STRATEGIC GOAL 3

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

Secretary's Priorities:

- **Provide high-quality health care that meets or exceeds community standards.**
- **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.**
- **Maintain the high level of service to insurance policy holders and their beneficiaries.**
- **Ensure the burial needs of veterans and their eligible family members are met.**

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 – root cause analyses completed
- Patient satisfaction with health care service
- Number of Veterans Service Standard problems reported
- Cost and efficiency for the health care system
- Waiting times for appointments and treatments
- Average days to process insurance disbursements
- Percent of veterans served by a burial option
- Quality of service provided by national cemeteries

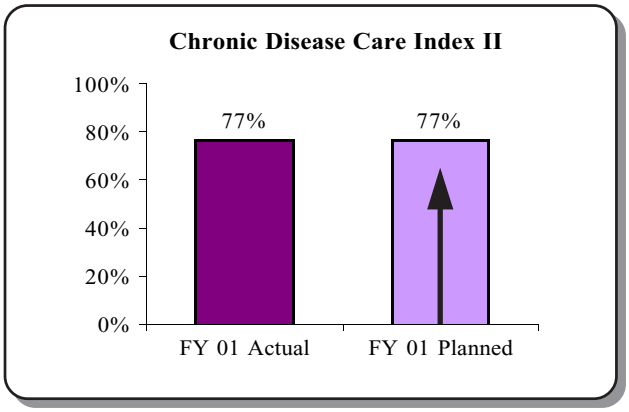
Secretary's Priority

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

Performance Goals

- **Perform at 77 percent on the Chronic Disease Care Index II.**
- **Perform at 73 percent on the Prevention Index II.**
- **Increase to 67 percent the proportion of inpatients and outpatients rating VA health care service as "very good" or "excellent."**
- **Decrease the percent of Veterans Service Standard problems reported per patient in the areas of patient education, visit coordination, and pharmacy.**
- **Perform 95 percent of root cause analyses in the correct format within the appropriate time frame.**
- **Increase the Quality-Access-Satisfaction/Cost VALUE Index to 5.8.**
- **Increase the Balanced Scorecard: Quality-Access-Satisfaction-Cost to 94 percent.**

These performance goals address VA's priority of providing high-quality medical care that meets or exceeds community standards. The Veterans Health Administration (VHA) ensures 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 six Domains of Quality: quality, patient satisfaction, functional status, access, cost efficiency, and building healthy communities.

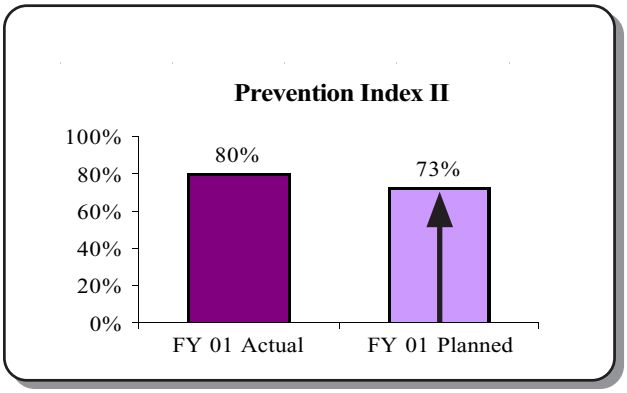


A new methodology was adopted for FY 2001. Therefore, prior year comparisons are not available.

Chronic Disease Care Index II and Prevention Index II

VA achieved the planned target levels for these measures by continuing to emphasize the importance of the many clinical practices that comprise these aggregated index measures. Emphasis on these important areas of quality will continue to be a cornerstone of clinical performance measurement for the Department. The purpose of emphasizing effective chronic disease management is to improve the health of veterans while reducing the use of services and enhancing efficiency. Since a large percentage of veterans seek care for one or more chronic diseases, improved management of chronic disease results in reduced inpatient costs, admissions, and lengths of stay.

The Chronic Disease Care Index II (CDCI II) follows nationally recognized guidelines for seven high-volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder, schizophrenia, and tobacco use cessation. It uses 23 medical interventions as assessments. This is a significant increase from the FY 2000 baseline that used 13 interventions. The revised index provides a more comprehensive representation of chronic care management.



A new methodology was adopted for FY 2001.
Therefore, prior year comparisons are not available.

VA has designed the Prevention Index II (PI II) that includes several indicators allowing a comparison of VA and private health care outcomes. This measure replaces the Prevention Index, which tracked outcomes associated with a smaller number of medical interventions and diseases. The change adds new challenges in the area of disease prevention. In 16 of the 18 indicators that have data comparable to managed care organizations and population-based surveys,[1] VA is the benchmark exceeding the best competitor's performance. In many cases, VA has moved from the comparative measure to require more stringent indicators of care. For example, evidence shows patients who have had heart attacks have less risk of additional heart attacks and death if they take beta-blockers. The Health Plan Employer Data Information Set (HEDIS) comparative indicator measures whether patients who have had a heart attack have a prescription for a beta-blocker upon discharge from the hospital. VA's performance on this measure has been in the 90 percent range for several years. Results of the 18 comparable indicators for FY 2001 are as follows:

1 VA data are compared with National Committee for Quality Assurance (NCQA) (The State of Managed Care Quality, Industry Trends and Analysis, 2001: patients are all ages in private managed care programs); Medicare Managed Care Plans (MMCP), CDC sponsored surveys (CDC, Behavioral Risk Factor Surveillance System (BRFSS) survey from National Center for Chronic Disease Prevention & Health Promotion: telephone survey of states, sample intended to be representative of the population of each state with varying numbers of states involved in each of the measures); HHS, National Center Health Statistics (NCHS) reports and Healthy People 2010 goals. When non-VA data are not available, VA compares its current performance to its past trend data.

MEASURE	VA AVERAGE	BEST COMPETITOR
Advise smokers to quit at least once in past year	93%	66% NCQA
Beta-blocker on discharge after heart attack	94%	92% MMCP
Breast cancer screening	80%	75% MMCP
Cervical cancer screening	89%	78% NCQA
Cholesterol screening in all patients	88%	69% BRFSS 2
Cholesterol measured after heart attack[3]	89%	76% NCQA
Cholesterol less than 130 after heart attack[4]	71%	57% NCQA
Colorectal cancer screening	60%	44% BRFSS 5
Diabetes: HgbA1c done past year	93%	84% MMCP
Diabetes: Poor control[6] (lower number is better)	20%	43% NCQA
Diabetes: Cholesterol (LDLC) measured	91%	84% MMCP
Diabetes: Cholesterol (LDLC) Controlled (<130)	68%	46% NCQA
Diabetes: Eye Exam	66%	68% MMCP
Diabetes: Renal Exam	72%	46% NCQA
Hypertension: BP $\leq$140/90 most recent visit[7]	57%	52% NCQA
Immunizations: influenza, patients 65 and older[8]	73%	75% MMCP
Immunizations: pneumococcal, patients 65 and older[9]	79%	46% NHIS
Mental Health follow-up within 30 days of inpatient discharge	84%	73% NCQA

2 BRFSS scores are median; VHA scores are average

3 VA ongoing annually; NCQA 1st year after attack

4 VA ongoing annually; NCQA 1st year after attack

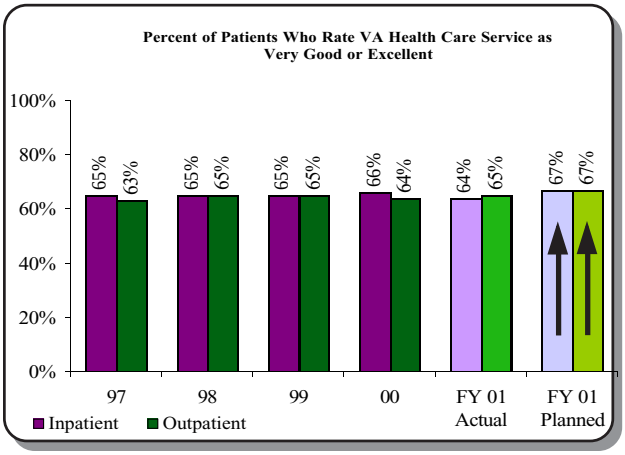
5 BRFSS scores are median; VHA scores are average

6 DM poor control defined by VHA ≥ 9.5; NCQA > 9.5 values for most recent HgbA1c

7 VA includes all ages; NCQA includes ages 46-85 years

8 This VHA number matches NCQA methodology to exclude high-risk patients less than 65. VHA Network Directors performance measure includes high risk patients and patients 65 or older (68%).

9 VHA includes high-risk patients less than 65 in this number; comparative data indicate even though at high risk, patients under 65 have a lower rate of having the immunization.

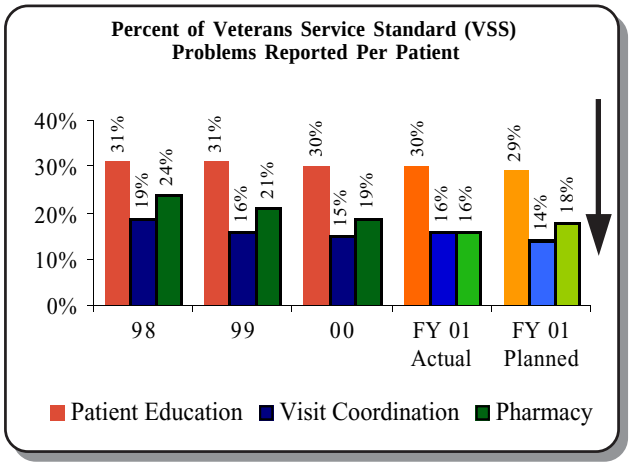


Percent of patients rating VA health care service as very good or excellent (Inpatient/Outpatient)

While the results of the FY 2001 survey reflect that 9 out of 22 Veterans Integrated Service Networks (VISNs) met the performance goal for the inpatient setting, the majority of VISNs did not meet the target of 67 percent. In the outpatient setting, there has been progress in this past year on Overall Satisfaction at the VISN level. A little over half of the VISNs improved their performance on overall quality.

The overall quality measure from the Inpatient Veterans Satisfaction Survey 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 Injury, or Rehabilitation Medicine). For the Outpatient survey, patients are asked to rate the quality of care they received in the outpatient setting over the past 2 months. Both use a five-point scale ranging from "poor" to "excellent." When evaluated using the traditional methodology of including "good" as well as "very good" and "excellent," the overall satisfaction rate increases to 86 percent for inpatient and 91 percent for outpatient. Analysis was conducted regarding 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 for inpatient and patient education/information for outpatient. Challenges within any one of these areas can adversely impact a given VISN's performance in the Overall Satisfaction measure itself.

Percent of Veterans Service Standard (VSS) problems reported per patient: patient education, visit coordination, and pharmacy



VHA achieved and surpassed the planned performance level for the pharmacy component of this overarching measure of patient satisfaction while nearly meeting the patient education and visit coordination components of this measure. It is important to note that "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. Because we achieved our performance goal for this element, we will not maintain it as a measure for FY 2002.

The VSS representing patient education/ information is a complex enterprise requiring that health care entities have the optimal mix of information technology support, teaching media, and effective communicators that can best meet the learning needs of their local patients. Despite these challenges, improvement was realized in three of the seven questions from the 2000 survey results. The issues needing focused attention within this VSS include 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 out of 22 VISNs improved performance on this standard, illustrating the commitment by VHA to address and improve patient education/information.

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. This progress reflects active and effective interventions within all levels of VHA. Also, the PULSE (Patient User Local Survey Evaluator), a hand-held, touch-screen device that can be used to gather satisfaction data at the point of care, was introduced. As the use of PULSE increases, VA medical centers will have the ability to administer recurring surveys as often as they choose (for example, daily). By emphasizing the importance of overall satisfaction and implementing the PULSE, VHA expects improvement in overall patient satisfaction.

The issues needing focused attention within this VSS, however, include 1) explaining to patients when and how test results can be obtained and 2) who to contact with additional questions after the visit.

Root cause analyses (RCAs) are in correct format and completed within appropriate time frame

Root cause analysis (RCA) is a process for identifying the basic or contributing causal factors related to harm caused by adverse events or "close calls" involving VA patients. The National Center for Patient Safety (NCPS) evaluated the timeliness of RCAs in FY 2001 to understand the origins and circumstances of safety problems and to improve outcomes of patient safety in health care facilities.

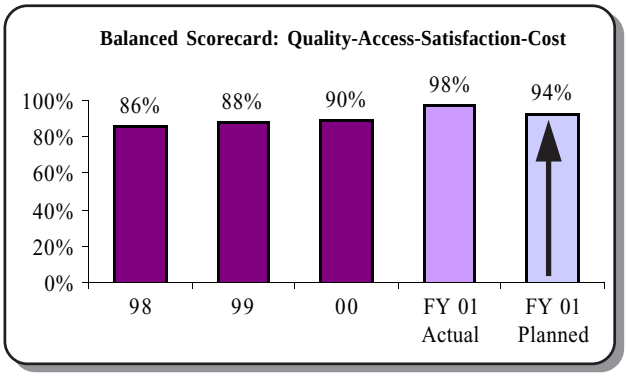
We achieved our planned performance level of 95 percent implementation for this measure and decided to replace it in FY 2002 with one that will measure the success of implementing Bar Code Medication Administration (BCMA) to continue to emphasize new methods in assuring patient safety.

It is important to note that in FY 2001, NCPS provided all VA medical centers individualized feedback about the quality of investigations considering the specificity of the identified root causes and contributing factors, the strength of the proposed mitigating actions, and the value of the developed outcome measures. NCPS encourages this kind of broad focus about analyzing factors affecting patient safety.

Quality-Access-Satisfaction/Cost VALUE Index and Balanced Scorecard: Quality-Access-Satisfaction/Cost

For FY 2001, we exceeded our target of 5.8 with an index score of 6.3. This was an improvement over the prior year index of 5.4. This index includes both cost and other domains of value such as quality, access, and satisfaction that express meaningful outcomes for VA's resource investments. Unlike a simple cost measure that can lead to false impressions of efficiency, the VALUE measure demonstrates a balanced perspective of cost efficiency along with desired outcomes. The

measure simply portrays the desired outcomes (as percentage of goals) that VA achieves with its budgeted resources by establishing a value relationship of Quality-Access-Satisfaction to dollars (QAS/cost).



The Balanced Scorecard provides a framework for translating our strategic objectives into performance measurements driven by key performance measures. This measure uses the same components used in the QAS/Cost VALUE Index but establishes a percent of goal relationship for cost in the same manner as done for desired outcomes of Quality, Access, and Satisfaction. All four components in the scorecard are of equal weight (each component is 25 percent of the total). Progress toward the goal is identified as well as areas where the goal is exceeded.

Means and Strategies

Chronic Disease Care Index II and Prevention Index II

We included the components of this measure among the set of Network director annual performance measures for FY 2001. These measures are rolled up nationally on a quarterly basis, but many VISNs separately track their own performance on a monthly basis.

Percent of patients rating VA health care service as very good or excellent (Inpatient/Outpatient)

VHA is increasing the frequency of administration of the inpatient satisfaction survey from an annual cycle to a semi-annual cycle and the outpatient satisfaction survey from semi-annual to quarterly. This will provide VA medical centers (VAMCs) with more frequent monitoring capabilities. The use of PULSE will empower direct care providers and managers to support improvement more directly by affording VAMCs the ability to administer recurring surveys as often as they choose.

Percent of Veterans Service Standard (VSS) problems reported per patient: patient education, visit coordination, and pharmacy

With the increased frequency of outpatient satisfaction surveys, VAMCs will have the ability to better support local improvement efforts. The use of PULSE will also assist in this effort.

Root cause analyses are in correct format and completed within appropriate time frame

The National Center for Patient Safety (NCPS) provides ongoing training and assistance to front line staff, managers, facility directors, and VHA leadership to support efficient completion of RCAs. The NCPS strategy is to actively solicit success stories and then develop these into information that can be acted upon, disseminating this advice through a variety of means such as NCPS' newsletter, Web site, monthly conference calls, and stand-alone PowerPoint presentations. 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.

Quality-Access-Satisfaction/Cost VALUE Index and Balanced Scorecard: Quality-Access-Satisfaction/Cost

Because the value index and balanced scorecard measures are computations that use data from other measures, the specific means and strategies are the same as those identified for the specific components comprising the Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient satisfaction; and waiting times for primary and specialty care.

Crosscutting Activities

Chronic Disease Care Index II and Prevention Index II

Although the actual areas measured may be different, clinical practice guideline development and indicators and identification of at-risk populations are coordinated with the Department of Defense (DoD).

Root cause analyses are in correct format and completed within appropriate time frame

NCPS is considered a leader in patient safety, with other health care systems and countries emulating our program and adopting our tools. To reduce the need for re-work, NCPS actively collaborates with entities such as the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), thereby ensuring that NCPS' programmatic structure and processes also meet JCAHO requirements. NCPS provides leadership in Quality Interagency Coordination Taskforce (QuIC) activities (such as the recent National Summit on Patient Safety) and has actively shared activities and information with the Institute for Safe Medication Practices (ISMP), as well as with the FDA's Center for Devices and Radiological Health (CDRH).

These collaborations produce secondary efficiencies through sharing of information, but probably have not substantively impacted the timeliness of RCAs. They do, however, provide a powerful method for leveraging individual activities of NCPS.

Quality-Access-Satisfaction/Cost VALUE Index and Balanced Scorecard: Quality-Access-Satisfaction/Cost

While VA does not rely exclusively on any other organization for support of these performance goals, 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 the Department of Health and Human Services (HHS) to develop non-VA benchmarks for bed days of care, which are obtained from the Centers for Medicare and Medicaid Services (CMS) database. In addition, VA is able to obtain data on ambulatory procedures from the National Center for Health Statistics. Since this is a computation of data obtained from other

performance measures, the crosscutting activities related to those performance measures apply to the balanced scorecard and value index measures.

Data Source and Validation

Chronic Disease Care Index II and Prevention Index II

Data is collected using an external contractor through VHA's External Peer Review Program (EPRP). Data collection is accomplished through chart abstraction by professionals such as registered nurses or registered records administrators who use specific chart abstraction logic and standardized definitions.

Data validity is ensured through a number of processes that include: specific orientation and ongoing training for all abstractors, an inter-rater reliability process, software alerts that identify out-of-range data (for example, weight = 550 kg instead of 55 kg), and statistical analysis of all questions and responses to identify potential 'problem' questions, that is, questions that have large variation in responses. New statistical methods to identify non-random variation have been developed and presented at national conferences as state-of-the-art techniques for data validation.

Percent of patients rating VA health care service as very good or excellent (Inpatient/Outpatient) and Percent of Veterans Service Standard (VSS) problems reported per patient: patient education, visit coordination, and pharmacy (uses outpatient survey)

The semi-annual inpatient Veteran Satisfaction Survey is a survey distributed and analyzed by the Office of Quality and Performance, Performance Analysis Center for Excellence (OQP/PACE). Veterans eligible for survey are those discharged from an acute care VA medical center to home within a specified time period. During randomization, duplicate information on an individual patient is omitted. The semi-annual (soon-to-be quarterly) outpatient Veterans Satisfaction Survey is distributed and analyzed by OQP/PACE. Currently, veterans are eligible for survey if they have had at least one outpatient visit to a general medicine, primary care, or women's clinic within a specified time period.

OQP/PACE employs a process to obtain the largest response rate possible for inpatient surveys or that is financially feasible for outpatient surveys. Veterans selected for survey are sent a pre-survey notification letter explaining the nature and goals of the upcoming survey. One week later, the first questionnaire is mailed to everyone in the sample population. One week after that, a thank you/ reminder postcard is sent to the entire sample population. Two weeks later, a second copy of the questionnaire is sent to those veterans who have not yet responded. Comparisons of respondents and non-respondents on gender, age, race, period of service, and service connection are evaluated to determine if there are any meaningful differences. If any are found, cautions are given to the VISNs when generalizing to any of the groups identified.

Root cause analyses are in correct format and completed within appropriate time frame

NCPS maintains Access databases that store information related to RCAs including facility name, number, RCA number, date of initiating RCA, date of completion of RCA, extension requests, extension date, and the text of the actual RCA. NCPS staff developed queries of this database to identify all RCAs meeting the previously stated date parameters. Where there was any question about the data, we reviewed the actual paper copy of the RCAs for dates, as well as our record of electronic mail requests for extensions. Finally, all data were submitted to the Networks for confirmation of validity.

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 because 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.

All data used in this performance measure have been carefully audited. NCPS employed a multi-step process including a secondary verification of all information by staff, a paper audit of selected data elements to confirm information, a face-validity check by additional staff, and a final audit by all Networks of their data. These data serve a valuable purpose in terms of focusing the teams on a timely completion of the RCA. It is, however, but one measure and must be balanced against other components of a successful patient safety program. NCPS emphasizes a broader focus to ensure the quality of investigations related to the specificity of the identified root causes and contributing factors, the strength of the proposed mitigating actions, and the value of the developed outcome measures.

Quality-Access-Satisfaction/Cost VALUE Index and Balanced Scorecard: Quality-Access-Satisfaction/Cost

The sources of data for the VALUE Index are the same as those identified for the specific components comprising the measures-Chronic Disease Care Index II; Prevention Index II; inpatient and outpatient 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.

The VHA balanced scorecard identifies the same components used in the QAS/cost VALUE but establishes a percent of goal relationship for cost in the same manner as done for desired outcomes of Quality, Access, and Satisfaction. All four components in the scorecard are of equal weight (each component is 25 percent of the total). Progress toward the goal is identified as well as areas where the goal is exceeded.

Secretary's 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

- **Establish a baseline for the percent of primary care appointments scheduled within 30 days of the desired date.**
- **Establish a baseline for the percent of specialist appointments scheduled within 30 days of the desired date.**
- **Increase the percent of patients who report being seen within 20 minutes of their scheduled appointments at VA health care facilities to 73 percent.**

Access and waiting times are key to enabling VA to improve its patients' perceptions of the quality of care and their overall satisfaction. In FY 2000, we established a set of performance goals, which we refer to as "30-30-20," concerning the ability of patients to schedule a non-urgent primary care visit (within 30 days) or a specialty care visit (within 30 days) and how long they must wait once they arrive to be seen by a practitioner (20 minutes). 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.

Percent of appointments with primary care provider within 30 days

Eighty-seven percent of primary care appointments were scheduled within 30 days of the desired date in the baseline year of FY 2001. We did this by continuing to modify our scheduling practices, hiring and retraining/reassigning clinical staff to outpatient primary care, opening additional new community-based outpatient clinics (CBOCs), and renovating existing facility-based clinic space to provide clinicians with two examination rooms each, thus improving patient flow. In addition to the overall measures outlined above, internally VHA has additional measures that evaluate subgroups within these clinic wait times: "next available" appointment and "new" patient "next available" appointment. This allows for further analysis to determine areas where action can be taken to improve the overall waiting times.

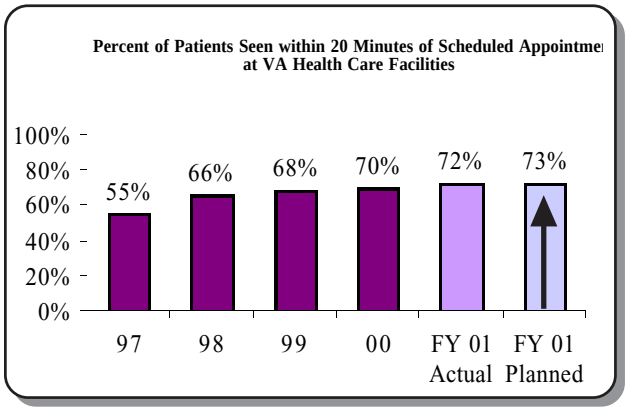
Percent of appointments with a specialist within 30 days

Eighty-four percent of specialty care appointments were scheduled within 30 days of the desired date in the baseline year of FY 2001. We did this by continuing to implement and reap the benefits from modified appointment scheduling and pre-appointment patient reminders as ascribed by the Institute for Healthcare Improvement. Other process-related improvements included dual credentialing for specialists in primary care practice (especially useful for cardiac, diabetic, high blood pressure, cancer, and other patients with an overriding condition that needed to be monitored by a specialist) and retraining primary care clinicians to treat lower level, specific conditions. This combined approach, along with augmented and redirected specialty care and other resources, improved spatial configurations via renovation, and updated equipment will continue to help us achieve greater efficiencies without compromising access to, or quality of, specialty care.

Using a weighted averaging methodology, the average number of days to obtain an appointment in the specialty clinics listed below was 39 days in FY 2001. The waiting times for individual clinics in the fourth quarter, FY 2001, were:

Audiology	30 days
Cardiology	31 days
Optometry/Ophthalmology	58 days
Orthopedics	34 days
Urology	41 days

Percent of patients who report being seen within 20 minutes of scheduled appointment



A VISN-specific analysis of all 22 VISNs indicates that 10 VISNs met an internal target level between 75 and 81 percent while 1 VISN attained 82 percent or greater. The overall national average was 72 percent as compared to a target of 73 percent. This minor target shortfall does not affect corporate outcome since the variance from target is well within one standard deviation of the VISN mean performance. VISNs continue to explore and implement ways to provide scheduled appointments in a timely fashion.

Starting in FY 2002, a new methodology for calculating this percentage will be adopted. Although the new methodology will at first lower our overall percentage, it will provide a model that is more sensitive to change than the one used previously. This increased sensitivity, along with an increase in the frequency of the survey (to quarterly), will provide medical centers with a more accurate reflection of the impact of actions taken to improve patient satisfaction. The new methodology applied to the FY 2001 survey results lowers the compliance to 63 percent. This new baseline number will be used to project improvement in FY 2002 and beyond. This measure will remain in the Network directors' performance contracts in FY 2002.

Means and Strategies

The following strategies were implemented during FY 2001 to improve access to, and timeliness of, health care:

- Trained or retrained existing transferable staff from inpatient to outpatient care.
- Implemented the Institute for Health Care Improvement initiatives.
- Evaluated, and where appropriate, added mental health care to existing CBOCs. Planning for mental health is now added to all new CBOC proposals.
- Increased the number of contracts for specialists to provide services to veterans.
- Continued infrastructure renovation in existing facilities to ensure that at least two exam/treatment rooms are available per clinician providing care on a given day.
- Continued to develop transplant-sharing agreements.
- Continued to provide outpatient medication-dispensing technology in CBOCs and hospital-based clinics.

Major Management Challenges

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 (either primary care or specialty care) and the time they spend waiting in a provider's office. 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. By improving waiting times, through process improvements, physical plant renovations, pharmacy refills by mail, and other means, VHA will effectively improve patient satisfaction and patient perceptions of the quality of their health care.

Data Source and Validation

In early 2000, software was implemented to measure the average next-available clinic appointment time experienced by patients needing an appointment. The software computed 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 will explore mechanisms to quantify the waiting times of newly enrolled patients.

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 measures, 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.

The source of data for the 20-minute waiting time measure is the semi-annual (soon to be quarterly) outpatient satisfaction survey. The survey is distributed and analyzed by the Office of Quality and Performance, Performance Analysis Center for Excellence (OQP/PACE). 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.

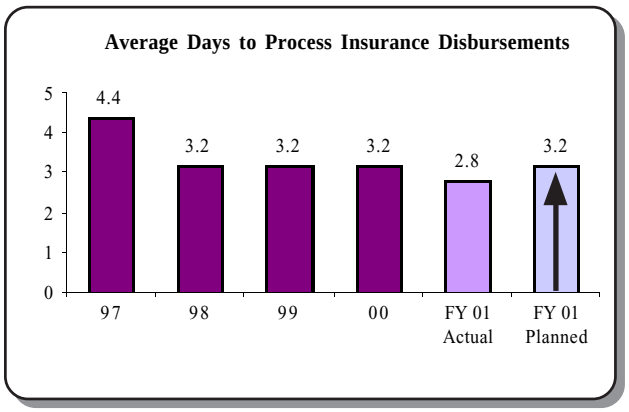
Secretary's Priority

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

Performance Goal

➢ **Maintain average processing time for insurance disbursements at 3.2 days.**

VA met its goal by processing insurance disbursements in an average of 2.8 days, a significant improvement over the 3.2 days in FY 2000. The Philadelphia VA Regional Office and Insurance Center was selected as the winner of the Department's prestigious Robert W. Carey Quality Award in the "Benefits Category" for the second year in a row. Foremost among the many accomplishments noted by the judges was that the Center has developed a special relationship with their policyholders and is dedicated to constantly improving service and products.



A program evaluation was conducted to assess the effectiveness and efficiency of VA programs that assist survivors of veterans and servicemembers who die of, or have, service-connected disabilities. The study determined the extent to which Servicemembers Group Life Insurance (SGLI), Veterans Group Life Insurance (VGLI), Service-Disabled Veterans Insurance (S-DVI), Veterans Mortgage Life Insurance (VMLI), and Dependency and Indemnity Compensation (DIC) meet their statutory intent and expectations of stakeholders. The final report was delivered to VA in May 2001. The study identified key factors in meeting program intent and stakeholder expectations. Study findings indicate that several of the expected outcomes are largely fulfilled but there are important exceptions. Seventeen recommendations were made to enhance these programs. The contractor also provided suggested outcomes and generic suggestions on outcome measures.

Means and Strategies

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.

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 3 years, we processed over 1.5 million beneficiary designations of policyholders who had 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. The folder retirement was completed in

January 2002, almost 2 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.

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.

Following are accomplishments and initiatives achieved in FY 2001:

- American Customer Satisfaction Index (ACSI): ACSI is a uniform and independent measure of consumption experience. The index tracks trends in customer satisfaction and provides insights into benchmarking activities. The index is produced through a partnership of the University of Michigan Business School, the American Society for Quality, and the international consulting firm, CFI Group. This partnership surveyed recipients of insurance death claims using a methodology that allows for direct comparisons with other organizations and types of businesses. The result was an ACSI rating for VA insurance of 90 on a scale of 100, one of the highest scores ever recorded. By comparison, the governmentwide average is 71, and the life insurance industry average is 75.

- VGLI Premium Rate Reduction: As part of a continuing effort to make VGLI premiums more competitive, VA reduced VGLI premiums for approximately 70 percent of its policyholders effective July 9, 2001. This is the second reduction of VGLI premium rates over the last 2 years. These rate reductions save veterans about $35 million per year in premium costs.

- SGLI Family Coverage: The Veterans Survivor Benefits Improvements Act of 2001, Public Law 107-14, extends SGLI coverage to spouses and children of members insured under the SGLI program. This includes both active service and ready reserves. The maximum amount of coverage available for spouses is $100,000 or the amount of the servicemember's SGLI, whichever is less. A member may elect to insure his or her spouse for amounts less than $100,000 in increments of $10,000. Premiums are age-based. All children will receive coverage of $10,000 for free.

- SGLI Coverage Increased to $250,000: The Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, increased the maximum amount of SGLI coverage available to $250,000, effective April 1, 2001. All SGLI policies were automatically increased to $250,000 on this date. Individuals may elect to reduce coverage in multiples of $10,000 on or after April 1, 2001. There is no cost to the Government for this increased coverage. The coverage increase, for those who had the previous maximum of $200,000, was made retroactive to October 1, 2000, for servicemembers who died while on duty.

- Capping of S-DVI Term Premiums: The Veterans Benefits and Health Care Improvement Act of 2000 also allowed for the capping of S-DVI term premiums effective November 1,

2000. Term insurance premiums increase each time a policy is renewed; however, with the passage of this law, premiums are frozen at the first renewal after the insured reaches age 70 and remain frozen thereafter. The additional annual subsidies required to cap S-DVI term premiums at the age 70 rate will be approximately $500,000 in the first full year, with a 5-year total of $2.8 million.

- Beneficiary & Option (B&O) Mailing: In FY 2001, the Insurance service completed a 3-year mass mailing, sending virtually every insured a new beneficiary designation. In total, our B&O unit has imaged over 1.6 million designations, laying the foundation for our paperless office and preparing the way for retirement of all insurance folders by imaging applications and various other documents.

- Outreach Efforts: Insurance is targeting additional outreach efforts to all separating servicemembers, especially severely disabled veterans. These efforts are designed to assist veterans in making an educated choice regarding their life insurance needs. Our outreach to severely disabled veterans began due to findings that this group underutilized insurance benefits. For these veterans, our efforts include personal letters, phone calls, and an expedited application process. VA hopes that these efforts will ensure the retention of a valuable benefit for those most in need and also raise all veterans' awareness of their earned insurance benefits.

Data Source and Validation

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. Data on processing time is collected and stored through the statistical quality control (SQC) program and the Distribution of Operational Resources (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.

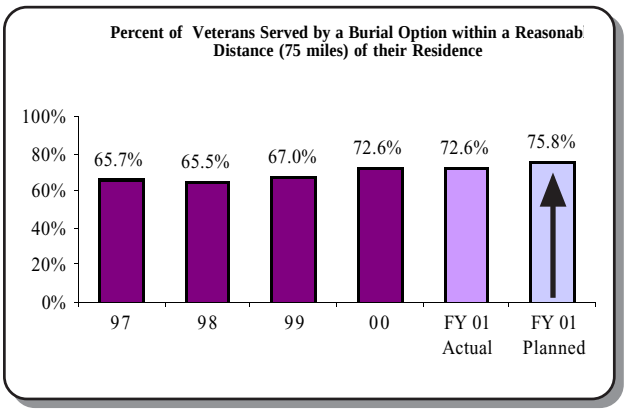
Secretary's Priority

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

Performance Goals

- **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 75.8 percent by 2001.**
- **Increase the percent of respondents who rate the quality of service provided by the national cemeteries as excellent to 90 percent by 2001.**

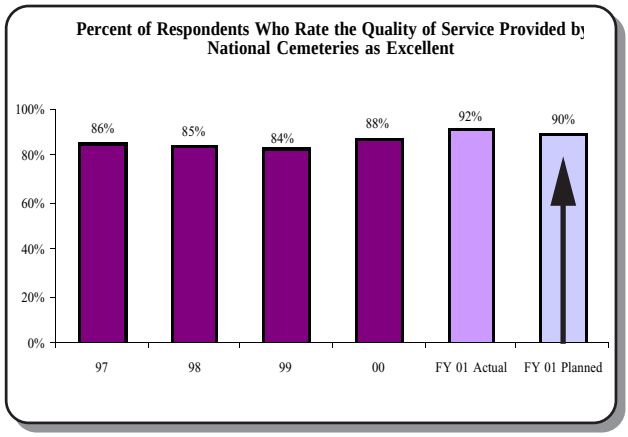
VA did not meet the FY 2001 performance goal to serve 75.8 percent of veterans with a burial option within a reasonable distance of their residence. This performance goal was established prior to the availability of the new VetPop2000 data released in April 2001. If the data model used to project the veteran population had not changed during the year, VA would have met its goal.



Satisfaction with the quality of service provided by national cemeteries remained at a high level in FY 2001. Cemetery service goals are set in keeping with the high expectations of all who visit.

VA provides interment of veterans and eligible family members upon demand. From FY 1997 to FY 2001, annual interments increased 16 percent, from 73,007 to 84,822. With the aging of World War II and Korean Conflict-era veterans, veteran deaths are increasing each year. Based on the 1990 census, the annual number of veteran deaths is expected to peak at 687,000 in the year 2006 before beginning a gradual decline. This progressive increase in veteran deaths results in a corresponding increase in the number of interments in national cemeteries.

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



At the end of FY 2001, of the 119 existing national cemeteries, only 60 contained available, unassigned gravesites for the burial of both casketed and cremated remains; 26 accepted only cremated remains and remains of family members for interment in the same gravesite as a previously deceased family member; and 33 performed only interments of family members in the same gravesite as a previously deceased family member.

Annual Interments

1997	1998	1999	2000	2001
73,007	76,718	77,680	82,717	84,822

Means and Strategies

In FY 2001, to meet the burial needs of veterans, VA continued planning for the development of new national cemeteries, completed construction projects to make additional gravesites or columbaria available for burials, and acquired land to continue burial options at existing national cemeteries.

VA continued to make progress in the development of new national cemeteries to serve veterans in the areas of Atlanta, Georgia; Detroit, Michigan; Miami, Florida; Oklahoma City, Oklahoma; Pittsburgh, Pennsylvania; and Sacramento, California. These locations were identified in a May 2000 report to Congress as the areas most in need of a new national cemetery, based on demographic studies. When open, these 6 cemeteries will provide a burial option to over 2 million veterans who are not currently served within a reasonable distance of their residence.

During FY 2001, VA accepted a land donation to develop a national cemetery near Atlanta, Georgia, a location identified in the above-referenced May 2000 report to Congress. When completed, the national cemetery will provide a burial option within 75 miles of the residence of over 400,000 veterans in the Atlanta metropolitan area. By receiving the donated land, America's taxpayers have been saved the costs of land purchase. In addition, Georgia's veterans have benefited from a reduced timetable for development of a new national cemetery.

In fall 2001, operations began at Fort Sill National Cemetery, near Oklahoma City, when the initial "fast track" development was completed. A "fast track" is a small-scale development that provides veterans with burial space nearly 2 years before cemetery construction is completed. This allows families to inter loved ones in the national cemetery without waiting for final completion of construction. This first burial area will provide 1,100 gravesites. A temporary committal shelter, access roads, and a flagpole are in place. Fort Sill National Cemetery will provide a burial option within 75 miles of the residence of 166,000 veterans in the Oklahoma City area.

The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, directs VA to contract for an independent demographic study to identify: (1) those areas of the country where veterans will not have reasonable access to a burial option in a national or state veterans cemetery; and (2) the number of additional cemeteries required to meet veterans' burial needs through 2020. The study is now in process and the contractor's report will be provided in the spring of 2002.

VA monitors gravesite usage and projects gravesite depletion dates at open national cemeteries that have land for future development. As those cemeteries approach their gravesite depletion dates, VA ensures that construction to make additional gravesites or columbaria available for burials is completed. In FY 2001, VA completed construction projects to extend burial operations at six national

cemeteries. For example, at the National Memorial Cemetery of Arizona, we completed a project that developed 14,000 full casket gravesites and 18,000 cremation burial sites. A 2,500-unit columbarium was completed at Calverton National Cemetery in New York. A construction project at Fort Logan National Cemetery in Denver, Colorado, included site preparation and placement of 2,500 double depth precast concrete burial vaults.

Appropriate land acquisition is a key component to providing continued accessibility to burial options. In FY 2001, VA acquired land to continue operations at Culpeper and Roseburg National Cemeteries. We will continue to identify national cemeteries that are expected to close due to depletion of grave space and determine the feasibility of extending the service life of those cemeteries by acquiring adjacent or contiguous land or by constructing columbaria. These actions, which depend on such factors as the availability of suitable land and the cost of construction, are not possible in every case. Efforts to acquire additional land are currently underway at eight national cemeteries.

The Department's goal is to make sure the Nation's veterans and their families are satisfied with the quality of service provided by national cemeteries. VA strives to provide high-quality, courteous, and responsive service. Veterans and their families have described national cemetery staff as "helpful, patient and understanding." In one of many letters of appreciation VA received in FY 2001, a family member observed that "a military funeral should be a first-class operation, conducted with dignity" and that the "cemetery staff provided such an atmosphere." Another family member commented that the service provided by one of VA's national cemeteries "made us proud that our country extended this kind of consideration."

To further enhance access to information and improve service to veterans and their families, NCA installs kiosk information centers at national and state veterans cemeteries to assist visitors in finding exact gravesite locations. In addition to providing the visitor with a map for use in locating the gravesite, the kiosk information center provides general information such as the cemetery's burial schedule, cemetery history, burial eligibility, and facts about NCA. By the end of FY 2001, VA had installed 33 kiosks at national and state veterans cemeteries.

In order to accommodate and better serve our customers, we have 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. The amount of time it takes to mark the grave after an interment is also extremely important to the decedent's family members. To meet these expectations, VA strives to schedule committal services at national cemeteries within 2 hours of the request and set headstones and markers at national cemeteries within 60 days of the interment.

During FY 2001, VA national cemeteries became the final resting places for victims of terrorist attacks. Three U.S.S. Cole crewmembers, killed during a terrorist attack in Yemen, were buried in VA national cemeteries, with military funeral honors provided by the Department of Defense. Four victims of the September 11th terrorist attack on the World Trade Center were interred in VA national cemeteries.

Sergeant William T. Carroll, Jr., was interred at Dallas-Fort Worth National Cemetery during FY 2001. Sergeant Carroll was killed in action in December 1944, while serving as a crewmember aboard a B-24 Liberator bomber. He and eight crewmembers were missing until 1997, when a French farmer found the airplane wreckage in a densely wooded area. After a positive identification of Carroll's remains by the Army's Central Identification Laboratory in Honolulu, Hawaii, the family decided on burial at the Dallas-Fort Worth National Cemetery.

Ohio Western Reserve National Cemetery interred the remains of U.S. Marine Corps Corporal Thomas A. Gopp, who had been missing in action in Vietnam since August 3, 1967. The U.S. Marine Corps conducted military funeral honors at a service attended by family members, friends, and members of various veterans organizations.

Gulf War Veteran Marlon F. Morales, a Metro Transit Police Officer, was interred at Quantico National Cemetery. Officer Morales was killed June 13 when he tried to stop a Metro fare evader at the U Street-Cardozo Metrorail Station in Washington, D.C. The Metro Transit Police provided military funeral honors at the service, which was attended by several hundred people including police officers; Metro transit employees; the Honorable Anthony Williams, Mayor of Washington, D.C.; the Honorable Louis Freeh, Director of the FBI; and other government representatives.

To ascertain how customers and stakeholders perceive the quality of service provided by national cemeteries, VA annually seeks feedback through surveys and focus groups. This information is used to determine expectations for service delivery as well as specific improvement opportunities and training needs. For FY 2001, VA developed a nationwide mail-out customer satisfaction survey. The new survey is an improvement over the previous data collection instrument in that it provides statistically valid performance information at the national and regional (Memorial Service Network) levels, and at the cemetery level for cemeteries having at least 400 interments per year. The information gathered will be used in NCA's strategic planning process to develop additional strategies for improvement. VA will continue to conduct focus groups to collect data on stakeholder expectations and their level of satisfaction with the quality of service provided by the national cemeteries.

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.

Crosscutting Activities

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 veterans' cemeteries, including the acquisition of initial operating equipment. To date, 47 state veterans cemeteries have been established, expanded, or improved through the SCGP. In FY 2001, state veterans cemeteries performed over 15,000 interments, and new grants were obligated to establish or expand state veterans cemeteries in 4 states.

Five new state veterans cemeteries were opened at Agawam, Massachusetts; Augusta, Maine; Little Rock, Arkansas; Miles City, Montana; and

Northern Wisconsin in FY 2001. These cemeteries provide service to over 250,000 veterans and their families not previously served within a reasonable distance of their residence. The new state veterans cemetery in Little Rock offsets the closure of Little Rock National Cemetery. Opening this new state veterans cemetery will enable over 110,000 veterans to continue to have access to a burial option within a reasonable distance of their residence.

In the fall of 2001, NCA and the State of Missouri co-sponsored the first national conference for directors of state veterans cemeteries. The conference provided the 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.

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

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

Data Source 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 VA 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.

In 1999, 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 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. VA has addressed these inconsistencies, and the adjustments are included in the data contained in this report.

From FY 1996 through 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 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. The measure for quality of service is the percent of respondents who agree that the quality of service received from cemetery staff is excellent.

VA Central Office 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).

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, a new performance measure will be established and included in the Department's performance plan.