges, and the status of each, are summarized in the table below:

Challenge	Status
Appointment of Chief Information Officer	In 1998, VA established the position of Assistant Secretary for Information and Technology to serve as VA's Chief Information Officer (CIO). On July 17, 2001, John A. Gauss was nominated to be Assistant Secretary for Information and Technology in the Department of Veterans Affairs. He was confirmed by the Senate on August 3, 2001.
IT investment management	VA has established a process for selecting, controlling and evaluating its IT capital investments. The following efforts are under way to implement the improvements GAO recommended: 1) VA has retained a contractor to assist in conducting formal in-process reviews at key project milestones and 2) providing data to decision-makers on lessons learned from post-implementation reviews. VA

Challenge	Status
	developed guidance to better manage projects below thresholds established by VA's Strategic Management Council, and has issued the IT Capital Investment Guide (http://www.va.gov/OIRM/IT Planning/IT_Capital_Investment_guide).
Integrated business process reengineering	VA maintains that business process reengineering is the principal responsibility of the process owner, but it must be consistent with the Department's Enterprise Architecture (EA) and Strategic Plan. The proposed EA will be submitted to the Secretary for signature before the end of FY 2001. Once approved, the Department's CIO or designee will work closely with all business owners to develop a logical architecture and an integrated IT architecture.
Integrated IT architecture	The Secretary's department-level innovation team has completed its work to: • Define Enterprise Architecture (EA) principles; • Select an EA framework; • Develop an EA strategy and governance process. The team has drafted and given unanimous concurrence to a strategy and governance document, which will be submitted to the Secretary for approval prior to the beginning of FY 2002. The proposed EA, which is defined at the One-VA level, will replace the separate administration architectures. It will be business and service focused and will require that sponsors of all new IT initiatives: • Clearly identify and measure the service improvements that their project will provide; • Demonstrate that the service they propose is not provided or being developed elsewhere within VA; • Show their approach will yield a system that is interoperable, scaleable and adaptable to evolving technologies.
Tracking IT expenditures	VA has delegated the responsibility for tracking IT expenditures to managers in the Administrations and staff offices.
Assessing IT performance	As part of VA's Capital Investment Process, IT initiatives undergo an Execution Review to assess project conformance with planned costs and schedule goals. Additionally, initiatives are potentially subject to In-Process Reviews at points in their development cycle. Post-Implementation Reviews are conducted on initiatives once they are fully deployed. Results of these reviews and studies are made available to decision-makers in the Capital Investment Process to assist in making decisions about continued funding of initiatives.
Computer Security (see also OIG's management	See narrative under Item 6 "Security of Systems and Data" (p. 176)

Challenge	Status
challenge on IT Security)	

Financial Management

VA has made substantial progress in implementing GAO's recommendations for gaining accountability and control over its direct loan and loan sales activities, and for complying with credit reform accounting requirements. For more information, see the OIG's management challenge about VA's Consolidated Financial Statements on page 178.

Assessment of Data Quality

Due to diligent efforts over the past several years, the quality of VA data is good – not perfect, but very usable. Our efforts have taken many forms -- each program office initiated specific improvement actions; the Office of the Inspector General (OIG) conducted a series of audits to determine the accuracy of our data; we established a Department-level Chief Actuary to assist program officials in assessing the validity and accuracy of performance data; and our budget office worked with program officials to prepare an assessment of each key measure.

After identifying corporate data issues, a coordinated effort was made to improve the quality of the data we collect. For example, VHA established a data quality council to lead their improvement efforts. The council's focus has been centered on:

- Creating standard processes that support on-going maintenance of data quality;
- Defining and implementing local accountability for data quality;
- Establishing a data quality education, training, and communication structure;
- Focusing efforts on data that support patient access processes.

OIG audits are an integral part of our data quality assessment efforts. We consider OIG reviews to be independent and objective. For each VA program, we collect a great deal of information from veterans and other users through customer satisfaction surveys. We are continually improving our survey processes and standards -- a long-term project. The following discussion describes in specific detail the actions each VA Administration has taken to improve its data quality.

Veterans Health Administration

Data reliability, accuracy, and consistency have been a targeted focus of the Veterans Health Administration (VHA) for the past several years. The principles of data quality are integral to VHA's efforts to provide excellence in health care. In FY 2001, the Under Secretary for Health commissioned a new high-level crosscutting task force on data quality and standardization, co-chaired by two Chief Officers (Quality and Performance and Policy and Planning). In its early stage of development, this task force will focus on strategic planning to provide consistent definitions of clinical and business data for more effective clinical and organizational decision support.

VHA has long been recognized as a leader in documenting credentials and privileges of VA health care professionals. In FY 2001, VHA implemented a new electronic data bank, VetPro, on health care professionals' credentialing in partnership with the Department of Health and Human Services. VetPro

promotes and demonstrates to other federal and private agencies the potential of a secure, easily accessible, valid data bank of health professionals' credentials.

VetPro improves the process of ensuring that health care professionals have the appropriate credentials for their clinical roles. It will also help VHA verify that practitioners have a good and desirable track record, consistent with high-quality and safe patient care. When a doctor or dentist is credentialed using VetPro, a permanent electronic file is created that will be accessible across the VA system and other federal health care programs. As VetPro is used, the process of updating credentials will be streamlined because files will not be redone from scratch. As providers add information, it will be verified by the credentialers who create the permanent record. The Joint Commission on Accreditation of Health Care Organizations reviewed VetPro and stated, "The program appears, if used as designed, to be consistent within considerable detail with the current Joint Commission Standards..."

In 1998, the Under Secretary for Health convened a data quality summit and tasked VHA's Chief Information Officer with leading the effort to address identified issues. Outcomes of the summit are described below.

A VHA Data Consortium was formed to address organizational issues and basic data quality assumptions. The Data Consortium works collaboratively to improve information reliability and customer access for the purposes of quality measurement, planning, policy analyses, and financial management. The ongoing initiatives and strategies address data quality infrastructure, training and education, personnel, policy guidance, and data systems.

In July 2000, VHA hired a full-time data quality coordinator. The coordinator, along with data quality workgroups, provides guidance on data quality policies and practices. Several initiatives underway that support the integrity and data quality of coding include:

- Development of strategies and standard approaches to help field staff understand the data content and meaning of specific data elements in VHA databases;

- Development of coding resources for field facilities, to include negotiating the purchase of knowledge-based files/edits from Ingenix™ for use within the Veterans Health Information Systems and Technology Architecture (***V***ist***A***). This supports the use of national code sets, Current Procedural Terminology, 4th Edition (CPT-4), and Health Care Financing Procedural Coding System (HCPCS) Level II. The availability of these code sets will enable VHA to accurately describe outpatient and other professional services provided to patients;

- Complete revision of **V***ist***A** software to accommodate the use of national code set modifiers, giving providers the ability to document care more completely and accurately.

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

VHA's Office of Information sponsors the "*Close Encounters*" newsletter, which provides expert guidance to field facilities on encounter forms, insurance billing, coding, and Medicare compliance. It also sponsors a data quality newsletter, "*Data Quality Highlights,*" which provides data quality facts and tips.

Training and education opportunities that support data quality initiatives and compliance (such as the airing of national satellite broadcasts on data quality issues) are provided to staff. Future topics include external impacts on data reliability, guidance from the Centers for Medicare and Medicaid Services, national standards bodies issuance, and internal data requirements of the Veterans Equitable Resource Allocation (VERA) funding model.

In an effort to improve the reliability of Decision Support System (DSS) data, a directive on standardization was released to all VA medical facilities. The directive provides guidance for the standardization of managerial accounting and serves as a clinical information tool to assess the delivery of medical care across facilities.

In addition to guidance, training, and education, the Office of Information is involved in several key projects that are targeted to improve data quality and system reliance. These include the Meta Data Repository (MDR) and the Master Patient Index (MPI). The MDR houses data from 49 VHA databases. This registry contains definitions, business rules, names of database stewards, and descriptive information about the data elements contained in **V***ist***A** databases. The MDR was released to a limited audience of data users in January 2001. General release will be completed in the fall of 2002. The MDR provides a single source of data element description to users and technical staff. Use of the MDR will also help eliminate data redundancies and improve standardization.

VHA also completed the implementation of a national MPI in FY 2001. MPI provides the ability to view clinical data from various VA medical facilities via the remote data view functionality within the Computerized Patient Record System (CPRS). MPI provides the access point mechanism for linking patient information from multiple clinical, administrative, and financial records across VHA health care facilities, enabling an enterprise-wide view of individual and aggregate patient information. Responsibility for MPI data integrity exists on both corporate and facility levels. This effort will be accomplished through the

use of software reporting tools and interaction with both sites of care and external authoritative sources.

Future Efforts

VHA is in the process of examining its current health information processing environment in order to plan how to best implement improvements over the next 5 years. As part of this process, VHA is assessing:

- What a high-performance automated health system needs to provide;
- What the ideal health and information system would look like;
- What the advantages and disadvantages are of our current system;
- How best to use a phased approach for moving from the current to the ideal environment.

VHA intends to pursue efforts to move toward an ideal health and information system. This system would promote the sharing of information any time, any place, by any authorized provider, and in real-time, while ensuring that stringent privacy and security regimes are maintained. It would maximize use of the best available technology to allow users to effectively manage across programs, time, and distance, and within budget constraints, while balancing the resource needs of health and information. The ideal health and information system would provide a high-performance platform that maximizes patient health.

In the near term, VHA will enhance the current **V***ist***A** platform by completing the Decision Support System and implementing **V***ist***A** Imaging. Based on the availability of funds, mid/long-term efforts will include the development of a health database accessible across all levels of care, times, locations, and providers; the enhancement of Eligibility/Enrollment processing to meet One VA goals; the reengineering of the **V***ist***A** Scheduling package; and enhancement or replacement of the Billing and Fee Basis Systems. The following narrative provides a description of these projects:

***All-VA* Registration**

This effort will involve forming a collegial partnership with Departmental counterparts (VHA, VBA, and NCA) to explore a seamless continuum of registration and eligibility services to improve access to veterans' benefits and information on veterans' health status and improve customer service relationships with the veteran population. While the effort will be challenging given the disparate nature of many of the systems and processes associated with these entities, it offers opportunities to improve the quality of and access to data, enhance services to veterans, and realize cost-efficiencies through an integrated Department systems approach. Current information sharing and communication tools hamper access to the administrative information needed for daily

operations. Yet all VA programs have the need for a common set of demographic and eligibility data for their individual core business functions. The goal of this phase of the project is to create an authoritative database accessible to all VA components that require veteran information.

The *All-VA* registration system will hold all administrative data common to VA program areas. It will contain data on every veteran and dependent. Data on a subset of veterans will comprise the National Demographic Database. An Expert Eligibility System will be created to automate the determination of a veteran's eligibility for various veteran and dependent benefits. The eligibility determination system is rule-based, supporting ease-of-change to eligibility rules with immediate reassessment of potential eligibility. The system will determine eligibility as of specified dates in the past, basing its determination on the statutory eligibility rules in force on those dates. This will incorporate a centralized concept of all eligibility data, including the financial portion of eligibility determination.

Replacement of V*ist*A Integrated Billing and Accounts Receivable System

The billing and accounts receivable modernization project will continue the trend towards industry standardization. It will include required functionality of the existing application, as well as additional necessary functionality identified through previously conducted requirements analysis. The information system will interact with all current and future systems that support the registration, billing, and accounts receivable processes.

The transformed billing and accounts receivable system will also move VHA health care in the direction of industry standards, in that it will utilize account-based management. VA currently uses bill-based management, in which non-billable treatment and services are not entered into the billing application. In an account-based management system, a patient's account is started when he/she arrives for care, and flows to the billing system regardless of billability. If not billable, a bill will not be generated. This allows for accurate potential revenue calculation and projection.

Fee Basis

The Fee Basis portion of the above initiative supports VHA's efforts to improve operations, comply with impending health care regulations within the Health Insurance Portability and Accountability Act that require the acceptance of electronic claim submissions, control its costs, and prevent fraud and abuse. Fee Basis operations have been the subject of several internal and external studies in which reengineering, process, and organizational redesign have been recommended and piloted, but not implemented across the country. The transformation of the Fee Basis process, together with the replacement of Central Fee by the core Financial and Logistics System (coreFLS), will facilitate a redesigned and improved Fee Basis process. A new system will allow the Fee

Basis process greater flexibility in terms of location, volume, and type (manual vs. automated) of processes being performed. Replacing Central Fee and IFCAP, the main interfaces of Fee Basis, with one commercial product will ease the implementation and the resulting processes.

In addition to process improvement, a new system will accommodate increased clinical data capture and have the flexibility to capture workload data currently being missed and/or not reported correctly. This will have several effects on the Fee Basis program. First, the program will function to accurately account for the services for which VHA is paying. Next, it will allow Veterans Integrated Service Networks (VISNs) and medical centers to appropriately capture their actual workload. Also, VISNs and medical centers will be able to provide Fee patients a full continuum of care, regardless of the location of care, by capturing the services performed by non-VA providers. Finally, the new Fee Basis system will allow VHA to pursue reimbursement from the patient's insurer with medical documentation if appropriate.

Veterans Benefits Administration

The Veterans Benefits Administration (VBA) steadily continues to improve its data systems and the integrity of information within those systems. When it comes to delivering $27.9 billion in benefits annually to more than 3.2 million veterans and their families, VBA believes data integrity must remain a core competency.

For many years, data integrity has been a significant concern for VBA. Eliminating the practices of manipulating numbers and allowing incorrect input into essential reporting systems has been a primary focus. As outlined in its *Roadmap for Excellence*, VBA created the Data Management Office (DMO) in 1998 to incorporate a strong focus on administration-wide data integrity. The DMO plays a key role in this effort, working in concert with all VBA components.

Data integrity requires improving the information we collect and publish regarding veterans and dependents and the operations of VBA's five business lines. The data that are collected must lead to accurate, current, consistent, and germane information that serves the needs of internal and external users now and in the future. A key initiative in fostering data integrity is the deployment of a balanced scorecard approach to measuring organizational performance. Using this methodology, performance is measured consistently from the national level down through the regional offices. Maintained by the DMO and delivered via Intranet technology, the balanced scorecard provides VBA employees, managers, and executives with a better understanding of organizational strengths and areas for improvement in a timely and consistent manner. The balanced scorecard promotes information sharing and cooperation within VBA, which directly improves the delivery of benefits to veterans. Results from the balanced scorecard are shared

with external stakeholders such as Congress and veterans service organizations during quarterly briefings.

To ensure the integrity of transactions in the compensation and pension (C&P) business line, data regarding specific transactions that appear suspect are posted to the C&P Service Intranet Web site. Stations monitor this site and review those transactions that appear questionable (for example, multiple work credits taken on the same case within a short period of time, or a very short period of time between the establishment of the claim and the disposition). The C&P Service tracks station reports to ensure proper review and corrective actions are taken. This process has resulted in a reduction of suspect transactions and has helped identify areas for training or policy clarification.

Another major initiative to facilitate data-driven decision-making is VBA's Operations Center, an Intranet portal supported by user-friendly analytical tools, where the balanced scorecard and other core business information are made available for review and analysis. The Operations Center provides all levels of employees and managers with the same data used in decision-making and performance reporting. This wide dissemination of data ensures that constant review and analysis take place, facilitating improved data validation, and ultimately, improved service to veterans.

VBA's data warehouse and operational data store support the Operations Center. Both these technology environments, and their accessibility to end-users via the Intranet, dramatically improve the reliability, timeliness, and accuracy of core business information. Data collection and dissemination that once took weeks are now completed inexpensively and efficiently and are available on-line for review and analysis. Because the data are so accessible, anomalies or inconsistencies are readily noted and corrective action can be taken.

Facing the challenge to modernize systems and improve data integrity, VBA has made great strides in the past 3 years to ensure the quality of information and data-driven decision-making. The continued refinement of processes and systems, including the construction of a single corporate database where consistent information is available regarding veterans and business transactions conducted for those veterans, remains a key focus of VBA. These efforts, building upon a modernized infrastructure, ultimately lead to improved delivery of benefits and services to veterans and their families.

National Cemetery Administration

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

NCA determines the percent of veterans served by existing national and state veterans cemeteries within a reasonable distance of their residence by analyzing census data on the veteran population. Since FY 2000, actual performance and the target levels of performance have been based on the new VetPop2000 model developed by the Office of the Actuary. VetPop2000 is the authoritative VA estimate and projection of the number and characteristics of veterans. It is the first revision of official estimates and projections since 1993. The new VetPop2000 methodology resulted in significant changes in the nationwide estimate and projection of the demographic characteristics of the veteran population. These changes affected the separate county veteran populations from which NCA determines the percentage of veterans served.

For FY 2001 and subsequent years, NCA has developed a new customer satisfaction survey process to measure the quality of service provided by national cemeteries as well as their appearance. The new survey provides statistically valid performance information at the national and regional levels and at the cemetery level (for cemeteries having at least 400 interments per year). The annual survey is done via mail; the data are collected from family members and funeral directors who recently received services from a national cemetery. To ensure sensitivity to the grieving process, NCA allows a minimum of 3 months after an interment before including a respondent in the sample population. VA headquarters staff oversees the data collection process and provides an annual report at the national level.

When headstones or markers are lost, damaged, or incorrectly inscribed, it is important to determine both the cause and the party responsible for the expense of a replacement. NCA developed new codes for ordering replacement headstones or markers; use of these new codes produces reliable and accurate data on replacement actions and provides management with an effective tool for improving the overall business process.

Office of Inspector General (OIG) Audits

The OIG continued its assessment of the accuracy and reliability of VA's key performance measures in accordance with the Government Performance and Results Act. During FY 2001, we continued an assessment of the Chronic Disease Care Index (CDCI) and Prevention Index (PI), and initiated an audit of the Vocational Rehabilitation and Employment Rehabilitation Rate. The OIG assessed the procedures used by VHA to compute the CDCI and PI indices during FY 2000 and demonstrated that these were adequate. During FY 2001, we began a review of the appropriate source documents to determine the validity of data used in computing the CDCI and PI. This audit will be completed during FY 2002.

To date, the OIG has completed audits of six key measures, and we plan to conduct several others in the near future. We will confer with program and other key officials during the second quarter, FY 2002, to determine which key measures should be the next ones to audit.

Crosscutting Activities

To assist us in achieving our goals and objectives, VA has formed numerous partnerships and alliances with other Federal agencies, state and local governments, and private sector organizations. These crosscutting activities have the potential for providing improved delivery of service to our veterans through administrative simplification, reduction of barriers, better allocation of limited resources, and achievement of cost savings. They provide a clear focus on measurable outcomes. In addition, VA anticipates working with other agencies and Departments in crosscutting activities such as data sharing with Centers for Medicare and Medicaid Services (CMS) and DoD.

Department	VA Business Line and Activity
Commerce	**Insurance** • In conjunction with the Dept. of Commerce, VA coordinates and monitors SGLI/VGLI activities for NOAA. VA receives and monitors SGLI premium payments and monitors death claims against SGLI.
Defense	**Medical Care** • In conjunction with DoD, VA develops and implements clinical practice guidelines with a long-range view toward assuring continuity of care and a seamless transition for a patient moving from one system to the other. • VA's Office of Environmental Hazards works with DoD to address war-related medical issues. The two agencies participate jointly in the following standing committees: Gulf War Program; Veterans Health Coordinating Board on Gulf War Illnesses; and the Canadian and UK Gulf War Veterans Advisory Committee. • VA's AIDS Service works with The Office of the Secretary of Defense (OSD)/Force Management and Readiness Committee to understand and interpret disability ratings for active military personnel with HIV. • With DoD and GSA, VA distributes excess property (sleeping bags, blankets, and clothing) for homeless veterans. The Compensated Work Therapy (CWT) Program at the VA New Jersey Health Care System employs formerly homeless veterans to unload, inventory, and ship these goods across the country. • Four traumatic brain injury (TBI) lead centers have been jointly established and cooperatively funded by VA and DoD to receive and screen all TBI patients and maintain a national registry of TBI patients. • VA, by Public Law 97-174, has the added mission to serve as principal health care backup to DoD in the event of war or national emergency. VA, at the request of DoD, may authorize DoD to use its medical facilities (hospital and nursing home care), medical services, office space, supplies, and administrative support. • VA partners with DoD's Pacific e-Health Center in Honolulu, HI, to provide peer consultation and patient care to participants separated by distance. • VA and DoD participate in the Alaska Federal Health Care Partnership, with a goal of providing specialized care to isolated or remote patient populations in Alaska.

Department	VA Business Line and Activity
Defense (cont'd)	**Medical Education** • VHA's Office of Public Health and Environmental Hazards works with DoD in the development and subsequent changes to smoking cessation guidelines. This is being done to standardize smoking cessation practices for active military personnel as well as for veterans. **Medical Research** • The Cooperative Studies Program collaborates with DoD on a number of studies, including an antibiotic treatment trial and an exercise/behavioral medicine treatment trial for Gulf War Syndrome. • DoD participates in a nationwide study assessing the rate of amyotrophic lateral sclerosis (ALS), or Lou Gehrig's disease, among veterans who were on active duty during the Gulf War. **Compensation and Pension** • VA is working with DoD officials to support claims development and the physical examination process prior to separation. VA encourages national, state, and county VSOs to be an integral part of the execution in this effort. • VA is working with DoD and National Personnel Records Center (NPRC) to develop the electronic control and exchange of military records and service verification. • VA is working to expand its relationship with the Defense Manpower Data Center (DMDC) to interface and use more of their data. This will provide the opportunity for potentially reducing overpayments caused by dual benefit payments using on-line matches against DMDC databases. **Education** • VA works with DoD to provide educational assistance to veterans and servicemembers. These benefits are an important DoD recruiting tool. **Insurance** • VA coordinates and monitors SGLI/VGLI activities for the Army, Air Force, Marines and Navy. VA receives and monitors SGLI premium payments, monitors death claims against SGLI and monitors the maximum coverage limit. VA receives data on recently separated reservists and recently discharged seriously disabled retirees for VGLI outreach efforts. • VA monitors NSLI/SDVI activities by establishing and monitoring allotments from retired pay and assuring that addresses are correct. **Burial** • VA works closely with components of DoD and veterans service organizations to provide military funeral honors at national cemeteries. • VA provides headstones and markers for national cemeteries administered by the Department of the Army and the American Battle Monuments Commission. In addition, Arlington National Cemetery, which is administered by the Department of the Army, orders headstones and markers directly through VA's AMAS-R monument ordering system. VA also contracts for all niche inscriptions at Arlington National Cemetery.

Department	VA Business Line and Activity
Interior	**Burial** • VA provides headstones and markers for Andrew Johnson National Cemetery and Andersonville National Cemetery, which are administered by the Department of the Interior. In addition, these cemeteries order headstones and markers directly through VA's AMAS-R monument ordering system.
Agriculture	**Medical Care** • VA works with Agriculture's National Rural Development Council to identify how VA's Telemedicine capability may be utilized to provide specialized patient care to rural populations. • VA participates in joint design and construction projects.
FEMA	**Medical Care** • The Federal Response Plan outlines how agencies will implement the Robert T. Stafford Disaster Relief Act that stipulates the Federal Government will provide assistance to state and local governments during times of disasters or terrorist attacks. VA is responsible for providing support under four of twelve functional areas of the Plan. VA is most often called upon to provide medical assistance.
HHS	**Medical Care** • VA works with HHS to develop non-VA benchmarks for bed days of care, which are obtained from a CMS database. VA obtains data on ambulatory procedures from the National Center for Health Statistics. • VA participates with the National Cancer Institute, DoD, and the American Diabetes Association on the Joslin Diabetes Telemedicine Project. • Improving mammography and cervical cancer screening rates includes collaboration with the National Center for Health Promotion and liaisons with other private and public health care agencies involved in women's health. • VA's AIDS Service is working closely with HHS' Health Resources and Services Administration (HRSA) to develop collaboration in the Ryan White CARE Act related provision of services to veterans with HIV. • VA collaborates with HHS' HRSA to create credentialing and privileging guidelines for clinicians providing patient care through use of telemedicine technology when participants are separated by distance. • An Interagency Agreement with the National Institutes of Health/National Library of Medicine provides for information kiosks to be placed in selected VA medical centers to enhance the capabilities of VA patients and their caregivers to have immediate access to current information about HIV disease. • VA participates in joint design and construction projects with HHS and specifically the U.S. Public Health Service and the Indian Health Service. **Medical Education** • VA works with the American Diabetes Association, the Centers for Disease Control and Prevention, and other organizations in the education of providers and persons with diabetes in the prevention of foot problems

Department	VA Business Line and Activity
HHS (cont'd)	through the "Feet Can Last a Lifetime" Project. • VA's National Center for Patient Safety is working with the Department of Health and Human Services' Patient Safety Task Force and is collaborating with the Centers for Disease Control and Prevention, the Food and Drug Administration, the Agency for Healthcare Research and Quality, and the Health Care Financing Administration to implement new initiatives in Patient Safety, based on VA and joint VA/NASA experience. **Medical Research** • VA disseminates results from the National Institute on Aging (NIA) Collaborative Studies of Dementia Special Care Units and from VA-sponsored research on dementia care. VA also explores areas of research collaboration on Alzheimer's and related dementia, including medical, rehabilitation, and health services research. • VA and NIDA are working together to evaluate new pharmacological treatments for substance abuse. This partnership conducts clinical trials of possible treatments for abuse of alcohol and other drugs. • VA has entered collaborations with the NCI and the Southwest Oncology Group to study whether selenium and Vitamin E, alone or in combination, prevent prostate cancer. • VA is now working with the National Institute of Allergy and Infectious Disease to determine if a vaccine can prevent shingles. Approximately 37,000 volunteers will help study whether the vaccine offers protection against the painful skin and nerve infection that is common among the elderly. • HSR&D met with CDC in July to discuss opportunities to collaborate on projects. "Translating Research into Action for Diabetes" (TRIAD) was identified as a project that will allow the benchmarking of VA diabetes care with the care of diabetics in the private sector. The proposal was submitted by VA's Diabetes QUERI where it was approved and will start immediately. • HSR&D and CMS continue to work together toward a merging of the VA patient database with CMS's database. • VA's Cooperative Studies Program is collaborating with CMS to evaluate the economic differences between different means of erythropoiten administration to dialysis patients. **Insurance** • VA coordinates and monitors SGLI/VGLI activities for the Public Health Service. VA receives and monitors SGLI premium payments and monitors death claims against SGLI.
HUD	**Medical Care** • VA and HUD jointly sponsor the HUD-VA Supported Housing (HUD-VASH) Program for homeless veterans in 35 locations across the country. VA clinicians provide ongoing case management and other needed assistance to homeless veterans who have received dedicated Section 8 housing vouchers from HUD.
Interagency	**Medical Research** • VA serves on the Interagency Council on the Homeless. The Secretary,

Department	VA Business Line and Activity
Interagency (cont'd)	Department of Veterans Affairs is the Co-Vice Chair. The Interagency Council on the Homeless serves as a forum for the exchange of information to ensure coordination of Federal efforts to assist the Nation's homeless population. **Insurance** • VA meets annually with the SGLI Advisory Council, which is made up of representatives of the Departments of Treasury, Defense, Commerce, HHS, Transportation and OMB to review the operations of the SGLI program. The group discusses potential legislative changes to the program such as the spousal and dependent coverage and the maximum coverage increase added this year. • **Compensation and Pension** VA is a participating member of NRC's Federal Facilities Council, a cooperative organization of 19 Federal agencies with interests and responsibilities related to all aspects of facility design, acquisition, management, and evaluation.
Justice	**Medical Care** • VA and DoJ's Bureau of Prisons (BoP) are creating a model to use VA's telemedicine capability to provide specialized health care to BoP's population. **Burial** • An Interagency Agreement with the Bureau of Prisons provides for the use of selected prisoners to perform work at national cemeteries. This agreement provides a supplemental source of labor to assist in maintaining the national cemeteries.
Labor	**Medical Care** • DOL's Homeless Veterans Reintegration Project (HVRP) grant recipients coordinate their efforts to assist homeless veterans with employment and vocational training with VA's Health Care for Homeless Veterans (HCHV) Programs and Domiciliary Care for Homeless Veterans (DCHV) Programs. **Education** • With Commerce and Agriculture, DOL helps VA by conducting approval and oversight activities for job training programs. **Vocational Rehabilitation and Employment** • VA partners with DOL to conduct training on employment assistance and techniques including referrals of job-ready veterans to DOL's America's Job Bank Internet site.
NASA	**Medical Care** • VA's National Center for Patient Safety is working with NASA to develop and implement an external, voluntary, identified adverse event and close call reporting system for VHA nationally.
National Academy of Sciences	**Medical Research** • VA Research Service is collaborating with other agencies in the Institute of Medicine's Pathophysiology and Prevention of Adolescent and Adult Suicide initiative to develop strategies and research designs

Department	VA Business Line and Activity
	for the study of suicide and its prevention. VA is particularly interested in suicide among the elderly.
NRC	**Medical Education** • VA is among the 17 Federal agencies participating in the Federal Radiological Emergency Response Plan (FRERP). The purpose of the FRERP is to establish and organize an integrated capability for a timely and coordinated response by Federal agencies to peacetime radiological response. Authorities for this Plan are P.L. 96-295 and E.O. 12241. **Medical Research** • VA's Office of Public Health and Environmental Hazards works with NRC and the Institute of Medicine on research concerning herbicides, Agent Orange exposure, and the health status of Vietnam era veterans. **Medical Education** • VA's Office of Public Health and Environmental Hazards supports the NRC's medical education on Gulf War veterans.
SSA	**Medical Care** • Health Care for Homeless Veterans (HCHV) Programs staff and Domiciliary Care for Homeless Veterans (DCHV) Programs staff coordinate outreach and benefits certification at three sites to increase the number of eligible homeless veterans who receive SSI and SSDI benefits and to otherwise assist in their rehabilitation. **Compensation and Pension** • VA is a participating member of NRC's Federal Facilities Council, a cooperative organization of 19 Federal agencies with interests and responsibilities related to all aspects of facility design, acquisition, management, and evaluation. **Insurance** In conjunction with Social Security, VA obtains assurances of correct addresses of NSLI and SDVI policyholders and beneficiaries, obtains dates of death from Social Security's Death Master File and verifies social security numbers.
DOT	**Insurance** • VA coordinates and monitors SGLI/VGLI activities for the Coast Guard. VA receives and monitors SGLI premium payments and monitors death claims against SGLI.
International	**Medical Research** • The Cooperative Studies Program works with the Medical Research Councils of the United Kingdom and the Canadian Institutes for Health Research in planning a study designed to determine the optimal anti-retroviral therapy for AIDS and HIV infection.
State/Local	**Medical Care** • VA's Homeless Grant and Per Diem Program provide grants to community-based organizations, state or local governments, or Native American tribes to assist with the construction or renovation of new transitional beds and other supportive services programs. Grant recipients may receive per diem payments to help offset operational expenses for their programs for homeless

Department	VA Business Line and Activity
State/Local (cont'd)	veterans. • VA maintains community-based Vet Centers through continued outreach contacts with all aspects of the veterans' community and local service providers. • VA's State Home Program provides a grant to states to assist with the construction or renovation of nursing home, domiciliary or adult day health care facilities. Following completion of construction, VA recognizes these facilities as State Veterans Homes and provides four different per diem grants related to the provision of nursing home, domiciliary, adult day health care or hospital care to eligible veterans. • VA's National Center for Patient Safety is providing training and advice in human factors, adverse event and close call reporting and analysis systems to staff from Baylor University, Dartmouth University, Thomas Jefferson University, the University of Michigan, the University of Pennsylvania and the University of Texas. • VA's NCPS is providing advice on how to develop and use error reporting systems for Michigan health care systems as guided by Michigan Peer Review and Michigan's "Leap Frog" group. • Under VA's Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Homeless Veterans, VA medical centers work with representatives from other Federal agencies, state and local governments and community-based service providers to identify the unmet needs of homeless veterans and develop action plans to meet these needs. **Burial** • VA partners with the states to provide veterans and their eligible family members with burial options in a national or state veterans cemetery. VA administers the State Cemetery Grants Program, which provides grants to states of up to 100 percent of the cost of establishing, expanding, or improving state veterans cemeteries that are owned and operated by the states. • VA encourages state veterans cemeteries to place their orders for headstones and markers directly into NCA's AMAS-R monument ordering system. • VA extends its second inscription program to state veterans cemeteries. In this program, the second inscription is added *in situ* (i.e., at the gravesite) to the currently existing headstone following the death and interment of a subsequent family member. In order to participate, state cemeteries must use upright headstones and have the capability to submit requests electronically.
White House	**Medical Care** • VA has close liaison with the Office of National Drug Control Policy, whose national drug strategy significantly informs VA's addictive disorders treatment goals. **Burial** • VA administers the White House program for issuing Presidential Memorial Certificates to the deceased veteran's next of kin and other loved ones,

Department	VA Business Line and Activity
	conveying the Nation's gratitude for the veteran's service.
Veterans Service Orgs.	**Medical Research** • Eastern Paralyzed Veterans Association: EPVA provides support for meritorious career development candidates and has just begun a new initiative to fund small projects proposed by spinal cord clinicians. • VA has established an MOU with the American Legion to share workload data to facilitate American Legion reviews of VA medical centers. Similar sharing with other service organizations is under study. • VA has a liaison agreement with the Paralyzed Veterans of America to partner in developing the functional design of spinal cord injury (SCI) facilities to ensure SCI service centers best meet customer needs.
Private	**Medical Care** • VA will continue to work with the Paralyzed Veterans of America and other concerned veterans service organizations to ensure VHA continues to improve its excellent spinal cord-injured care. • VA works closely with the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) in regard to general accreditation issues as well as specific patient safety programs. • VA works with the National Academy of Sciences' Institute of Medicine to provide strategic direction for the clinical, research, education, and outreach programs for veterans who have health problems, possibly as a result of exposure to Agent Orange and other herbicides used in Vietnam. • VA works together with nonprofit organizations, including VSOs, to enhance assistance to homeless veterans. VA collaborates with U.S. Vets, Inc., and the Corporation for National Service to expand AmeriCorps member services to homeless veterans. • VA's Chaplain Service partners with religious organizations to help re-establish community support systems for homeless veterans. • VA medical centers and VA regional offices collaborate with community service providers, including VSOs, to hold Stand Downs for homeless veterans. At Stand Downs, homeless veterans receive clothing, haircuts, food, health screening, benefits assistance, information about housing and employment opportunities and access to longer-term treatment programs. • Under sharing agreements and enhanced use lease agreements, VA medical centers are making underutilized properties available to nonprofit organizations to develop supported housing programs for homeless veterans. **Medical Research** • VA's Medical Research Service and the Juvenile Diabetes Foundation (JDF) have established a partnership against diabetes. Special centers in Iowa City, Nashville, and San Diego are devoted to research in diabetes, one of the leading causes of illness and death among veterans. • VA and the National Parkinson Foundation have joined forces to seek a cure and improve treatments for Parkinson's disease, a major health problem among veterans and the general population. The Alliance to Cure

Department	VA Business Line and Activity
Private (cont'd)	among veterans and the general population. The Alliance to Cure Parkinson's Disease has initiated a variety of activities designed to enhance both organizations' work. • VA is in the process of developing an affiliation with the George Washington (GW) University School of Public Health that will enable VA to jointly recruit new staff to the HSR&D central office in Washington. Initially VA and GWU will jointly recruit a director of the Management Consultation Program. The affiliation will allow faculty appointments, teaching opportunities, opportunities to participate in research and possibly funding supplements. Training opportunities would also be made available for graduate students. • VHA has issued a contract for external accreditation of human subjects programs to the NCQA, an independent, not-for-profit accrediting organization that is nationally renown for it objective evaluations of health care organizations. **Medical Education** • VA's National Center for Patient Safety is providing training and advice in adverse event reporting systems to staff from the American Hospital Association, Joint Commission on the Accreditation of Healthcare Organizations, and Kaiser Permanente. **Housing** • VA executes the housing program through the private home building and mortgage lending industries. Most home loans are based on the automatic approval process that does not require VA underwriting approval before loan closure. • VA uses private sector management and sales brokers to manage and sell homes that VA acquires after foreclosure. **Insurance** • VA partners with the Prudential Insurance Company in administering and managing the SGLI/VGLI programs. VA meets with Prudential quarterly to discuss the performance of the SGLI/VGLI programs. VA works with Prudential in formulating new initiatives to help improve the programs. **Burial** • VA continues its partnerships with various civic associations that provide volunteers and other participants to assist in maintaining the national cemeteries. • VA works with funeral homes and veterans service organizations to increase awareness of burial benefits and services.

Communication

VA is committed to open, accurate, and timely communication with veterans, employees, and external stakeholders. We listen to their concerns to bring about improvements in the benefits and services we provide. The 2003 Performance Plan represents the roadmap that will guide the day-to-day operations and activities of VA staff around the country as we pursue the Secretary's priorities to improve claims processing, increase access to high quality health care, expand access to burial options, and maintain the national cemeteries as shrines. This plan identifies strategic goals, objectives, and performance goals specifically focusing on VA's key policy issues. For this to be an effective management tool, however, veterans, VA employees, and stakeholders must know about it and understand it.

To ensure we make our plan available to the widest possible audience, we use a combination of techniques to communicate it. Specifically, staff will be informed through our electronic mail system; in VA's publication, VAnguard; and in the Office of Management Bulletin. A press release will be issued to the general public informing them of the Performance Plan's availability. Anyone will be able to access the Performance Plan through VA's Internet Web site.

Tax Expenditure and Regulation

The Department of Veterans Affairs does not rely on tax expenditures or regulations to achieve program or policy goals.

Preparation of the Departmental Performance Plan

This plan was prepared entirely by employees of the Department of Veterans Affairs. VA's Office of Management -- in partnership with the Veterans Health Administration, the Veterans Benefits Administration, the National Cemetery Administration, and selected staff offices -- developed this plan. No contractor support was involved in the preparation of the plan.

Performance Measures by Departmental Goals and Objectives and Performance Measures by Program

The following two tables present the full set of performance measures by which VA evaluates its success. The first table identifies performance measures and associated target levels of performance according to the strategic goal and objective they support. The second table shows the same set of measures and targets grouped by program. The performance targets presented in these tables represent the basis upon which our Performance Report will be prepared.

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

The following tables demonstrate the balanced view of performance the Department uses to establish performance targets and to assess how well we are doing in meeting our strategic goals, objectives, and performance targets.

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

Interim Objective: Maximize the physical, mental, and social functioning of disabled veterans, including special populations of veterans, and be recognized as a leader in the provision of these specialized services.

Performance Measure	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Percent of veterans who were discharged from a Domiciliary Care for Homeless Veterans (DCHV) program, or (HCHV) community-based contract residential care program to an independent or a secured institutional living arrangement	50%	48%	75%	75%	**75%**	75%
Percent of veterans who obtained employment upon discharge from a DCHV program or (HCHV) community-based contract residential care program	55%	51%	51%	59%	**59%**	59%
Percent of homeless patients with mental illness who receive a follow-up mental health outpatient visit, admission to a CWT/TR or admission to a PRRTP within 30 days of discharge	65%	63%	63%	63%	**63%**	68%
Proportion of discharges from SCI center bed sections to non-institutional settings	93%	97%	98%	95%	**95%**	95%
Percent of patients in specialized substance abuse treatment settings who have an Addiction Severity Index (ASI) assessment:						
Initial ASI	56%	60%	77%	83%	**84%**	86%
Six-month follow-up ASI	N/A	N/A	23%	28%	**29%**	31%
Blind Rehabilitation - Percent change in functional status from admission to discharge from a blind rehabilitation program or unit	N/A	100%	108%	90%	**90%**	90%
Percent of prosthetics orders delayed	2%	1%	1%	2%	**2%**	2%
Percent of randomly selected admissions to SIPPs programs that are enrolled in the Outcomes Monitoring program	N/A	N/A	85%	85%	**85%**	85%
Percent of brain dysfunction patients undergoing rehabilitation whose discharge scores on the Functional Indepedence Measure (FIM) are in the expected or higher than expected performance categories	N/A	N/A	69%	71%	**72%**	75%
Percent of eligible patients undergoing rehabilitation for a lower extremity amputation whose efficiency scores using the Efficiency Pattern Analysis (EPA) is classified into one of the three highest efficiency categories	N/A	N/A	64% Baseline	65%	**67%**	70%

Interim Objective: Provide timely and accurate decisions on disability compensation claims, thereby improving the economic status and quality of life of service-disabled veterans.

National accuracy rate (core rating work)	68%	59%	78%	85%	**88%**	96%
Overall satisfaction	57%	56%	56%	62%	**67%**	90%
Rating-related actions - average days to process	166	173	181	208	**165**	74
Note: The Secretary has set an intermediate goal of 100 days during the summer of 2003.						
Rating-related actions - average days pending	144	138	182	186	**100**	78
Non-rating actions - average days to process	44	50	55	52	**43**	17
Non-rating actions - average days pending	94	84	117	82	**66**	44
National accuracy rate (authorization work)	63%	51%	62%	63%	**70%**	96%
National accuracy rate (fiduciary work)	48%	60%	68%	70%	**74%**	96%
Telephone activities - abandoned call rate	9%	6%	6%	4%	**4%**	3%
Telephone activities - blocked call rate	27%	3%	3%	4%	**4%**	2%
Fiduciary activities -Initial Appeals and Fiduciary Beneficiaries - percent of initial appointments > 45 days	N/A	6%	12%	10%	**8%**	1%
Deficiency free decision rate	84%	86%	87%	91%	**92%**	95%
Court remand rate	65%	61%	97%	80%	**70%**	33%
Appeals resolution time (Days)	745	682	595	590	**520**	365
BVA Cycle Time	140	172	182	125	**180**	150
Appeals decided per FTE	78.2	72.7	69.3	61.1	**64.3**	65.4
Cost per case (BVA)	$1,062	$1,219	$1,401	$1,666	**$1,767**	$1,922

Interim Objective: Enable service-disabled veterans, through vocational rehabilitation, to become employable, obtain and maintain suitable employment, and achieve independent living with special focus on seriously disabled veterans.

Speed of entitlement decisions in average days	88	75	62	60	**60**	60
Employment timeliness in average days	53	42	38	50	**50**	50
Accuracy of decisions (Entitlement)	86%	89%	93%	92%	**94%**	96%
Accuracy of decisions (Services)	87%	86%	79%	87%	**90%**	96%
Accuracy of decisions (Fiscal)	94%	94%	86%	92%	**94%**	99%
Rehabilitation rate	53%	65%	65%	67%	**68%**	70%
Serious Employment Handicap (SEH) rehabilitation rate	49%	62%	64%	64%	**65%**	65%
Customer satisfaction (Access)	N/A	76%	76%	79%	**81%**	92%
Customer satisfaction (Survey)	N/A	76%	74%	80%	**81%**	92%
Accuracy of program outcome	N/A	N/A	N/A	84%	**90%**	95%

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

Interim Objective: Ease the reentry of new veterans into civilian life by increasing awareness, access to, and use of benefits and services, including readjustment counseling.

Percent of veterans using Vet Centers who report being satisfied with services and saying they would recommend the Vet Center to other veterans	100%	100%	99%	95%	**95%**	95%

Interim Objective: Provide timely and accurate decisions on education claims, thereby enhancing veterans' and service-members' ability to achieve educational and career goals.

Montgomery GI Bill usage rate	56%	55%	56%	58%	**61%**	70%
Compliance survey completion rate	98%	94%	92%	90%	**90%**	90%
Customer satisfaction-high ratings (Education)	78%	78%	82%	82%	**85%**	95%
Telephone Activities - Blocked call rate (Education)	16%	39%	45%	20%	**15%**	10%
Telephone Activities - Abandoned call rate (Education)	N/A	17%	13%	11%	**9%**	5%
Payment accuracy rate	94%	96%	92%	94%	**96%**	97%
Average days to complete original education claims	26	36	50	38	**30**	10
Average days to complete supplemental education claims	16	22	24	21	**17**	7

Interim Objective: Improve the ability of veterans to purchase and retain a home by meeting or exceeding lending industry standards for quality and timely service, while minimizing VA loss on foreclosed properties.

Veterans satisfaction	93%	93%	93%	94%	**95%**	95%
Lender satisfaction	67%	74%	74%	76%	**78%**	80%
Return on sale	101%	N/A	108%	100%	**100%**	100%
Property holding time (months)	6.7	N/A	8.2	9.0	**8.0**	8.0
Statistical quality index	N/A	94%	96%	96%	**97%**	98%
Foreclosure avoidance through servicing (FATS) ratio	38%	30%	40%	39%	**40%**	40%

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

Interim Objective: Provide consistently reliable, accessible, timely and efficient high quality care through a health care system that maximizes functional status, improves veteran satisfaction, and fosters healthy communities.

Percent of patients who use tobacco products	27%	25%	27%	27%	**25%**	16%
Percent of patients rating VA health care service as very good or excellent - Inpatient	65%	66%	64%	66%	**68%**	72%
Percent of patients rating VA health care service as very good or excellent - Outpatient	65%	64%	65%	67%	**69%**	72%
Percent of primary care appointments scheduled within 30 days of desired date	N/A	N/A	87%	88%	**89%**	90%
Percent of specialist appointments scheduled within 30 days of desired date	N/A	N/A	84%	85%	**87%**	90%
Percent of patients who report being seen within 20 minutes of scheduled appointment at VA health care facilities	N/A	N/A	63%	70%	**72%**	90%
Implement and maintain patient access to telephone care 7 days a week, 24 hours a day in all VISNs as follows: - Number of VISNs providing basic telephone service	N/A	N/A	21	22	**22**	22

- Number of VISNs fully compliant with VHA Directive 2000-035, except for accreditation and direct access by clinical staff to clinical medical records	N/A	N/A	N/A	22	**22**	22
- Number of VISNs providing direct access to clinical medical records and having applied for accreditation	N/A	N/A	N/A	N/A	**N/A**	22
Percent of all patients evaluated for the risk factors for Hepatitis C	N/A	N/A	Baseline = 51%	56%	**61%**	80%
Percent of all patients tested for hepatitis C subsequent to a positive hepatitis C risk factor screening	N/A	N/A	Baseline = 48%	61%	**65%**	82%
Percent of patients with hepatitis C who have annual assessment of liver function	N/A	N/A	N/A	Baseline	**TBD**	TBD
Chronic Disease Care Index II	N/A	N/A	77%	78%	**79%**	82%
Prevention Index II	N/A	N/A	80%	80%	**80%**	85%
Percent of Veterans Service Standard (VSS) problems reported per patient (decrease is intended direction):						
Patient Education	31%	30%	30%	29%	**29%**	27%
Visit Coordination	16%	15%	16%	15%	**15%**	13%
Develop a Bar Code Medication Administration (BCMA) contingency plan and conduct test of the plan annually	N/A	N/A	N/A	100%	**100%**	100%
Percent of pharmacy orders entered into CPRS by the prescribing clinician	N/A	N/A	Baseline = 74%	85%	**86%**	90%
Percent cumulative reduction in excess capacity as a result of CARES. Total excess capacity will be identified by the CARES initiative.	N/A	N/A	N/A	10%	**30%**	TBD
Dollars derived from alternative revenue generated from health care cost recoveries	$574 M	$573M	$771M	$1,051M	**$1,489M**	$2,000M
Quality-Access-Satisfaction / Cost VALUE Index	5.12	5.36	6.31	6.91	**7.04**	N/A
Balanced Scorecard: Quality-Access-Satisfaction-Cost	88%	90%	98%	101%	**102%**	100%
Percent of spinal cord injury (SCI) respondents to the Performance Analysis Center of Excellence (PACE) Survey who rate their care as very good or excellent - Inpatient	55%	52%	53%	55%	**56%**	60%
Percent of SCI respondents to the Performance Analysis Center of Excellence (PACE) Survey who rate their care as very good or excellent - Outpatient	55%	57%	2001 data not available	55% (baseline)	**56%**	60%
Percent increase in number of enrolled veterans who have access to home and community-based care when clinically appropriate (2000 baseline = 14,111)	N/A	N/A	14%	50%	**72%**	144%

Interim Objective: Maintain the high level of service to insurance policy holders and their beneficiaries, thereby enhancing the financial security for veterans' families.

High customer ratings (Insurance)	96%	96%	95%	95%	**95%**	95%
Low customer ratings (Insurance)	1%	2%	2%	2%	**2%**	2%
Percentage of blocked calls (Insurance)	6%	4%	3%	4%	**3%**	1%
Average hold time in seconds	20	20	17	20	**20**	20
Percentage of insurance disbursements paid accurately	99%	99%	99%	99%	**99%**	99%
Average days to process insurance disbursements	3.2	3.2	2.8	3.2	**3.2**	3.0

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

Percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence	67.0%	72.6%	72.6%	73.9%	**76.2%**	85.0%
Percent of veterans served by a burial option in a national cemetery within a reasonable distance (75 miles) of their residence	56.7%	67.5%	66.0%	66.7%	**68.8%**	75.4%
Percent of veterans served by a burial option only in a state veterans cemetery within a reasonable distance (75 miles) of their residence	10.3%	5.1%	6.6%	7.2%	**7.4%**	9.4%
Percent of respondents who rate the quality of service provided by the national cemeteries as excellent	84%	88%	92%	93%	**96%**	100%
Cumulative number of kiosks installed at national and state veterans cemeteries	14	24	33	40	**48**	80

Interim Objective: Provide veterans and their families with timely and accurate symbolic expressions of remembrance.

Percent of graves in national cemeteries marked within 60 days of interment	N/A	N/A	N/A	Baseline	**TBD**	TBD
Percent of monuments ordered on-line by other federal and state veterans cemeteries using AMAS-R	65%	87%	89%	89%	**90%**	90%
Percent of individual headstone and marker orders transmitted electronically to contractors	88%	89%	92%	92%	**93%**	95%
Percent of Presidential Memorial Certificates that are accurately inscribed	98%	98%	98%	98%	**98%**	98%
Percent of headstones and markers that are undamaged and correctly inscribed	95%	97%	97%	97%	**97%**	98%

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

Interim Objective: Advance VA medical research and development programs that address veterans' needs, with an emphasis on service-connected injuries and illnesses, while contributing to the Nation's knowledge of disease and disability.

Institutional Review Board compliance with NCQA accreditation and maintenance, as appropriate, of AAALAC or NRC accreditation or certification	N/A	N/A	0%	10%	**40%**	100%

Increase by 5% over the previous fiscal year the number of HSR&D funded research projects related to health systems and methodology to evaluate outcomes	N/A	N/A	14	15	**15**	19

Interim Objective: Maintain sustained partnerships with the medical education community that maximize care to veterans and provide a high level of educational experience for health care providers.

Medical residents and other trainees' scores on a VHA Survey assessing their clinical training experience	N/A	N/A	84	81	**82**	85
Increase the number and dollar volume of sharing agreements by 10% over the previous year (Baseline = FY 2000):						
Non-DoD Agreements						
Number	N/A	1136	2506	1,373	**1,510**	3000
$ Purchased	N/A	$290M	$379M	$420M	**$460M**	$650M
$ Sold	N/A	$32M	$49M	$54M	**$59M**	$80M
DoD Agreements	0	0	0	0	**0**	0
Number	N/A	717	604	604	**604**	694
Revenue	N/A	$37.1M	$61M	$63M	**$65M**	$78M

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

Percent of VA-managed Federal Coordinating Centers that complete at least one NDMS casualty reception exercise every three years	50%	66%	63%	75%	**80%**	100%

Interim Objective: Enhance the socioeconomic well-being of the Nation and local communities through veterans' benefits, business assistance programs, and other community initiatives.

Percent of statutory minimum goals met for small business concerns	37%	33%	23%	23%	**23%**	23%

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

Percent of respondents who rate national cemetery appearance as excellent	79%	82%	96%	96%	**98%**	100%

Enabling Goal: Create an environment that fosters the delivery of One VA world-class service to veterans and their families by applying sound business principles that result in effective communication and management of people, technology, and governance.

Interim Objective: Improve communications with veterans, employees, and stakeholders about the Department’s mission, goals, and current performance and of the benefits and services VA provides.

Percent of stakeholders who are satisfied or very satisfied with their level of participation in VA's planning process	N/A	N/A	N/A	75%	**80%**	85%

Percent of VA employees who indicate they understand VA's strategic goals	N/A	N/A	N/A	65%	**75%**	85%

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

Employee development (Voc Rehab)	N/A	N/A	N/A	67%	**67%**	95%
Employee satisfaction (Voc Rehab)	N/A	N/A	3.5	3.6	**3.7**	4.0
Employee skills matrix (Insurance)	N/A	N/A	88%	87%	**87%**	95%
Employee satisfaction (Insurance)	N/A	3.3	3.3	3.8	**3.9**	4.0
Employee job satisfaction (Education)	2.8	3.3	3.3	3.3	**3.4**	4.0
Percent of employees who are aware of ADR as an option to address workplace disputes	N/A	N/A	50%	60%	**70%**	100%

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

Percent of CIO designated major IT systems that conform to the One VA Enterprise Architecture	N/A	N/A	N/A	25%	**100%**	100%
Percent of the Government Information Security Act reviews and reporting completed	N/A	N/A	80%	100%	**100%**	100%

Interim Objective: Improve the overall governance and performance of VA by applying sound business principles and ensuring accountability.

Favorable IG audit opinion (Insurance)	Y	Y	Y	Y	**Y**	Y
Number of audit qualifications identified in the auditor's opinion on VA's Consolidated Financial Statements	0	0	0	0	**0**	0
Percent increase of EC/EDI usage over 1997 base year	48%	86%	178%	100%	**110%**	150%
Percent of cases using alternate dispute resolution (ADR) techniques	12%	13%	29%	15%	**16%**	20%
Number of indictments, arrests, convictions, and administrative sanctions	696	938	1,655	1,675	**1,675**	1,800
Number of reports issued	162	108	136	160	**160**	200
Value of monetary benefits (in millions) from:						
IG Investigations	$24	$28	$52	$30	**$31**	$35
IG audit and health care inspection reviews	$610	$254	$4,088	$643	**$656**	$696
IG contract reviews	$47	$35	$42	$48	**$50**	$60

Performance Measures by Program

Veterans Health Administration

Medical Care

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

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Resources						
FTE	186,595	183,396	186,832	185,587	**185,397**	
Medical care costs ($ in millions)	$17,859	$19,434	$21,653	$23,531	**$25,995**	
Performance Measures						
Percent of patients who use tobacco products	27%	25%	27%	27%	**25%**	16%
Percent of patients rating VA health care service as very good or excellent - Inpatient	65%	66%	64%	66%	**68%**	72%
Percent of patients rating VA health care service as very good or excellent - Outpatient	65%	64%	65%	67%	**69%**	72%
Percent of primary care appointments scheduled within 30 days of desired date	N/A	N/A	87%	88%	**89%**	90%
Percent of specialist appointments scheduled within 30 days of desired date	N/A	N/A	84%	85%	**87%**	90%
Percent of patients who report being seen within 20 minutes of scheduled appointment at VA health care facilities	N/A	N/A	63%	70%	**72%**	90%
Implement and maintain patient access to telephone care 7 days a week, 24 hours a day in all VISNs as follows:						
- Number of VISNs providing basic telephone service	N/A	N/A	21	22	**22**	22
- Number of VISNs fully compliant with VHA Directive 2000-035, except for accreditation and direct access by clinical staff to clinical medical records	N/A	N/A	N/A	22	**22**	22
- Number of VISNs providing direct access to clinical medical records and having applied for accreditation	N/A	N/A	N/A	N/A	**N/A**	22
Percent of VA-managed Federal Coordinating Centers that complete at least one NDMS casualty reception exercise every three years	50%	66%	63%	75%	**80%**	100%
Percent of all patients evaluated for the risk factors for Hepatitis C	N/A	N/A	Baseline = 51%	56%	**61%**	80%
Percent of all patients tested for hepatitis C subsequent to a positive hepatitis C risk factor screening	N/A	N/A	Baseline = 48%	61%	**65%**	82%
Percent of patients with hepatitis C who have annual assessment of liver function	N/A	N/A	N/A	Baseline	**TBD**	TBD
Chronic Disease Care Index II	N/A	N/A	77%	78%	**79%**	82%
Prevention Index II	N/A	N/A	80%	80%	**80%**	85%

Performance Measures by Program

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Percent of Veterans Service Standard (VSS) problems reported per patient (decrease is intended direction):						
Patient Education	31%	30%	30%	29%	**29%**	27%
Visit Coordination	16%	15%	16%	15%	**15%**	13%
Develop a Bar Code Medication Administration (BCMA) contingency plan and conduct test of the plan annually	N/A	N/A	N/A	100%	**100%**	100%
Percent of pharmacy orders entered into CPRS by the prescribing clinician	N/A	N/A	Baseline = 74%	85%	**86%**	90%
Percent cumulative reduction in excess capacity as a result of CARES. Total excess capacity will be identified by the CARES initiative.	N/A	N/A	N/A	10%	**30%**	TBD
Dollars derived from alternative revenue generated from health care cost recoveries	$574 M	$573M	$771M	$1,051M	**$1,489M**	$2,000M
Quality-Access-Satisfaction / Cost VALUE Index	5.12	5.36	6.31	6.91	**7.04**	N/A
Balanced Scorecard: Quality-Access-Satisfaction-Cost	88%	90%	98%	101%	**102%**	100%
Increase the number and dollar volume of sharing agreements by 10% over the previous year (Baseline = FY 2000):						
Non-DoD Agreements						
Number	N/A	1,136	2,506	2,600	**2,600**	3,000
$ Purchased	N/A	$290M	$379M	$420M	**$460M**	$650M
$ Sold	N/A	$32M	$49M	$54M	**$59M**	$80M
DoD Agreements						
Number	N/A	717	604	604	**604**	694
Revenue	N/A	$37.1M	$61M	$63M	**$65M**	$78M

Special Emphasis Programs

Percent increase in number of enrolled veterans who have access to home and community-based care when clinically appropriate (2000 baseline = 14,111)	N/A	N/A	14%	55%	**91%**	144%
Percent of veterans who were discharged from a Domiciliary Care for Homeless Veterans (DCHV) program, or (HCHV) community-based contract residential care program to an independent or a secured institutional living arrangement	50%	48%	75%	75%	**75%**	75%
Percent of veterans who obtained employment upon discharge from a DCHV program or (HCHV) community-based contract residential care program	55%	51%	51%	59%	**59%**	59%
Percent of homeless patients with mental illness who receive a follow-up mental health outpatient visit, admission to a CWT/TR or admission to a PRRTP within 30 days of discharge	65%	63%	63%	63%	**63%**	68%
Percent of veterans using Vet Centers who report being satisfied with services and saying they would recommend the Vet Center to other veterans	100%	100%	99%	95%	**95%**	95%

Performance Measures by Program

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Percent of spinal cord injury (SCI) respondents to the Performance Analysis Center of Excellence (PACE) Survey who rate their care as very good or excellent - Inpatient	55%	52%	53%	55%	**56%**	60%
Percent of SCI respondents to the Performance Analysis Center of Excellence (PACE) Survey who rate their care as very good or excellent - Outpatient	55%	57%	2001 data not available	55% (baseline)	**56%**	60%
Proportion of discharges from SCI center bed sections to non-institutional settings	93%	97%	98%	95%	**95%**	95%
Percent of patients in specialized substance abuse treatment settings who have an Addiction Severity Index (ASI) assessment:						
Initial ASI	56%	60%	77%	83%	**84%**	86%
Six-month follow-up ASI	N/A	N/A	23%	28%	**29%**	31%
Blind Rehabilitation - Percent change in functional status from admission to discharge from a blind rehabilitation program or unit	N/A	100%	108%	90%	**90%**	90%
Percent of prosthetics orders delayed	2%	1%	1%	2%	**2%**	2%
Percent of randomly selected admissions to SIPPs programs that are enrolled in the Outcomes Monitoring program	N/A	N/A	85%	85%	**85%**	85%
Percent of brain dysfunction patients undergoing rehabilitation whose discharge scores on the Functional Indepedence Measure (FIM) are in the expected or higher than expected performance categories	N/A	N/A	69%	71%	**72%**	75%
Percent of eligible patients undergoing rehabilitation for a lower extremity amputation whose efficiency scores using the Efficiency Pattern Analysis (EPA) is classified into one of the three highest efficiency categories	N/A	N/A	64% Baseline	65%	**67%**	70%

Medical Education P&F ID Codes: 36-0160-0-1-703

Resources						
Education costs ($ in millions)	$902	$884	$898	$953	**$979**	
Performance Measures						
Medical residents and other trainees' scores on a VHA Survey assessing their clinical training experience	N/A	N/A	84	81	**82**	85

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

Resources						
FTE	2,974	3,014	3,019	2,983	**3,167**	
Research costs ($ in millions)	$779	$830	$877	$969	**$1,008**	
Performance Measures						
Institutional Review Board compliance with NCQA accreditation and maintenance, as appropriate, of AAALAC or NRC accreditation or certification	N/A	N/A	0%	10%	**40%**	100%
Increase by 5% over the previous fiscal year the number of HSR&D funded research projects related to health systems and methodology to evaluate outcomes	N/A	N/A	14	15	**15**	19

Performance Measures by Program

Veterans Benefits Administration

Compensation and Pension

P&F ID Codes: 36-0153-0-1-701; 36-0153-2-1-701; 36-0153-4-1-701; 36-0154-0-1-701; 36-0155-0-1-701; 36-0153-1-1-701; 36-0151-0-1-705; 36-0110-0-1-703; 36-0111-0-1-703

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Resources						
FTE	6,841	7,123	8,035	8,656	**8,762**	
Benefits cost ($ in millions)	$21,112	$22,054	$23,277	$24,900	**$26,391**	
Administrative costs ($ in millions)	$549	$586	$706	$809	**$849**	
Performance Measures						
National accuracy rate (core rating work)	68%	59%	78%	85%	**88%**	96%
Overall satisfaction	57%	56%	56%	62%	**67%**	90%
Rating-related actions - average days to process	166	173	181	208	**165**	74
Note: The Secretary has set an intermediate goal of 100 days during the summer of 2003.						
Rating-related actions - average days pending	144	138	182	186	**100**	78
Non-rating actions - average days to process	44	50	55	52	**43**	17
Non-rating actions - average days pending	94	84	117	82	**66**	44
National accuracy rate (authorization work)	63%	51%	62%	63%	**70%**	96%
National accuracy rate (fiduciary work)	48%	60%	68%	70%	**74%**	96%
Telephone activities - abandoned call rate	9%	6%	6%	4%	**4%**	3%
Telephone activities - blocked call rate	27%	3%	3%	4%	**4%**	2%
Fiduciary activities -Initial Appeals and Fiduciary Beneficiaries - percent of initial appointments > 45 days	N/A	6%	12%	10%	**8%**	1%

Education

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

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Resources						
FTE	849	781	852	942	**952**	
Benefits cost ($ in millions)	$1,210	$1,197	$1,387	$1,974	**$2,307**	
Administrative costs ($ in millions)	$70	$66	$64	$89	**$105**	
Performance Measures						
Montgomery GI Bill usage rate	56%	55%	56%	58%	**61%**	70%
Compliance survey completion rate	98%	94%	92%	90%	**90%**	90%
Customer satisfaction-high ratings (Education)	78%	78%	82%	82%	**85%**	95%
Telephone Activities - Blocked call rate (Education)	16%	39%	45%	20%	**15%**	10%
Telephone Activities - Abandoned call rate (Education)	N/A	17%	13%	11%	**9%**	5%
Payment accuracy rate	94%	96%	92%	94%	**96%**	97%
Average days to complete original education claims	26	36	50	38	**30**	10
Average days to complete supplemental education claims	16	22	24	21	**17**	7
Employee job satisfaction (Education)	2.8	3.3	3.3	3.3	**3.4**	4.0

Performance Measures by Program

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Vocational Rehabilitation and Employment	P&F ID Codes: 36-0137-0-1-702; 36-0140-0-3-702; 36-4259-0-3-702 (Off Budget); 36-4260-0-3-702; 36-0151-0-1-705; 36-0111-0-1-703					
Resources						
FTE	972	940	1,061	1,178	**1,404**	
Benefits cost ($ in millions)	$412	$439	$427	$441	**$629**	
Administrative costs ($ in millions)	$72	$81	$109	$127	**$154**	
Performance Measures						
Speed of entitlement decisions in average days	88	75	62	60	**60**	60
Employment timeliness in average days	53	42	38	50	**50**	50
Accuracy of decisions (Entitlement)	86%	89%	93%	92%	**94%**	96%
Accuracy of decisions (Services)	87%	86%	79%	87%	**90%**	96%
Accuracy of decisions (Fiscal)	94%	94%	86%	92%	**94%**	99%
Rehabilitation rate	53%	65%	65%	67%	**68%**	70%
Serious Employment Handicap (SEH) rehabilitation rate	49%	62%	64%	64%	**65%**	65%
Customer satisfaction (Access)	N/A	76%	76%	79%	**81%**	92%
Customer satisfaction (Survey)	N/A	76%	74%	80%	**81%**	92%
Accuracy of program outcome	N/A	N/A	N/A	84%	**90%**	95%
Employee development (Voc Rehab)	N/A	N/A	N/A	0.67	**0.67**	0.95
Employee satisfaction (Voc Rehab)	N/A	N/A	3.5	3.6	**3.7**	4.0
Housing	P&F ID Codes: 36-0137-0-1-702; 36-1119-0-1-704; 36-1119-0-2-704; 36-4127-0-3-704 (Off Budget); 36-4129-0-3-704 (Off Budget); 36-4025-0-3-704; 36-0140-0-3-702; 36-4259-0-3-702 (Off Budget); 36-0151-0-1-705; 36-0111-0-1-703; 36-1119-0-1-704					
Resources						
FTE	2,108	2,057	1,759	1,780	**1,763**	
Benefits cost ($ in millions)	$1,811	$1,866	$540	$986	**$646**	
Administrative costs ($ in millions)	$160	$157	$162	$165	**$176**	
Performance Measures						
Veterans satisfaction	93%	93%	93%	94%	**95%**	95%
Lender satisfaction	67%	74%	74%	76%	**78%**	80%
Return on sale	101%	N/A	108%	100%	**100%**	100%
Property holding time (months)	6.7	N/A	8.2	9	**8**	8
Statistical quality index	N/A	94%	96%	96%	**97%**	98%
Foreclosure avoidance through servicing (FATS) ratio	38%	30%	40%	39%	**40%**	40%
Insurance	P&F ID Codes: 36-0120-0-1-701; 36-4012-0-3-701; 36-4010-0-3-701; 36-4009-0-3-701; 36-8132-0-7-701; 36-8150-0-7-701; 36-8455-0-8-701; 36-0151-0-1-705; 36-0111-0-1-703					
Resources						
FTE	548	525	507	520	**519**	
Benefits cost ($ in millions)	$2,559	$2,458	$2,534	$2,755	**$2,772**	
Administrative costs ($ in millions)	$40	$40	$41	$42	**$47**	
Performance Measures						
High customer ratings (Insurance)	96%	96%	95%	95%	**95%**	95%
Low customer ratings (Insurance)	1%	2%	2%	2%	**2%**	2%
Percentage of blocked calls (Insurance)	6%	4%	3%	4%	**3%**	1%
Average hold time in seconds	20	20	17	20	**20**	20
Percentage of insurance disbursements paid accurately	99%	99%	99%	99%	**99%**	99%

Performance Measures by Program

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Average days to process insurance disbursements	3.2	3.2	2.8	3.2	**3.2**	3.0
Favorable IG audit opinion (Insurance)	Y	Y	Y	Y	**Y**	Y
Employee satisfaction (Insurance)	N/A	3.3	3.3	3.8	**3.9**	4.0
Employee skills matrix (Insurance)	N/A	N/A	88%	87%	**87%**	95%

National Cemetery Administration

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

Resources						
FTE	1,357	1,399	1,385	1,460	**1,519**	
Benefits cost ($ in millions)	$106	$109	$111	$140	**$151**	
Administrative costs ($ in millions):						
Operating costs	$92	$103	$116	$130	**$147**	
State cemetery grants	$5	$19	$24	$42	**$32**	
Capital construction	$21	$30	$33	$109	**$109**	
Performance Measures						
Percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence	67.0%	72.6%	72.6%	73.9%	**76.2%**	85.0%
Percent of veterans served by a burial option in a national cemetery within a reasonable distance (75 miles) of their residence	56.7%	67.5%	66.0%	66.7%	**68.8%**	75.4%
Percent of veterans served by a burial option only in a state veterans cemetery within a reasonable distance (75 miles) of their residence	10.3%	5.1%	6.6%	7.2%	**7.4%**	9.4%
Cumulative number of kiosks installed at national and state veterans cemeteries	14	24	33	40	**48**	80
Percent of graves in national cemeteries marked within 60 days of interment	N/A	N/A	N/A	Baseline	**TBD**	TBD
Percent of headstones and markers that are undamaged and correctly inscribed	95%	97%	97%	97%	**97%**	98%
Percent of monuments ordered on-line by other federal and state veterans cemeteries using AMAS-R	65%	87%	89%	89%	**90%**	90%
Percent of individual headstone and marker orders transmitted electronically to contractors	88%	89%	92%	92%	**93%**	95%
Percent of Presidential Memorial Certificates that are accurately inscribed	98%	98%	98%	98%	**98%**	98%
Percent of respondents who rate the quality of service provided by the national cemeteries as excellent	84%	88%	92%	93%	**96%**	100%
Percent of respondents who rate national cemetery appearance as excellent	79%	82%	96%	96%	**98%**	100%

Performance Measures by Program

Board of Veterans' Appeals

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

	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	Strategic Target
Resources						
FTE	478	468	455	464	**451**	
Administrative costs ($ in millions)	$40	$41	$44	$47	**$51**	
Performance Measures						
Deficiency free decision rate	84%	86%	87%	91%	**92%**	95%
Court remand rate	65%	61%	97%	80%	**70%**	33%
Appeals resolution time (Days)	745	682	595	590	**520**	365
BVA Cycle Time	140	172	182	125	**180**	150
Appeals decided per FTE	78.2	72.7	69.3	61.1	**64.3**	65.4
Cost per case (BVA)	$1,062	$1,219	$1,401	$1,666	**$1,767**	$1,922

Departmental Management

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

Resources						
FTE	2,483	2,564	2,674	2,987	**3,022**	
Administrative costs ($ in millions)	$357	$416	$449	$554	**$558**	
Performance Measures						
Percent of stakeholders who are satisfied or very satisfied with their level of participation in VA's planning process	N/A	N/A	N/A	75%	**80%**	85%
Percent of VA employees who indicate they understand VA's strategic goals	N/A	N/A	N/A	65%	**75%**	85%
Percent of statutory minimum goals met for small business concerns	37%	33%	23%	23%	**23%**	23%
Percent of employees who are aware of ADR as an option to address workplace disputes	N/A	N/A	50%	60%	**70%**	100%
Percent of cases using alternate dispute resolution (ADR) techniques	12%	13%	29%	15%	**16%**	20%
Number of audit qualifications identified in the auditor's opinion on VA's Consolidated Financial Statements	0	0	0	0	**0**	0
Percent increase of EC/EDI usage over 1997 base year	48%	86%	178%	100%	**110%**	150%
Percent of CIO designated major IT systems that conform to the *One VA* Enterprise Architecture	N/A	N/A	N/A	25%	**100%**	100%
Percent of the Government Information Security Act reviews and reporting completed	N/A	N/A	80%	100%	**100%**	100%

Office of Inspector General

P&F ID Code: 36-0170-0-1-705

Resources						
FTE	342	354	370	429	**426**	
Administrative costs ($ in millions)	$38	$45	$48	$55	**$61**	
Performance Measures						
Number of indictments, arrests, convictions, and administrative sanctions	696	938	1,655	1,675	**1,675**	1,800
Number of reports issued	162	108	136	160	**160**	200
Value of monetary benefits (in millions) from:						
IG Investigations	$24	$28	$52	$30	**$31**	$35
IG audit and health care inspection reviews	$610	$254	$4,088	$643	**$656**	$696
IG contract reviews	$47	$35	$42	$48	**$50**	$60