Department of Veterans Affairs

Annual Performance Report
FY 2001

Office of Management
March 2002

Annual Performance Report FY 2001

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Letter of Transmittal

To the President of the United States, President of the Senate, President pro tempore of the Senate, and Speaker of the House of Representatives:

I am pleased to submit the Department of Veterans Affairs' Annual Performance Report FY 2001, as required by the Government Performance and Results Act of 1993. This report describes in detail how well we executed our responsibilities during fiscal year 2001, especially in regard to our top priorities:

- improving the timeliness and quality of claims processing,
- providing access to high-quality health care, especially to disabled and low income veterans, and
- ensuring access to burial benefits and maintaining national cemeteries as national shrines.

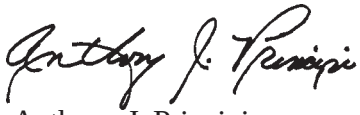
The events following the terrorist attacks on September 11, 2001, remind us of the awesome sacrifices the men and women of America's armed forces make on our behalf. Most of the 25 million living veterans have served during times of war. The Nation owes a tremendous debt to them, and we in the Department of Veterans Affairs are proud of the role we play in helping discharge that debt.

Although quality of claims processing improved significantly, timeliness remains unacceptable. A task force I commissioned to examine a wide range of issues affecting speedy processing of claims issued its report in October 2001. We are now pursuing implementation of a variety of short-term and mid-term recommendations. I am determined to solve the timeliness problem during my tenure as Secretary.

Veterans health care sets the national standard in patient safety and the measurement of quality outcomes. Our National Center for Patient Safety has been recognized for its achievements by the Innovations in American Government Program, administered by Harvard University and the Council for Excellence in Government.

To meet the burial needs of veterans, we began operations at Fort Sill National Cemetery in Oklahoma and extended burial operations at six others. Five new state veterans cemeteries were opened through VA grants. We started a long-term project to maintain the national cemeteries as national shrines.

Our veterans deserve the best our country can offer, and I intend to make sure they receive the care and service they have earned.



Anthony J. Principi
Secretary of Veterans Affairs

VA's PERFORMANCE SCORECARD FOR FY 2001

Strategic Goal	Performance Measure	Was the Goal Achieved? Yes	No	Performance Goal	Actual	Improved from FY 2000?
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 (pp. 25, 150)	✓		95%	98%	Same
	Compensation and pension rating-related actions – average days to process (pp. 27, 142)	✓		202	181	No
	National accuracy rate for core rating work (pp. 27, 147)	✓		72%	78%	Yes
	Vocational rehabilitation and employment rehabilitation rate (pp. 31, 151)	✓		65%	65%	Same
Ensure a smooth transition for veterans from active military service to civilian life	Montgomery GI Bill usage rate (pp. 34, 146)		✓	60%	56%	Yes
	Average days to complete: Original education claims (pp. 34, 141) Supplemental education claims (pp. 34, 141)		✓ ✓	35 23	50 24	No No
	Foreclosure avoidance through servicing (FATS) ratio (pp. 39, 145)	✓		33%	40%	Yes
Honor and serve veterans in life and memorialize them in death for their sacrifices on behalf of the Nation	Chronic Disease Care Index II (pp. 42, 143)	✓		77%	77%	N/A
	Prevention Index II (pp. 42, 150)	✓		73%	80%	N/A
	Percent of patients rating VA health care service as very good or excellent: Inpatient (pp. 42, 146) Outpatient (pp. 42, 146)		 ✓ ✓	 67% 67%	 64% 65%	 No Yes
	Percent of Veterans Service Standard (VSS) problems reported per patient: Patient education (pp. 42, 149) Visit coordination (pp. 42, 149) Pharmacy (pp. 42, 149)	 ✓	 ✓ ✓	 29% 14% 18%	 30% 16% 16%	 Same No Yes
	Root cause analyses are in correct format and completed within the appropriate time frame (pp. 42, 152)	✓		95%	95%	N/A
	Quality-Access-Satisfaction/Cost VALUE Index (pp. 42, 142)	✓		5.8	6.3	Yes
	Balanced Scorecard: Quality-Access-Satisfaction-Cost (pp. 42, 142)	✓		94%	98%	Yes
	Percent of non-urgent primary care appointments scheduled within 30 days of desired date (pp. 51, 154)			Baseline	87%	N/A
	Percent of non-urgent specialist appointments scheduled within 30 days of desired date (pp. 51, 154)			Baseline	84%	N/A
	Percent of patients who report being seen within 20 minutes of scheduled appointment at VA health care facilities (pp. 51, 147)		✓	73%	72%	Yes
	Average days to process insurance disbursements (pp. 54, 141)	✓		3.2	2.8	Yes
	Percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence (pp. 57, 153)		✓	75.8%	72.6%	Same
	Percent of respondents who rate the quality of service provided by the national cemeteries as excellent (pp. 57, 151)	✓		90%	92%	Yes
Contribute to the public health, 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 (pp. 64, 146)		✓	33%	0%	N/A
	Percent of respondents who rate national cemetery appearance as excellent (pp. 69, 151)	✓		88%	96%	Yes

N/A = Not applicable

EXECUTIVE SUMMARY

In FY 2001, with resources of $53.5 billion in obligations and nearly 207,000 full-time equivalent (FTE) employees, the Department of Veterans Affairs (VA) achieved significant accomplishments that brought us closer to attaining our long-term strategic goals. To help us gauge our progress, we established 126 performance goals at the beginning of the fiscal year, 26 of which were identified by VA's senior leadership as critical to the success of the Department.

VA's Performance Scorecard for FY 2001 summarizes how well we did in meeting the key performance goals directly associated with each of the strategic goals. This allows us to examine performance from a Departmental, or *One VA*, perspective.

In FY 2001, the Department made significant advances, but continued to have problems in certain areas. Although we met our goal for timeliness of processing compensation and pension rating-related actions, we still have a long way to go to achieve an acceptable record. Although claims processing has become increasingly complex because of new legislation and regulatory changes, the Department remains committed to improving the timeliness of claims processing and has developed strategies for accomplishing future performance goals.

Some of the most important successes attained in FY 2001 include:

- VA made a significant improvement in the quality of claims processing, from a 59 percent accuracy rate in 2000 to a 78 percent rate for rating-related actions in 2001.
- Although the average number of days to complete educational claims worsened, the Montgomery GI Bill usage rate increased due to improved benefits.
- The foreclosure avoidance rate improved due to VA's aggressive proactive servicing program to assist veterans whose mortgages are in default.
- The VA insurance program continued its excellent service as evidenced by the improvement in the timeliness of processing disbursements.
- Health care quality continued to improve, as measured by the Chronic Disease Care Index and the Prevention Index.
- VA health care continues to receive higher satisfaction ratings than the private sector.
- Although the Department just missed its target, the timeliness of health care delivery continued to rise as measured by the percentage of patients seen within 20 minutes of their scheduled appointment at a VA health care facility.
- The Department was recognized for its efforts to improve the quality of health care; VA was one of five winners of the "Innovations in American Government" award for reducing medical adverse events and developing a culture of safety.
- Three of VA's programs received high customer satisfaction ratings, as detailed in the American Customer Satisfaction Index. A compared to the Federal Government average of 71 (out of a possible 100), VA achieved ratings of 93 for burial services, 90 for the

processing of insurance death claims benefits, and 83 for pharmacy services.

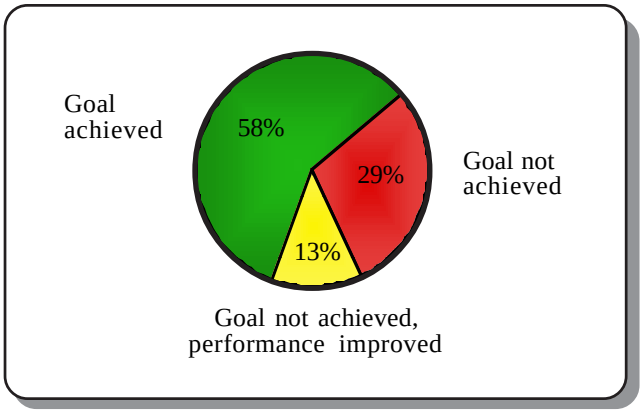
- VA began operations at Fort Sill National Cemetery and completed construction projects to extend burial operations at six other national cemeteries. Five new state veterans cemeteries were opened through the State Cemetery Grants Program.

- VA's national cemeteries continued to improve the quality of their service as well as their appearance. In 2001, 96 percent of respondents to a customer satisfaction survey rated the appearance of national cemeteries as excellent, up from 82 percent in 2000.

Summary of Performance on Key Performance Goals

VA's senior leadership identified 26 performance goals considered critical to the success of the Department. Some of these deal with program outcomes; others pertain to the management of our programs. FY 2001 data for all of these key performance goals are listed in the "performance actual" column of the performance scorecard on page 4.

The Department achieved 14 of the 24 (58 percent) key performance goals for which we had FY 2001 targets. For nine of those, actual performance in FY 2001 improved over that reported in FY 2000. For 3 of the 10 performance goals not met, actual performance in FY 2001 was better than that reported in FY 2000. We did not set performance goals for two measures but collected baseline data during the year.



Key Performance Results by Strategic Goal

This report is structured around the key priorities established by the Secretary. Within the narratives, we have incorporated the key measures that support these priorities. (In this report, years are fiscal years unless stated otherwise.)

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.

We use four key performance goals to gauge our progress toward achieving this strategic goal, which focuses on benefits and services for disabled veterans. We achieved all of these key performance goals. The Department maintained the proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings at 98 percent in FY 2001.

Although we exceeded our timeliness goal for rating-related work by 21 days with an achievement level of 181 days compared to our goal of 202 days, performance worsened from the 173 days recorded the previous year. We have a long way to go before we achieve an acceptable record for this goal.

During FY 2001, the national accuracy rate in processing the Department's most important types of claims for compensation and pension benefits (i.e., rating-related actions) improved to 78 percent from a rate of 59 percent in FY 2000.

Over 10,100 veterans were rehabilitated; 65 percent of service-disabled veterans who exited a vocational rehabilitation program acquired and maintained suitable employment, the same as in FY 2000.

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

We did not meet three of the four key performance goals relating to achievement of this strategic goal in FY 2001. Though we did not meet the Montgomery GI Bill (MGIB) usage rate goal, the rate improved from 55 percent in FY 2000 to 56 percent in FY 2001.

Veterans use their VA education benefit as one important means of readjusting to civilian life. The MGIB allows them the opportunity to achieve educational or vocational objectives that might not have been attained had they not entered military service.

The timeliness of processing education claims deteriorated during FY 2001. The processing of both original and supplemental education claims took longer in FY 2001 than it did in FY 2000. While our plan was to process original education claims in no more than 35 days, it took an average of 50 days. The average number of days needed to process supplemental education claims was 24 days, 1 day longer than the performance target.

We met our goal to assist veterans who are in default on a VA-guaranteed home mortgage, as measured by the foreclosure avoidance through servicing (FATS) ratio. The foreclosure avoidance rate improved from 30 percent in FY 2000 to 40 percent in FY 2001 due to VA's aggressive proactive servicing program to assist these veterans.

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

VA achieved 8 of the 14 key performance goals for this strategic goal. For two of the six key performance goals we did not meet, performance in FY 2001 improved over that reported in FY 2000.

During the last 5 years, the share of inpatients and outpatients rating VA health care service as "very good" or "excellent" has remained stable at about two-thirds. The inpatient and outpatient satisfaction levels recorded during FY 2001, although below the performance target of 67 percent, still indicate a very high level of satisfaction with VA health care. This is supported by the American Customer Satisfaction Index (ACSI), a national indicator of customer evaluations of the quality of goods and services. The FY 2001 ACSI scores for VA inpatient care and outpatient care were 82 and 79 (out of a possible 100), respectively. Both ranked above private sector hospitals, whose ACSI score was 68.

Although the Department did not meet its FY 2001 target – that 73 percent of patients would be seen within 20 minutes of their scheduled appointment at VA health care facilities – the actual performance level of 72 percent was an improvement over the 70 percent registered during FY 2000.

For FY 2001, the Department established baselines for two other performance measures related to the timeliness of providing health care: the percent of non-urgent primary care appointments scheduled within 30 days of the desired date and the percent of non-urgent specialist appointments scheduled within 30 days of the desired date. The baselines for these were 87 percent and 84 percent, respectively.

VA uses two key performance measures to assess the quality of health care delivery – the Chronic Disease Care Index II (CDCI II) and the Prevention Index II (PI II). These indices measure the degree to which the Department follows nationally recognized guidelines for the treatment and care of patients. The CDCI II focuses on the care of patients with ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, major depressive disorder, schizophrenia, and tobacco cessation. During FY 2001, VA met its target of 77 percent. The PI II focuses on primary-prevention and early-detection recommendations for nine diseases or health factors that significantly determine health outcomes: pneumococcal pneumonia, influenza, tobacco consumption, and alcohol consumption and screenings for colorectal cancer, breast cancer, cervical cancer, prostate cancer, and cholesterol levels. VA surpassed its target of 73 percent by achieving an 80 percent PI.

The Veterans Service Standard (VSS) performance goals are intended to measure patient satisfaction with health care services in select areas. The VSS percent of problems reported per patient remained the same as in FY 2000 for patient education. For visit coordination, the target of 14 percent was not met, and the actual of 16 percent for FY 2001 was worse than the 15 percent reported for FY 2000. VA surpassed the pharmacy target of 18 percent plus improved in this area from 19 percent in FY 2000 to 16 percent in FY 2001.

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 concerns. The Department met its target of 95 percent for root cause analyses being in correct format and completed within the appropriate time frame.

We met our targets for both the Quality-Access-Satisfaction/Cost VALUE Index and the Balanced Scorecard of Quality-Access-Satisfaction-Cost. The VALUE index demonstrates a balanced perspective of cost efficiency along with desired outcomes. The balanced scorecard tracks the same performance measures used in the VALUE index. In this case, though, the four domains (quality, access, patient satisfaction, and cost) are given equal weight and expressed in terms of how close actual performance is relative to established target levels of performance.

VA surpassed its target of 3.2 days for average days to process insurance disbursements and improved from the 2000 actual of 3.2 with a 2001 actual of 2.8 days.

The percent of veterans served by a burial option within a reasonable distance (75 miles) of their residence remained the same at 72.6 percent in FY 2001. This actual was obtained through the new VetPop2000 model, the first revision of official estimates and projections of the veteran population since 1993.

VA exceeded its 90 percent target for FY 2001 in the percent of survey respondents who rate the quality of service provided by the national cemeteries as excellent. The actual of 92 percent was an improvement over the 88 percent rating in FY 2000.

Strategic Goal 4: Contribute to the public health, socioeconomic well being and history of the Nation.

VA failed to meet one of the two key performance goals relating to this strategic goal in FY 2001. We did not meet the 33 percent goal for Institutional Review Board compliance with National Committee for Quality Assurance (NCQA) accreditation and maintenance, as appropriate, of AAALAC or NRC accreditation or certification. Although all appropriate AAALAC and NRC accreditation/certifications were maintained nationally, the initial implementation of the NCQA accreditation process for VHA research programs was delayed. The delay in starting NCQA accreditation surveys was initially due to a delay in a contract award. In addition, once standards were being developed with NCQA, the Institute of Medicine became aware of this initiative and asked if VHA would collaborate to develop national standards for accreditation that could be used for all research programs across the nation (not just within VHA). This additional component further delayed the first accreditation surveys. Surveys have been performed using the newly developed standards, but there are no final reports completed at this time.

In FY 2001, satisfaction with national cemetery appearance improved from 82 percent in FY 2000 to 96 percent of survey respondents rating national cemetery appearance as "excellent."

The Challenges Ahead

As we strive to provide the best quality benefits and services to our Nation's veterans, we realize we have many program and management challenges to overcome. The VA Office of Inspector General (OIG) and the General Accounting Office (GAO) have provided the most succinct description of our major challenges. The OIG challenges include:

- Health quality management and patient safety
- Resource allocation
- Compensation and pension timeliness, quality, and inappropriate benefit payments
- Government Performance and Results Act (GPRA) – data validity
- Security of systems and data
- Federal Financial Management Improvement Act and VA's Consolidated Financial Statements
- Debt management
- Workers' compensation costs
- Procurement practices
- Human capital management

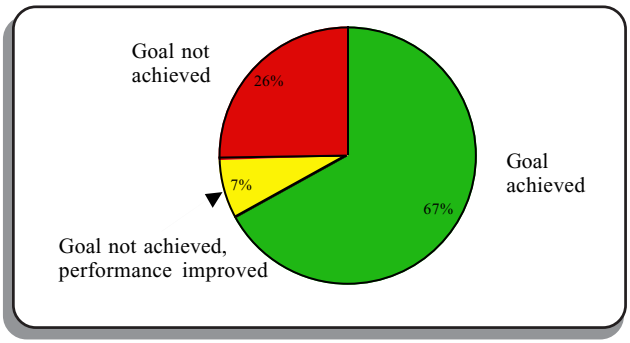
The GAO challenges include:

- Access to quality health care
- Health care resource utilization
- Compensation and pension claims processing
- Management capacity

For a thorough discussion of these challenges, see the section on Major Management Challenges that begins on page 93.

All Performance Goals

In addition to the key performance goals identified by VA's senior leadership as critical to the success of the Department, program managers established other performance goals at the beginning of FY 2001. Collectively, these performance goals demonstrate the full scope of the Department's programs and operations. A total of 126 performance goals were set at the start of the fiscal year. VA met 67 percent of the performance goals for which we had data. (We did not have data for six measures.) For another 7 percent, the Department's performance improved over that reported in FY 2000. For more detailed information on the full range of performance goals, refer to the tables shown on pages 128 to 140.



Alternative Ways of Viewing Performance

To meet the varied needs of Congress, OMB, veterans service organizations, the general public, and internal VA program managers, we have examined performance in several different ways. Most of our analysis focuses on the Secretary's priorities and the key performance goals and measures considered critical to the success of the Department.

The Performance Scorecard for FY 2001, shown on page 4, summarizes how well we did in meeting the limited number of key performance goals directly associated with each of VA's strategic goals, a *One VA* perspective.

While the *One VA* point of view is important, this is not the only way in which we analyze performance. We want to know how well we did in meeting the goals established for each of our programs, and we are interested in information on how well each of our major organizations performed. The following chart demonstrates the interrelationship between these alternative ways of viewing performance related to our key performance goals. During FY 2001, there was not a key measure for the Medical Education program.

Key Performance Measures by Responsible Organization and Program

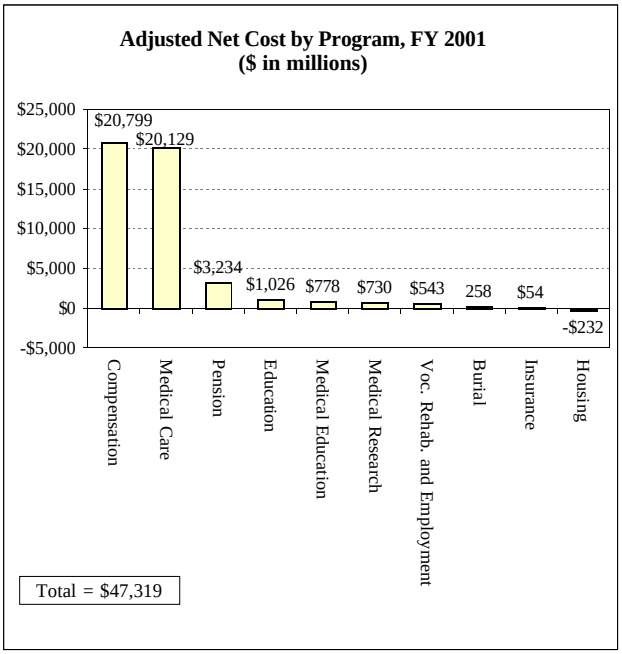
Responsible Organization and Measure	Program									
	Medical Care	Medical Research	Medical Education	Compensation	Pension	Education	Housing	Vocational Rehabilitation	Insurance	Burial
Veterans Health Administration										
Proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings	X									
Percent of patients who rate VA health care service as very good or excellent										
Inpatient	X									
Outpatient	X									
Percent of primary care appointments scheduled within 30 days of desired date	X									
Percent of specialist appointments scheduled within 30 days of desired date	X									
Percent of patients who report being seen within 20 minutes of scheduled appointment at VA health care facilities	X									
Chronic disease care index II	X									
Prevention index II	X									
Percent of Veterans Service Standard (VSS) problems reported per patient:										
Patient education	X									
Visit coordination	X									
Pharmacy	X									
Root cause analyses are in correct format and completed within the appropriate time frame	X									
Quality-Access-Satisfaction/Cost VALUE Index	X									
Balanced Scorecard: Quality-Access-Satisfaction-Cost	X									
Institutional Review Board compliance with NCQA accreditation and maintenance, as appropriate, of AAALAC or NRC accreditation certification		X								
Veterans Benefits Administration										
Average days to process rating-related actions				X	X					
National accuracy rate for core rating work				X	X					
Montgomery GI Bill usage rate						X				
Average days to complete original education claims						X				
Average days to complete supplemental education claims						X				
Foreclosure avoidance through servicing (FATS) ratio							X			
Vocational rehabilitation and employment rehabilitation rate								X		
Average days to process insurance disbursements									X	
National Cemetery Administration										
Percent of veterans served by a burial option within a reasonable distance (75 miles) from their residence										X
Percent of respondents who rate the quality of service provided by national cemeteries as excellent										X
Percent of respondents who rate the appearance of national cemeteries as excellent										X

FINANCIAL HIGHLIGHTS

- Pursuant to the requirements of 31 U.S.C. 3515 (b), VA's financial statements report the financial position and results of operations of the Department. The audit of the statements was performed by Deloitte & Touche LLP, under the direction of the Office of Inspector General. VA received an unqualified opinion on the Department's financial statements from the auditors in FY 2001 (which includes explanatory paragraphs relating to the adoption of Statement of Federal Financial Accounting Standards (SFFAS) Nos. 10 and 21, a change in the fixed asset capitalization policy, and the restatement, all discussed in Note 21 of the FY 2001 Annual Accountability Report), continuing the success first achieved in FY 1999. While the statements have been prepared from the books and records of the Department in accordance with the formats prescribed by the Office of Management and Budget (OMB), the statements are in addition to the financial reports used to monitor and control budgetary resources prepared from the same books and records. The statements are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so. For more information on VA's financial statements, refer to the FY 2001 Annual Accountability Report.

- As discussed in Note 21 to the Financial Statements, subsequent to the issuance of the FY 2000 Financial Statements, VA management determined that the calculation of the Veterans Benefits actuarial liability contained material errors. The errors relate to FY 2000 and prior periods. In accordance with VA's election to early adopt SFFAS No. 21, which requires that reporting entities restate prior period financial statements for material errors discovered in the current period, if such statements are provided for comparative purposes, and if the effect of the error would be material to the financial statements in either period, the accompanying FY 2000 Financial Statements have been restated to reflect the correction of the calculation errors. The FY 2000 Financial Statements have also been restated to correct an error in the Judgment Fund liability calculation. The following financial highlights give effect to the restatement.

- VA's programs operated at a net cost of $187.3 billion in FY 2001, compared with a net cost of $108.8 billion in FY 2000. The calculation of the actuarial liability for future years' veterans compensation and burial benefits, which increased by $139.4 billion during FY 2001 and by $64 billion in FY 2000, heavily impacts each year's cost. The most significant



sources of change associated with the Compensation and Pension (C&P) programs between September 30, 2000 and September 30, 2001 were the overall decrease in interest rates between these two dates and the number of new compensation awards made for diabetes. Excluding the change in this actuarial liability from the net cost would result in an adjusted net cost for VA's programs of $47.9 billion and $44.8 billion for FY 2001 and FY 2000, respectively. The majority of this increase applies to two programs – Compensation, $1.2 billion and Medical Care, $1.1 billion.

- An examination of assets and liabilities reported on VA's balance sheets reveals four lines with changes greater than $1 billion. The largest is the increase in the Federal Employee and Veterans Benefit Liabilities, related to the increase in the actuarial liability for future Compensation and Burial benefit payments. It should be noted that the future cash flows to liquidate this liability are not supported by any identifiable assets, as they are anticipated to be funded from the future general revenues of the U.S. Government. Loans Receivable, Net, increased by $1 billion in FY 2001 primarily due to two factors: First, the events of September 11th delayed the September 28th sale of VA-held loans to private investors. Second, changes in the economic assumptions in the OMB credit reform subsidy model used to calculate housing loan subsidies generated a downward reestimate. Finally, Fund Balance with Treasury, which represents the right of VA to draw on the Treasury to pay allowable expenses, includes the Compensation & Pension payment for September. While generally paid on the last day of the preceding month, this fiscal year ended on a Sunday. A corresponding Public Accounts Payable is also reported.

- Collections for the Medical Care Collection Fund continued to improve, with a total of $0.8 billion collected in FY 2001 – a significant increase over the FY 2000 total of $0.6 billion. VA has developed a Revenue Cycle Improvement Plan to increase collections to $1.4 billion by FY 2005. In addition, the amounts reported for patient and third-party insurers' medical debt continue to increase due to a change in billing methodology. VA now bills for medical services based on "reasonable charges" rather than "reasonable cost." Amounts collected under this program are retained by VA and used for medical care purposes.

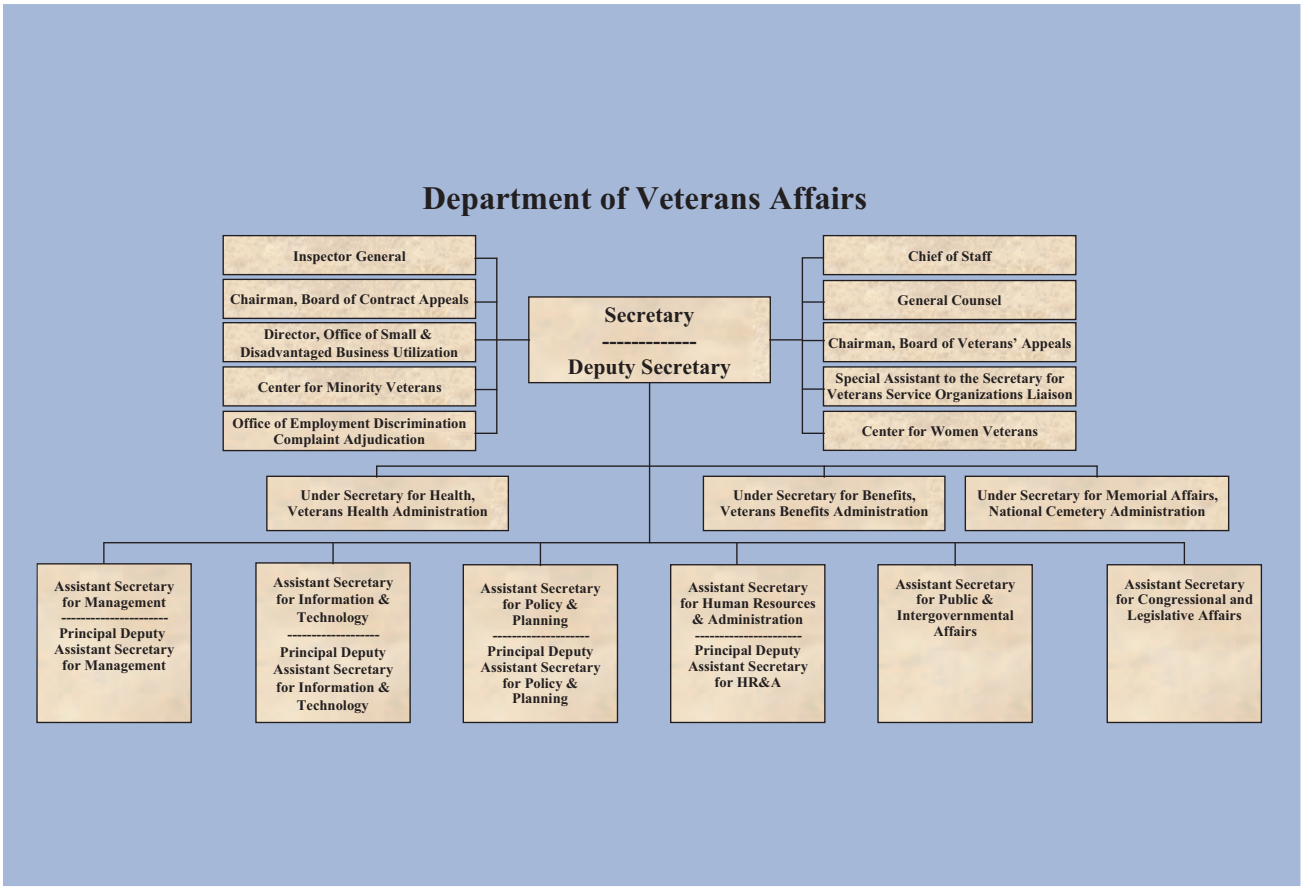
- The Department continued its aggressive use of the governmentwide commercial purchase card program. Purchase card disbursements for FY 2001 were over $1.5 billion, covering 2.6 million transactions and earning VA credit card rebates from Citibank totaling over $15.2 million. This is a 12 percent increase over the rebates earned in FY 2000 ($13.5 million).

- In the area of debt management, VA exceeded the goal established with the Department of the Treasury for the Treasury Offset Program. In FY 2001, VA referred a total of $0.33 billion representing 92 percent of eligible debt to Treasury, up from 67 percent referred in FY 2000. Under the Treasury Cross-servicing Program, VA referred $0.3 billion in FY 2001, representing 94 percent of eligible debt. This is an increase from 17 percent referred in FY 2000.

- Under 38 U.S.C. 8161, et seq., VA may enter into long-term (up to 75 years) outleases of VA property in return for fair consideration including goods, services, or space beneficial to VA's mission. In some cases, the lessee

provides "in-kind" consideration through a third party, including an independent trust. Once established, the independent trust assumes obligations to provide in-kind consideration to the Department. VA is not party to the Trust Agreement and does not "own" or control the trust, and has no beneficial, residual or other interest in the trust estate other than the assets that are specifically deposited into the enhanced-use leasing account for the purpose of providing in-kind consideration to VA. This arrangement has proven to be very beneficial to the Department in the several enhanced-use leases now in place. Consequently, as the Department uses the enhanced-use leasing program to address its capital and resource requirements, VA anticipates that most of its "in-kind" benefits will be received through these types of third-party providers.

WHO WE ARE



The FY 2001 Performance Report documents VA's progress in providing high-quality, timely benefits and services to the men and women who have served our country in the armed forces. This report identifies the achievements VA recorded during FY 2001 that have contributed to attaining the goals and objectives in the VA Strategic Plan and Annual Performance Plan. In so doing, we are providing detailed information–to Congress, OMB, veterans service organizations, and other stakeholders–to spell out not only what we do, but more importantly, *how well we are doing* in meeting our commitment to honor our veterans and to compensate them for their sacrifices.

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 this country.

The statutory mission authority for VA defines our responsibility 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)). The benefits and services we provide are directly shaped by veterans' needs, preferences, and expectations.

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 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, which transcend all organizational boundaries, include:

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.

Background

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, the territories, and the District of Columbia, we provide benefits and services through our 172 hospitals, 137 nursing homes, 43 domiciliaries, 859 outpatient clinics (i.e., 684 community-based, 163 hospital-based, 4 independent, and 8 mobile), 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 a veteran's death during active military service or, subsequent to discharge from military service, as a result of a service-connected disability. Recent legislation has also authorized compensation for certain children of veterans as well. Currently, we authorize compensation for children of Vietnam veterans with Spina Bifida and children of female veterans with certain birth defects.

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, servicemembers, reservists, survivors, and dependents in achieving their educational or vocational goals by providing financial assistance in the form of monthly payments while attending school or pursuing training.

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 life insurance benefits to veterans and servicemembers that may not be available from the commercial insurance industry due to lost or impaired insurability resulting from military service. Benefits and services will be provided in an accurate, timely, and courteous manner and at the lowest achievable administrative cost. Insurance coverage will be provided in reasonable amounts at competitive premium rates. 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 that commemorate their service to the Nation.

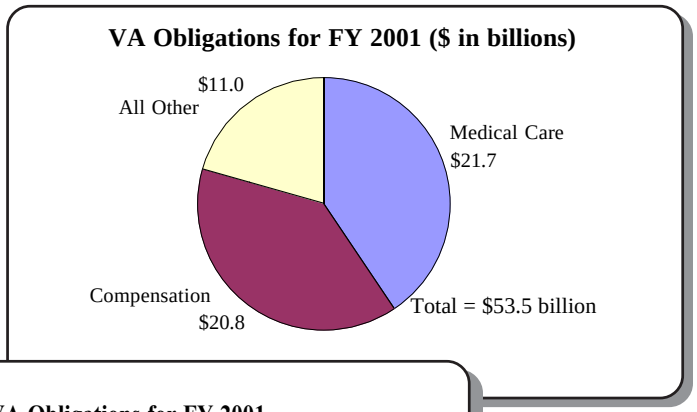
Program Participants

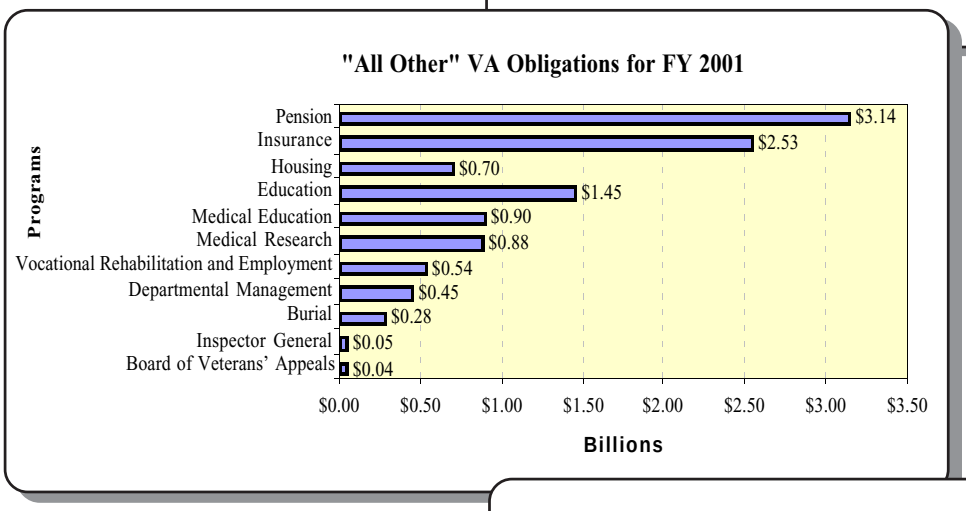
VA serves a significant portion of the veteran population. In FY 2001, more than 4.2 million patients used VA health care, over 2.6 million veterans and survivors received monthly VA disability compensation payments, and more than 2.4 million graves of deceased veterans and eligible family members were maintained at our national cemeteries. The following table summarizes the number of individual veterans or dependents who received benefits or services in each of our major programs during FY 2001.

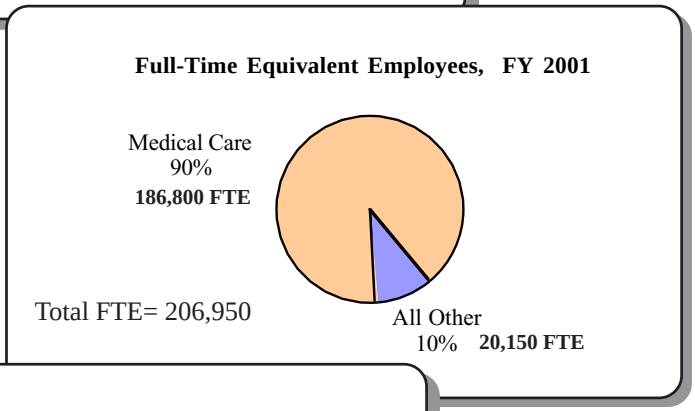
Program	Number of Participants
Medical Care	
Unique patients	4,247,200
Veterans	3,890,900
Non-veterans	356,300
Compensation	
Veterans	2,325,700
Survivors/children	305,800
Pension	
Veterans	348,700
Survivors	240,500
Education	
Veterans and service persons	289,800
Reservists	82,300
Survivors/dependents	46,900
Vocational Rehabilitation	
Veterans receiving services/subsistence	52,800
Veterans receiving services only	11,500
Housing	
Loans guaranteed	252,700
Insurance	
Administered policies (veterans)	2,079,200
Supervised policies (service members and veterans)	2,788,500
Burial	
Interments	84,800
Graves maintained	2,443,000
Headstones and markers	304,300

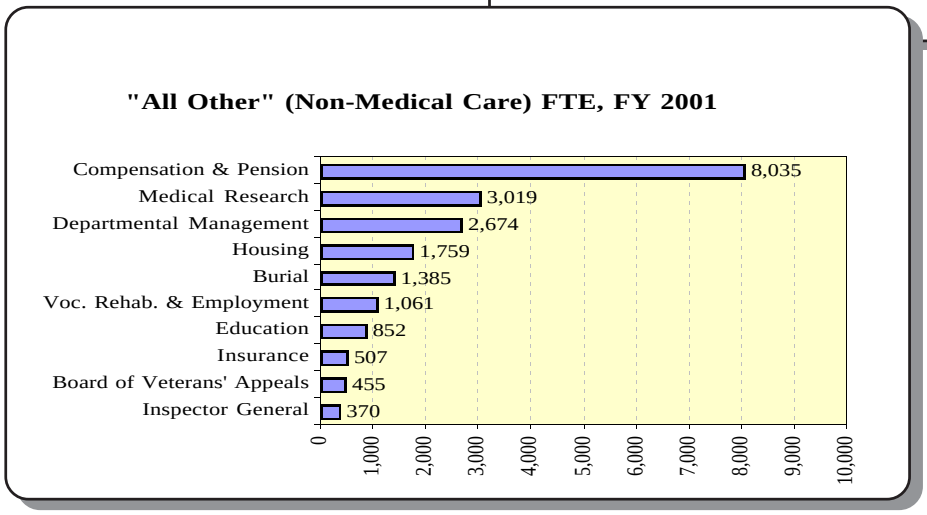
In FY 2001, VA resources totaled $53.5 billion in obligations and nearly 207,000 full-time equivalent (FTE) employees. Over 95 percent of total

obligations went directly to veterans in the form of monthly payments of benefits or for direct services such as medical care. The following charts show (1) how VA spent the taxpayer funds with which we were entrusted and (2) the distribution of FTE.









WHO WE SERVE

Our Continuous Focus on the Veteran

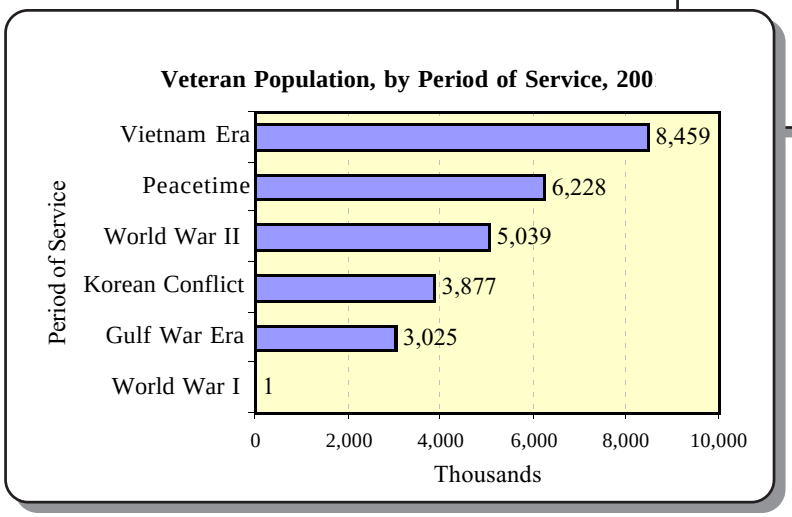
This section of the Performance Report presents social and demographic data on the veteran population. Data on the number of veterans by age, sex, period of service, and state of residence are from official VA estimates and projections.

Summary

Beginning with our Nation's struggle for freedom more than two centuries ago, approximately 42 million men and women have served our country during wartime. Most (85 percent) served in one or more of the four major conflicts of the 20th century. Today, an estimated 25.3 million veterans are living in the United States, Puerto Rico, and overseas. Of these, 19 million veterans served during wartime.

Number of Veterans and Periods of Service

The veteran population decreased by 560,000 in FY 2001. Vietnam-era veterans account for the largest segment of the present veteran population.

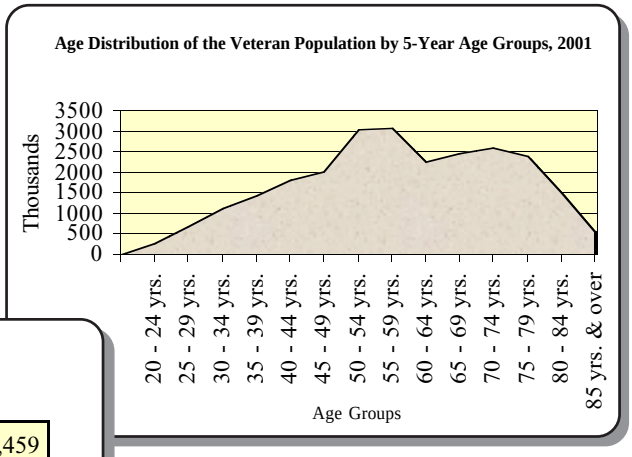


Data by period of service will add to more than total due to veterans who served in more than one period.

Age of Veterans

At the end of FY 2001, the median age of all living veterans was 58 years. Veterans under 45 years of age constituted 21 percent of the total veteran population; veterans 45 to 64 years old, 41 percent; and veterans 65 or older, 38 percent.

The number of veterans 85 years of age and older totals over 556,000. Eleven years ago, there were as few as 155,000 veterans in this age range. This large increase in the oldest segment of the veteran population has had significant ramifications on the demand for health care services, particularly in the area of long-term care.



Age distribution of the Veteran Population by 5 year age groups as of 9/30/01 in 000's

Female Veterans

In FY 2001, the female veteran population of 1.4 million constituted 6 percent of all veterans living in the United States, Puerto Rico, and overseas. The female veteran population as a percentage of all veterans is expected to increase because the number of former military service women continues to grow. Generally, the demographic profile of the female veteran population stands in contrast to that of the male veteran population (e.g., differences in age and period of service).

The median age of female veterans is 13 years younger than that of male veterans, 45 versus 58. The growing involvement of women in the military in recent years is reflected in period-of-service differences between male and female veterans. About 59 percent of all female veterans served during the post-Vietnam era.

State of Residence

Veterans in just three states–California, Florida, and Texas–comprised nearly 23 percent of the veterans living in the United States and Puerto Rico at the end of FY 2001. The three next largest states in terms of veteran population are New York, Pennsylvania, and Ohio. These 6 states account for more than 37 percent of the total veteran population.

At the other end of the scale, the two least populous states in terms of veteran population–Wyoming and North Dakota–and the District of Columbia collectively accounted for less than one percent of the total.

What We Accomplished

This section of the report presents detailed information on the Department's program and financial performance during FY 2001. The discussion is structured around our strategic goals, as published in VA's Strategic Plan in September 2000 and the Secretary's priorities. These strategic goals reflect the combined effort of all organizational elements to deliver benefits and services to disabled veterans, veterans in transition from the military, the overall veteran population and their families, and the Nation at large.

In addition to our strategic goals, we have an enabling goal that focuses on management issues and fosters a climate of world-class service and benefits delivery.

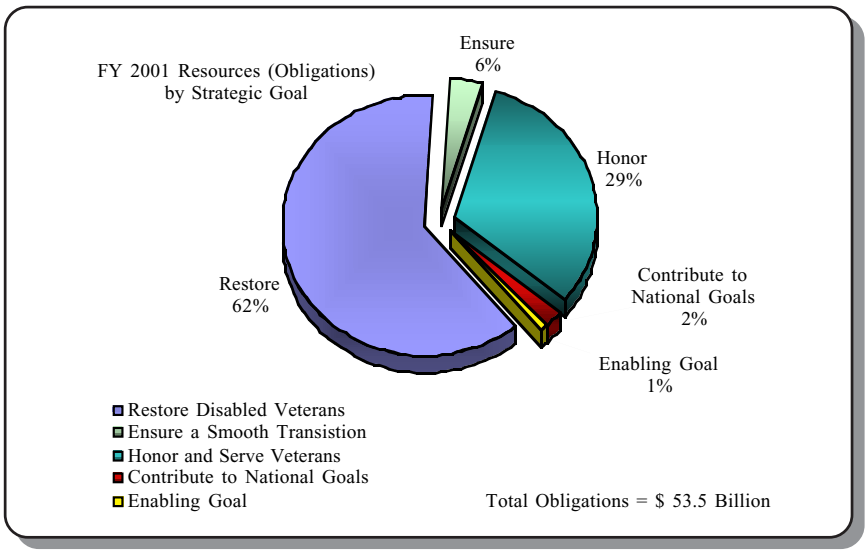
VA's Key Performance Goals and Measures

VA's senior leadership identified 26 key performance goals as critical to the success of the Department. Some of these deal with program outcomes; others pertain to the manner in which we administer our programs.

The Department is committed to continuously improving the delivery of benefits and services to veterans and their families. Whether the focus is on enhancing the quality of health care, expanding access to care, reducing the time it takes to complete claims for benefits, improving the accuracy of claims processing, or providing more veterans with a burial option, our aim is to better our performance each year.

At the end of each fiscal 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 more limited. 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. For example, we are



constantly striving for better ways to measure performance. This is an ongoing process - with the introduction of new measures each year that reflect a more sophisticated and mature performance measurement system. There are also 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.

While some of VA's key performance measures support achievement of more than one strategic goal, we have aligned them with the strategic goal and Secretarial priority that they most closely support. For each of the Secretarial priorities, we present:

- the performance measure or measures used to gauge progress toward achieving the goal;
- historical data;
- means and strategies used to achieve the actual level of performance;
- crosscutting activities with other federal and private organizations;
- descriptions of any relevant management challenges affecting goal achievement;
- the source of the performance information and how it was validated.

Other goals and measures deemed important by the program offices continue to be monitored and are presented in the data tables beginning on page 128.

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's Priorities

- **Be recognized as a leader in the provision of specialized services, particularly spinal cord injury, geriatrics, and mental health.**
- **Provide accurate decisions on compensation and pension rating-related claims within 100 days by summer of 2003.**
- **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 (for example, 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:

- Proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings
- 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

Secretary's Priority

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

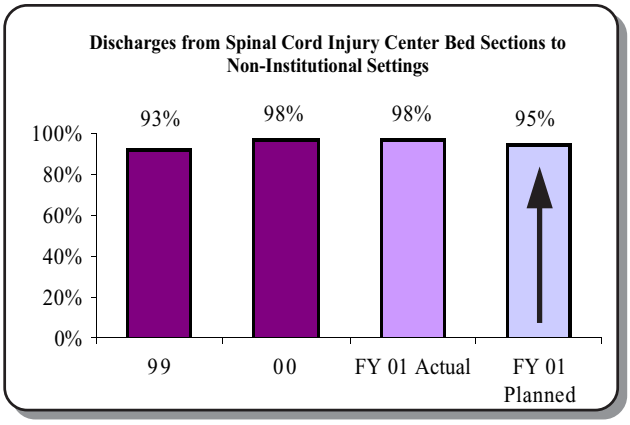
Performance Goal

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

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.

Special attention is accorded veterans with SCI for a number of reasons, primarily because of the severity of illness and disability associated with SCI. VHA closely monitors the performance measure described below to ensure responsiveness to veterans with SCI and maximize the potential for positive outcomes of care.

We exceeded the target level by achieving a discharge rate of 98 percent in FY 2001. VHA will continue to place high priority on assisting/enabling veterans with SCI to obtain discharge to non-institutional settings.



Means and Strategies

VHA is focused on promoting the health, independence, quality of life, and productivity of individuals with SCI. We view discharge to non-institutional, community living as a positive health outcome.

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

- In FY 2001, staffing at SCI Centers increased by 275 FTE from 1,368 to 1,643;
- Distributed Clinical Practice Guidelines from the Consortium for Spinal Cord Medicine to all VA SCI centers;
- Conducted annual national SCI-Primary Care team training;
- Improved the Spinal Cord Dysfunction (SCD) Registry to advance coordination of care;
- Achieved Rehabilitation Accreditation Commission (CARF) accreditation for acute Spinal Cord Injury and Disorders (SCI&D) rehabilitation programs at 19 of 20 SCI Centers;
- Continued identification and translation of best practices in SCI&D by the Quality Enhancement Research Initiative for Spinal Cord Injury (SCI QUERI);

- Expanded direct outreach to patients with SCI&D to increase the proportion of influenza and pneumococcal vaccinations;
- Distributed Veterans Health Initiative (VHI) SCI Continuing Medical Education Project information to physicians to enhance primary care knowledge of SCI&D issues;
- Improved access to care within patients' communities.

Crosscutting Activities

VHA works with the Paralyzed Veterans of America and other concerned veterans service organizations to continually improve VA SCI care, which is recognized as a health care leader for this Special Emphasis population. VHA will also continue to work towards complete, full CARF accreditation for all 20 SCI Centers. This credible acknowledgement of an outside review body will help ensure consistency of approach (clinical practice) and high-quality medical care.

Data Source and Validation

The origin of data for this performance goal is from the National Patient Care Database Patient Treatment File (PTF) at discharge. "Non-institutional care setting" includes community, foster home, halfway house, boarding house, residential hotel, and home-based health care services. Non-institutional care setting does not include hospitals, nursing home care units, state homes, domiciliaries, or penal institutions.

The numerator for this goal is inpatients that were discharged from SCI-center bed sections to non-institutional settings. The denominator is patients discharged from SCI-center bed sections alive who were discharged regularly and not transferred in from institutional care.

Secretary's Priority

Provide accurate decisions on compensation and pension rating-related claims within 100 days by summer 2003.

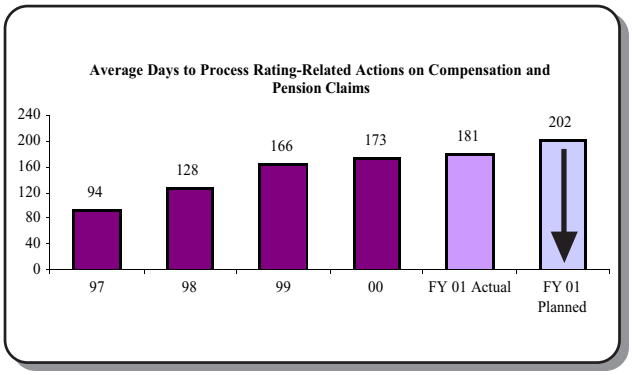
Performance Goals

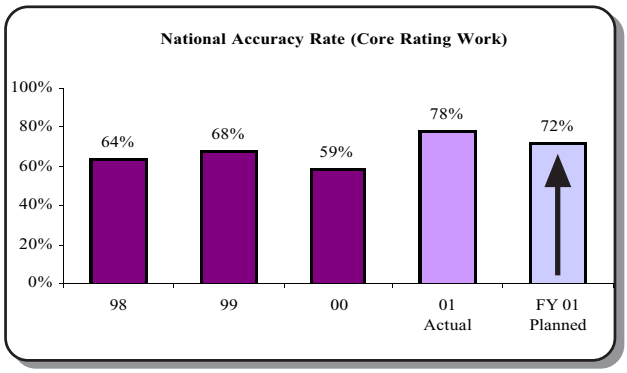
- **Complete rating-related actions on compensation and pension (C&P) claims in an average of 202 days.**
- **Attain a 72 percent national accuracy rate for core rating work.**

Quality and Timeliness of Claims Processing

Although we exceeded our timeliness goal by 21 days, with an achievement level of 181 days compared with our goal of 202 days, performance worsened from the previous year's level of 173 days. This level of performance is unacceptable. On the other hand, accuracy increased significantly in FY 2001 to 78 percent from 59 percent in FY 2000. This is 6 percent better than the goal of 72 percent.

FY 2001 was a transition year for VBA. Total Pending Workload increased from 332,300 claims and appeals at the end of FY 2000 to 565,800 claims and 117,800 appeals (including all appeals, not just C&P cases) at the end of FY 2001. This increase was largely the result of regulatory and legislative changes increasing benefits to veterans and lower-than-expected productivity. However, because of increases in staffing, productivity, and streamlining activities, we are beginning to turn the problem around. The percentage of rating-related claims completed during the first quarter of FY 2002 was 68 percent higher than during the first quarter of 2001. As we reduce the number of older claims, our timeliness will worsen, but it will allow us to achieve significant improvements by the end of FY 2002.





Appeals Processing

The 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 final decision by the Board of Veterans' Appeals (BVA). Appeals resolution processing impacts compensation and pension claims activities. Claims going through the appeal process require additional compensation and pension staff resources. The additional resource requirements reduce the available resources to work initial claims processing. A primary remand rate reduction strategy 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 system. A second strategy is to develop better bases of information and to improve 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. However, since enactment in November 2000 of Public Law 106-475 (Veterans Claims Assistance Act of 2000), the remand rate has soared to 48.9 percent. In order to ensure claimants due process rights, many pending appeals have to be remanded for the new law to be applied by the office of original jurisdiction. Also, affected cases pending at the U.S. Court of Appeals for Veterans Claims are remanded to the Board for further remand to the appropriate regional offices. Currently, there are about 32,300 cases in remand status. 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

We have implemented a variety of system changes to improve performance and address specific timeliness and accuracy-related problems. Initiatives dedicated to this effort have been both numerous and diverse, but all with one common goal – enhancement of the claims process. Key initiatives include a "tiger team," based in Cleveland, which is fully operational. The first priority for this team is to resolve long-pending claims of veterans who are 70 years of age and older. Once this has been accomplished, the team will move to other claims pending a decision for more than a year. A Claims Processing Task Force, created by the Secretary in May 2001, proposed 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. The Task Force report contains 34 recommendations comprised of 66 actionable tasks. Appropriate implementation plans with milestones have been established for each task and implementation is being tracked in VBA's Project Management System. Seven of the 66 tasks have already been completed and another 13 are scheduled for completion within the next 6 months.

VBA has taken many additional steps to offset the impact of legislative and regulatory changes, such as the Veterans Claims Assistance Act (VCAA) of 2000, the addition of diabetes mellitus type 2 as a presumptive Agent Orange condition, and the expansion of the list of radiation-related diseases for which we currently provide presumptive service connection. We have implemented countermeasures, within available resources, to continuously improve timeliness and accuracy in rating-related claims processing to better serve veterans. In FY 2001, we successfully:

- Hired 932 veterans service representatives (VSRs) and rating VSRs.
- Launched a centralized training initiative to train these new hires. This centralized training is now the standard for future hires.
- Reached an agreement between VBA and the Board of Veterans' Appeals (BVA) concerning remand development. VBA will provide training to BVA on its field office procedures as well as the computer tools used by VBA to develop and control its evidence requests. During 2002, BVA will begin initiating development on cases that would otherwise be remanded back to the field offices. At this time, we estimate that the time to process appeals will be reduced by 34 days on average.
- Established resource centers to focus on specialized claims processing.
- Expanded the St. Louis Helpline and made it fully operational in February 2001.
- Released personal computer generated letter (PCGL) notification letter packages in April and December 2001.
- Developed national production standards for VBA's decision-making positions. These proposals are being further evaluated.
- Published in the Federal Register on April 20, 2001, the amendment to 38 CFR 3.103 allowing VBA's decision-makers to gather evidence by oral communication.
- Tested and made available to all regional offices 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.
- Signed a memorandum of understanding with VHA 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 the tools and procedures needed to improve the quality and timeliness of C&P examinations. It is currently functioning and fully staffed with subject matter experts from both VBA and VHA.

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

- Provide field offices relief from doing local Statistical Technical Accuracy Reviews (STARs). The national STAR office located in Nashville, Tennessee is fully operational. Additional national reviews will be completed to account for the local reviews that were eliminated.
- Processing of pension maintenance workload began on January 2, 2002, at three centralized sites. Initially, these sites will process eligibility verification reports. VBA expects these sites to process all pension maintenance workload by the end of FY 2003.
- Fully test in FY 2002, virtual imaging technology at the pension maintenance centers.
- VBA has been working closely with the Department of Defense 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.
- Collaborate with BVA to create a procedure that will allow board members to develop cases that would have been remanded back to the regional office. This process was begun in February 2002.

External Factors

The requirements of the Veterans Claims Assistance Act (VCAA) and diabetes regulations continue to affect efforts to reduce the timeliness of claims processing. Pending legislation on radiation exposure could further increase the total number of expected claims, thereby offsetting improvements VBA has made in timeliness.

Crosscutting Activities

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.

Major Management Challenges

For the past quarter century, VBA has struggled with timeliness of claims processing; VBA continues to face a high workload backlog and takes an unacceptably long time to process claims.

For a more detailed discussion of this management challenge, see pages 98 – 103.

Data Source and Validation

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 Compensation and Pension (C&P) Service reports quarterly on its findings and reviews a sampling of cases from stations with the highest rates of questionable practices.

The C&P Service determines accuracy rates by reviewing a statistically valid sample of cases. 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 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, reducing the margin of error to +/-6 percent on the subsequent review. Program experts who are independent of field operations management conduct the reviews.

The Veterans Appeals Control and Locator System (VACOLS) is VA's appeals tracking system. It serves as the exclusive source of all data used to calculate appeals resolution time.

There are five categories of data that go into calculating the total appeals resolution time: (1) cases resolved in the field prior to receipt of a Substantive Appeal (VA Form 9), (2) cases closed for failure to respond to the Statement of the Case, (3) cases resolved in the field after receipt of a Substantive Appeal but prior to certification to BVA, (4) cases resolved through final BVA decisions, and (5) cases resolved in the field following BVA remands. Information for cases disposed of in each category is computed and totaled for each regional office, and an overall VA average is computed.

Edits have been built into the system to prevent data entry errors. There are checks and balances throughout the system to detect errors, and procedures are in place for correcting these errors.

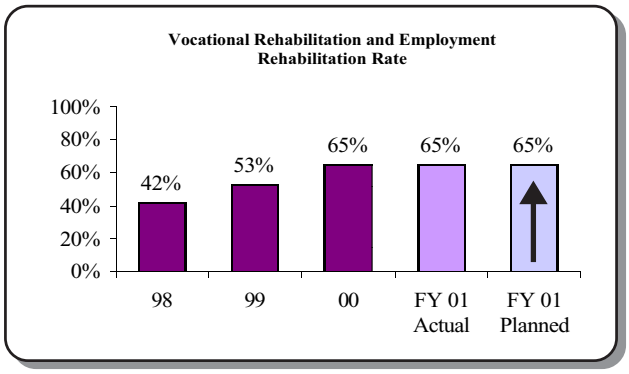
Secretary's Priority

Focus vocational rehabilitation resources on veterans with serious employment handicaps and on independent living services.

Performance Goal

- **At least 65 percent of all veteran participants who exit the vocational rehabilitation program will be rehabilitated.**

The rehabilitation rate is determined by comparing the number of veterans rehabilitated through the VA program versus the total number of veterans exiting the program. The Vocational Rehabilitation and Employment (VR&E) Program met its national goal of 65 percent for FY 2001 by continuing to place emphasis on employment. Over 10,100 service-disabled veterans were rehabilitated and returned to employment.



Means and Strategies

The following initiatives or activities contributed to the rehabilitation rate achievement in FY 2001:

- Increased the number of staff located within the community and outside the regional office to be available to serve veterans at a location convenient and easily accessible for veterans. Also, case managers were provided with equipment to access systems and data needed to provide a complete range of services to veterans at the time of counseling.
- Improved communications with veterans and stakeholders to ensure a full understanding of the program's focus on employment and the services offered.
- Continued to provide employee training in employment services by providing tools such as Transferable Work Skills Analysis, laptop computers, and the case management and information system.
- Increased working relationships with other public and private rehabilitation and employment organizations to assist veterans in achieving suitable employment more quickly and efficiently.
- Developed a matrix containing the key skills for VR&E staff and utilized this instrument to assess current skill levels and identify skills needing development.
- Deployed two major initiatives, Corporate WINRS (named for the regional offices that tested the system) and Case Management redesign, in support of the reengineering processes for the VR&E Service. Both these initiatives enabled improvement in the program's daily processing of cases and increased timeliness of services to veterans.
- Began measuring program outcomes through the Quality Assurance program to validate quality and accuracy of services provided to veterans.

- Tested the employment specialist pilot program, which proved effective in assisting veterans to achieve employment. As a result, field offices realigned their staff to include this position. Employment specialists work with veterans and the employment community to assist veterans in preparing for and obtaining employment.

Crosscutting Activities

The VR&E program, in partnership with DoD's Defense Manpower Data Center, developed a Transferable Work Skills Analysis to assist the VR&E staff in analyzing and converting military skills to civilian skills. Additionally, VA's VR&E Service and the Department of Labor's Veterans' Employment and Training Service work together to provide an annual training program for staff involved in the placement of disabled veterans in interim and permanent employment. This program will increasingly involve the Small Business Administration.

Data Source and Validation

VR&E Management Reports serve as data sources. Data are validated by the quality assurance (QA) review conducted by each station and by VR&E Service. VR&E Service implemented a QA program to review samples of cases for accuracy and to provide scoring at the regional office level. The program continually extracts data samples to evaluate validity and reliability throughout the year. Modifications such as reporting mechanisms to conduct trend analyses and multiple reviews in certain areas to improve inter-rater reliability are being incorporated to enhance the QA program. In FY 2001, the Balanced Scorecard data were reviewed monthly. VR&E provides training to clarify policies and procedures when a discrepancy is noted. Reviews are conducted on a sample of cases from the regional offices twice a year. At the end of each review, documentation of both positive and negative results is provided to each office to ensure sustained performance or demonstrate the need for countermeasures to improve performance.

STRATEGIC GOAL 2

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

Secretary's Priorities:

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

Secretary's 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

- **Increase the Montgomery GI Bill (MGIB) usage rate to 60 percent.**
- **Process original and supplemental education claims in 35 and 23 days, respectively.**

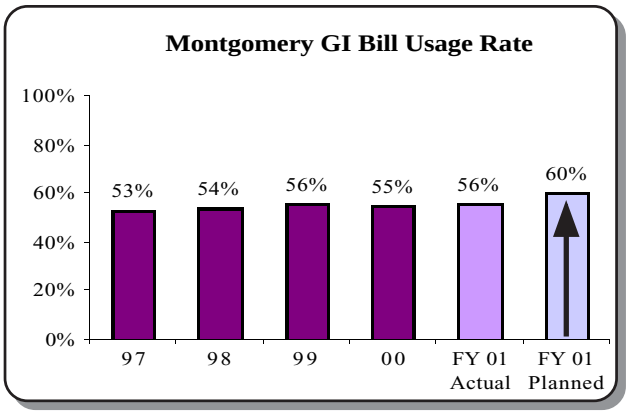
Over 20,000 more claimants received education benefits during FY 2001 than in FY 2000. Almost 70 percent of the 421,000 beneficiaries who used VA education benefits during FY 2001 qualified under the provisions of the Montgomery GI Bill (MGIB). Reservists accounted for nearly 20 percent, and the program for certain eligible dependents of veterans accounted for about 11 percent. Moreover, almost 100,000 individuals began using the benefits for the first time during 2001. They recognized the need to further their education or enhance their job skills and relied on their GI bill entitlement as a funding source.

The Veterans Benefits and Health Care Improvement Act of 2000 (Public Law 106-419) provided for MGIB benefits for some licensing and certification tests. This provision allows claimants to take an unlimited number of tests and receive MGIB benefits of up to $2,000 per test. The program took effect March 1, 2001. Though not widely recognized as a type of program for which VA education benefits are payable, 123 veterans received reimbursement for completing 136 tests by the end of the year. We predict that VA will pay for 25,000 tests during FY 2002. This number will continue to increase as the program matures.

The National Defense Authorization Act of FY 2001 (Public Law 106-398) allows in-service students to receive VA benefits to pay for any tuition or school expenses not paid by the military services through their tuition assistance programs. Referred to as Tuition Assistance Top-Up, or just "Top-Up," more than 12,000 service members received this benefit during FY 2001. Payments are generally less than VA pays veterans while attending school because active duty personnel use "Top-Up" to supplement the military tuition assistance programs. In addition, payment amounts vary by number of courses taken and the type of institution and tuition charged. Ranging from less than $100 to well over $1,000, the average payment is about $480. We are making about 1,000 of these payments each week and expect to exceed 50,000 payments during 2002. "Top-Up" may represent about 5 percent of our workload in 2002.

Increase the MGIB Usage Rate

The MGIB usage rate increased by one percentage point over last year. This was four percentage points short of our FY 2001 goal. Reasons for this deviation include:



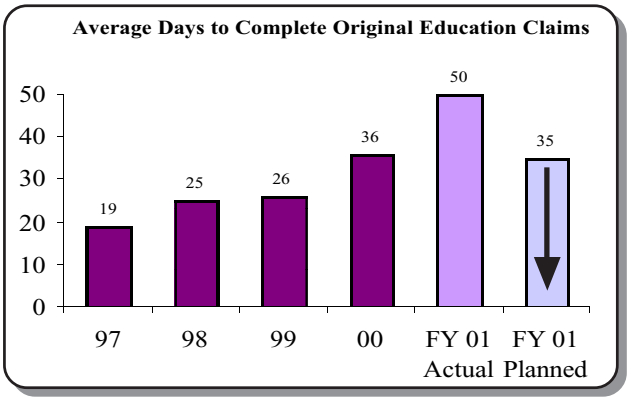
- The level of payment did not cover enough of the cost of education;
- Promotional material for MGIB did not arrive early enough;
- The potential MGIB benefits did not meet the veteran's expectation;
- Timeliness of claims processing deteriorated, thus discouraging veterans from applying for benefits.

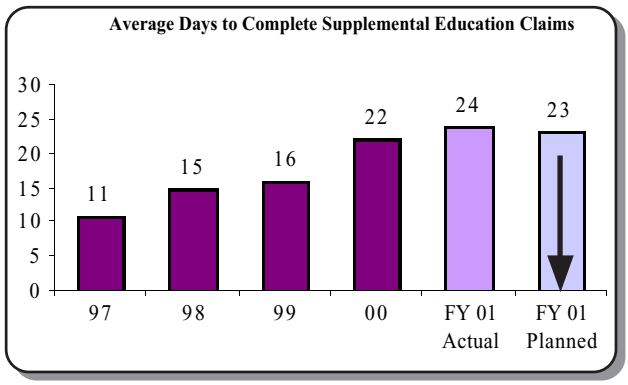
While there is no measure in place that clearly identifies the probable cause for not achieving our 2001 goal, the possible reasons cited above are derived from the findings of a program evaluation for VA's education benefit programs completed in 2000. That report recommended a significant increase to the benefit because it had lagged behind the rising cost of education. The rate increases enacted in the Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, should enable us to determine the extent to which benefit levels served as the primary barrier.

Improve Education Claims Processing

Although we missed the 23-day goal for processing supplemental claims by only 1 day, we missed the goal for original claims by 15 days. The reasons for not achieving the goal include:

- Because of the backlogs and recently enacted legislation, telephone traffic volume was 30 percent higher than during the prior year's first quarter. Increased phone duty resulted in less time available to process claims. Traffic returned to near normal levels throughout the rest of 2001.
- Hardware installation difficulties from FY 2000 affected 2001. For example, equipment malfunctioned sporadically, requiring replacement and resulting in operational delays. Although corrected by the end of the first quarter, recovery from the backlog took time.
- Many Education employees were promoted into Compensation & Pension (C&P) positions. Opportunities for advancement in a regional office environment are greater in the C&P area because the average grade levels are higher. The movement into C&P positions accelerated because additional hiring was authorized. As a result, new hiring and training in education were required. As of June 2001, 48 percent of the decision-makers in the Education business line were trainees.





Improvement trends that began during the last 3 months of 2001 are expected to continue through 2002. New hires are gaining experience and becoming more productive. Development of automated processing with expert systems will allow achievement of long-term strategic targets.

Means and Strategies

Increase the MGIB Usage Rate

During FY 2001, we continued our efforts to improve outreach to servicemembers and veterans regarding their access to benefits.

- VA continued to mail the brochure, "Focus on Your Future with the Montgomery GI Bill," to servicemembers who have completed 12 months of active duty. This brochure gives a general description of education benefits. It also has information to help servicemembers decide to enter vocational or on-the-job training and use their MGIB benefits.
- Toll-free phone service was maintained during the year. Seasonal employees and education liaison representatives answered calls to help reduce the number of callers who could not complete their calls. Veterans who cannot get questions answered will lack the information they need to begin their education or training efforts.
- Web Automated Verification of Enrollment (WAVE) became available to claimants in late FY 2001. WAVE allows MGIB beneficiaries to verify their continued enrollment each month over the Internet instead of mailing the verification form. This improves communication with claimants and speeds release of monthly payments. Although installed too late in the fiscal year to have a significant effect, it will reduce paperwork in the regional processing offices and speed the benefit payment process. This will help encourage veterans to use their benefits.

During FY 2002, we plan to increase outreach efforts. Findings from the program evaluation indicated that future veterans cite the military as the most frequent source of MGIB information and that information is not always clear, concise, and totally accurate. We are planning the following outreach activities:

- The mailing of a brochure and letter after 2 years of service;
- The mailing of an outreach letter 6 months before discharge;
- The testing of outreach materials at military bases to ensure the message in the materials is clear;
- Presentations at conferences attended by service coordinators and military education officers;
- Briefing of Army and Navy recruiters to ensure they have correct and current information. According to the 2000 customer satisfaction survey, 46 percent of veterans first learn about MGIB from their recruiters. Most military brochures directed at potential recruits emphasize money from MGIB to attend college as an inducement to consider serving in the military. The message is intended to give the potential recruit another reason to enlist, but does not provide sufficient information to begin planning for education or training after military service.

Improve Education Claims Processing

Means and strategies for achieving the performance goal included:

- Continued improvements in Enrollment Certification Automated Processing (ECAP), allowing more cases to be processed without human intervention. ECAP is a proof-of-concept prototype that uses "expert" or rules-based systems to process claims in a totally automated environment to the extent possible. At this point, only 3-4 percent of all incoming

work is completely processed in this way. A more sophisticated rules-based application will allow many more claims to be completed without human intervention.

- Electronic Funds Transfer (direct deposit) was expanded to the MGIB-SR (chapter 1606) program, making funds available to these claimants 3 to 5 days earlier than if a check is mailed.
- 100 new claims examiners were hired.
- Seasonal employees and education liaison representatives were used to relieve case managers from phone duty, freeing them for claims processing. Seasonal employees can be most beneficial during peak workload periods (August-October and January-February).

External Factors

Increase the MGIB Usage Rate

The cost of education has risen faster than the Consumer Price Index for the past several years. For example, according to the Department of Education, the cost of post-secondary education rose 3.8 percent in 2000. However, the Consumer Price Index rose 2.7 percent.

Legislation enacted in early FY 2001 helped restore lost purchasing power with increased monthly payments. This same legislation also provided for:

- Payment for licensing and certification tests.
- Additional voluntary contributions to a servicemember's MGIB account to increase benefits.

As time passes, these changes will increase the number of veterans who apply for and receive MGIB benefits. With the passage of transferability (that is, permission for an active duty servicemember to transfer part of his or her MGIB benefit to family members as a reenlistment incentive), we expect usage to increase because almost any combination of a servicemember's dependents could be entitled to receive part of his or her total MGIB benefit. The rate increases enacted in the Veterans Education and Benefits Expansion Act of 2001, Public Law 107-103, should enable us to determine the extent to which benefit levels served as the primary barrier.

Improve Education Claims Processing

Legislation enacted in early FY 2001 dramatically affects VA education benefits. Over time, provisions such as the Tuition Assistance Top-Up for active duty MGIB claimants and payment for licensing and certification tests will generate a significant number of new claims. Claims for these benefits will be processed "out-of-system" for the foreseeable future until systems can be modified to accommodate them. Out-of-System processing is more labor-intensive than regular work and adversely affects timeliness for those claims by adding a few extra days to the workflow process. The overall impact for about 5 percent of the work in 2002 should not be dramatic.

Crosscutting Activities

Increase the MGIB Usage Rate

Increasing the MGIB usage rate requires coordination among VA, the Department of Defense, and other organizations distributing MGIB information. In FY 2001, we began briefings to Army and Navy recruiters to help them give recruits a clear and realistic view of MGIB benefits. We also began supporting military base counselors by giving them a guide for education specialists working with servicemembers who may need MGIB benefits to pursue their educational or vocational objectives.

Improve Education Claims Processing

Overall processing timeliness is affected to some extent by the quality of the enrollment information and certification received from school officials. VA developed an application (called VACERT) that allows schools to send enrollment certifications to VA regional processing centers electronically. Currently, over half of all schools use VACERT. An Internet version of VACERT is being developed and will make the application more attractive to schools. This system will be tested and deployed in FY 2002. In addition, we are continuing to improve relationships with institutions. For example, we started offering "new certifying official" training in FY 2001 and will continue in FY 2002. Certifying officials are employed by educational institutions to serve the veteran/student and to submit enrollment information to VA for use in paying benefits. The more knowledge they possess, the more they are able to assist VA in serving veterans' needs.

Data Source and Validation

Increase the 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). We do not independently validate the DoD information.

Improve Education Claims Processing

We measure education claims processing timeliness by using data captured automatically through the Benefits Delivery Network. The Education Service staff in VA Central Office confirms reported data through ongoing quality assurance reviews conducted on a statistically valid sample of cases. They look at dates of claims in these sample cases to ensure they are reported accurately.

Each year, Central Office staff reviews a sample of cases from each of the four regional processing offices (RPOs). Quarterly samples are selected randomly from a database of all end products taken during the quarter. Since the cases are reviewed remotely through the use of TIMS (The Imaging Management System), the RPOs are completely divorced from the review process until they receive a report of the review. The results are valid at the 95 percent confidence level. Reviewers validate dates of claim and validity of end products for all cases reviewed. They report errors to the RPOs and track trends. The RPOs are given a chance to rebut errors called. This helps ensure the quality and fairness of the review.

An appraisal team visits each RPO annually. The team consists of Central Office staff and a representative from a “sister” RPO. While in the RPO, the appraisal team reviews all aspects of the operation including quality and consistency of data input.

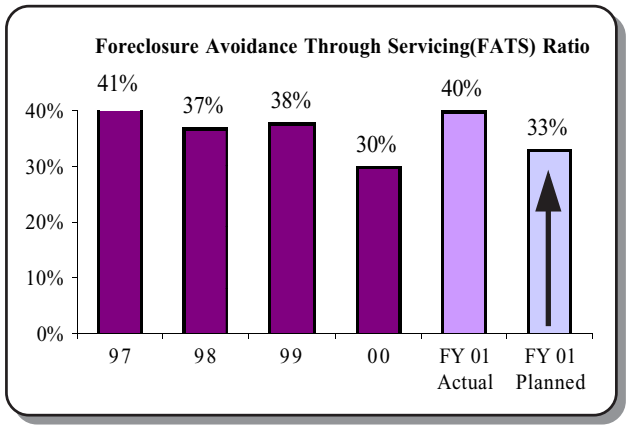
Secretary's Priority

Meet community standards for origination and servicing of home loan guaranty benefits, and minimize financial losses incurred on foreclosures.

Performance Goal

➢ **Improve the Foreclosure Avoidance Through Servicing (FATS) ratio to 33 percent.**

VA's home loan guaranty program has a significant impact on the housing economy of the United States. Over 16 million veterans and their families have used a guaranty since 1944; there are currently 3.1 million active loans. Veterans are able to purchase homes with little or no down payment, with terms not generally available to non-veterans. This benefit stimulates home buying, which spurs economic activity for builders, construction workers, realtors, appraisers, and the real estate finance industry. The benefit also impacts the sale of appliances and furniture, the market for home improvement materials and products, and the small businesses that provide these services.



The FATS ratio for FY 2001 was 40 percent, which substantially exceeded the planned level of 33 percent.

The FATS ratio measures the extent to which foreclosures would have increased had VA not pursued alternatives to foreclosure. Alternatives to foreclosure can help veterans either save their home or avoid damage to their credit rating, while reducing costs to the Government.

Means and Strategies

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 in cases where 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 a deed in lieu of foreclosure from the borrower, if doing so 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 that is 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.

Much of the improvement in FY 2001 can be attributed to restructuring field operations over the last several years. VA has moved the supplemental

servicing from 45 regional offices to 9 regional loan centers. This has allowed for concentration of resources and provides much greater flexibility to manage default workloads.

VA has also approved more lenders to participate in the Servicer Loss Mitigation Program (SLMP), which authorizes compromise sales and deeds in lieu of foreclosure. These two servicing tools are components of the FATS ratio. Greater use of SLMP allows VA staff to work more intensely on intervention actions, such as establishing repayment plans that are also a component of the ratio. VA continues to train employees on effective tools of servicing, which has contributed to helping more veterans avoid foreclosure.

External Factors

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.

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 the redesigned process.

Data Source and Validation

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

In November 2000, the OIG issued an audit report regarding the accuracy of data used to compute the FATS ratio. The OIG attempted to verify each of the five components of the computation. The auditors randomly selected a sample of records in each category and reviewed corresponding loan folders to determine whether records in the LS&C system were properly categorized. The OIG found that records in four of the five categories were correctly categorized. However, records categorized as successful interventions could not be verified because supporting documentation was not available. Evidence of defaults, intervention efforts, and cures was generally not retained in loan folders. Employees did record intervention efforts as electronic notes in the LS&C; however, the system did not retain the notes. Consequently, the OIG could not attest to the accuracy of the FATS ratio.

During the audit, VA activated a new computer system for loan servicing activities that retains electronic notes, which are used to document successful interventions. Because this should have corrected the only material deficiency identified, the OIG did not make any recommendations and considers the matter resolved.

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

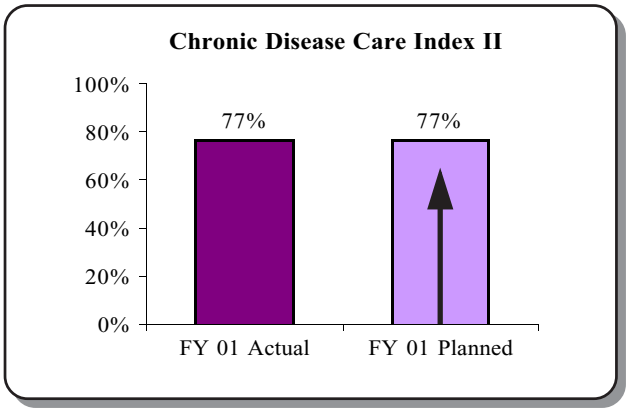
Secretary's Priority

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.

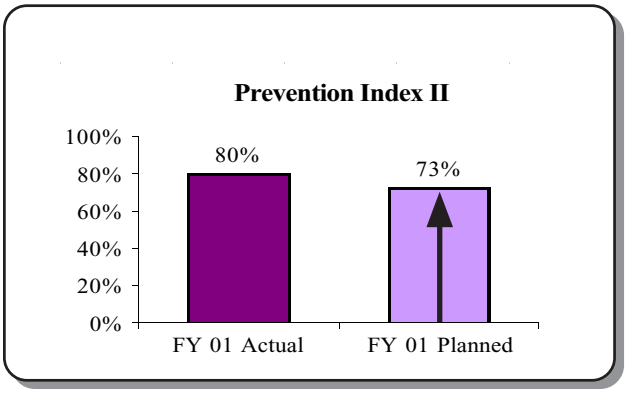


A new methodology was adopted for FY 2001. Therefore, prior year comparisons are not available.

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

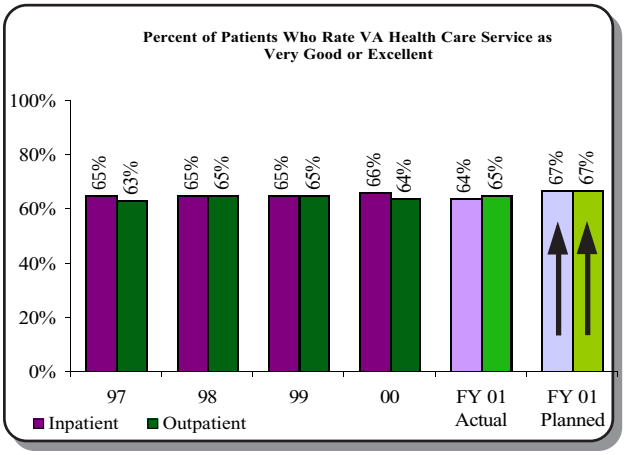
5 BRFSS scores are median; VHA scores are average

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.

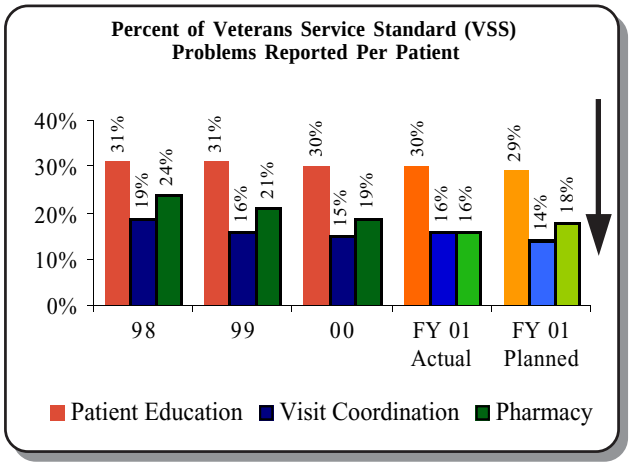


Percent of patients rating VA health care service as very good or excellent (Inpatient/Outpatient)

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.

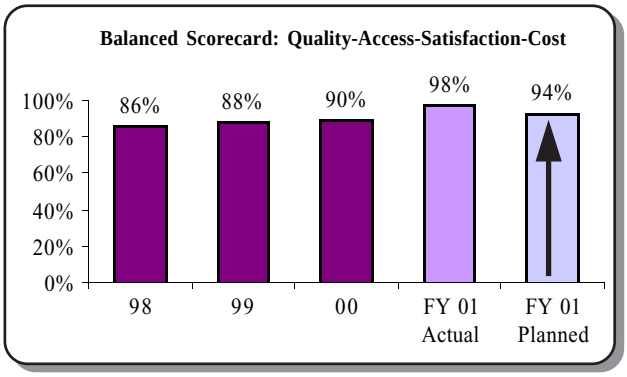
We achieved our planned performance level of 95 percent implementation for this measure and decided to replace it in FY 2002 with one that will measure the success of implementing Bar Code Medication Administration (BCMA) to continue to emphasize new methods in assuring patient safety.

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.

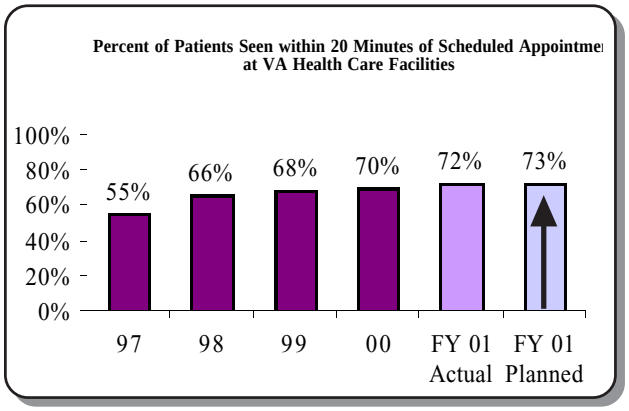
Percent of appointments with a specialist within 30 days

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.

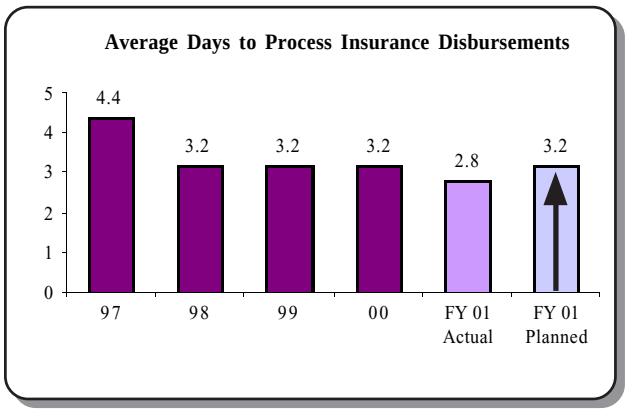
Secretary's Priority

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.

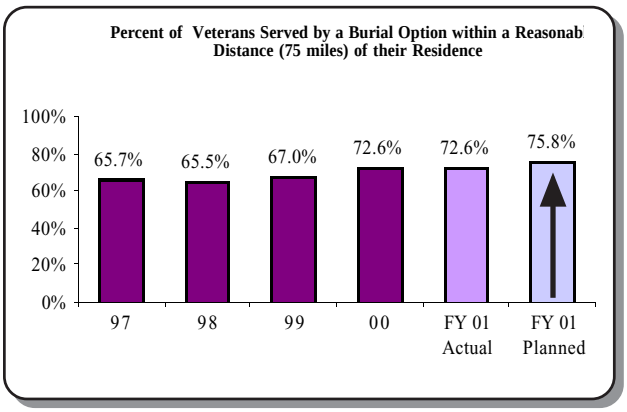
Secretary's Priority

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.**

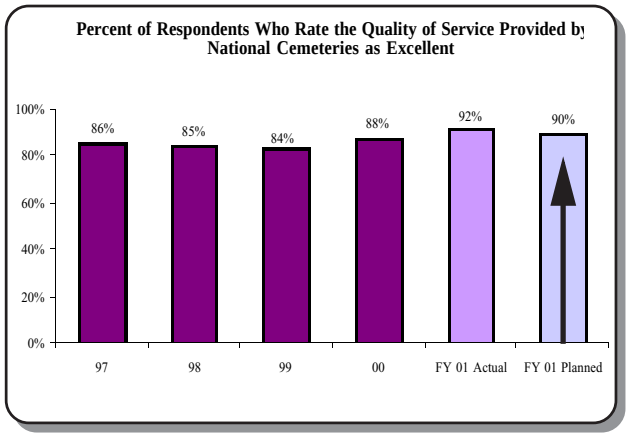
VA did not meet the FY 2001 performance goal to serve 75.8 percent of veterans with a burial option within a reasonable distance of their residence. This performance goal was established prior to the availability of the new VetPop2000 data released in April 2001. If the data model used to project the 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.

STRATEGIC GOAL 4

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

Secretary's Priorities:

- **Focus medical research on military associated issues, particularly rehabilitation, spinal cord injury/paralysis, and biomedical concerns.**
- **Improve the Nation's response in the event of a National emergency or natural disaster by providing timely and effective contingency medical support.**
- **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 by 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 with National Committee for Quality Assurance accreditation and maintenance, as appropriate, of Association for the Assessment and Accreditation of Laboratory Animal Care (AAALAC) or Nuclear Regulatory Commission (NRC) accreditation or certification
- Appearance of national cemeteries

Secretary's Priority

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

Performance Goal

➢ **Perform at 33 percent compliance of the Institutional Review Board (IRB) with National Committee for Quality Assurance (NCQA) accreditation and maintenance, as appropriate, of Association for the Assessment and Accreditation of Laboratory Animal Care (AAALAC) or Nuclear Regulatory Commission (NRC) accreditation or certification.**

Under the direction of the Office of Research and Development (ORD), VA's research portfolio of more than 2,400 projects has resulted in numerous discoveries that have improved the quality of health care for veterans and the American public. Virtually all VA research projects are directed toward health conditions relevant to the veteran population. While all VA research is relevant to veterans, the Designated Research Areas are of particular importance to VHA's veteran patient population. The Designated Research Areas include aging, chronic disease, mental illness, substance abuse, sensory loss, trauma-related illness, health systems, special populations, and military occupations/ environmental exposures.

Designated Research Area	Number of Projects Conducted in 2001
Aging	470
Chronic Disease	1,538
Mental Illness	169
Substance Abuse	146
Sensory Loss	74
Trauma-Related Illness	199
Health Systems	218
Special Populations	104
Military Occupations and Environmental Exposures	137

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

The FY 2001 goal for NCQA accreditation of VA Human Subjects Protection Programs was not achieved. Two test site visits were made in the second quarter, four full-scale pilot site visits were completed in the third quarter, and one accreditation site visit was conducted in the fourth quarter. The final accreditation decision from that visit is pending.

The implementation of the NCQA accreditation process for VHA research programs was delayed due to a delay in a contract award. In addition, once standards were being developed with NCQA, the Institute of Medicine became aware of this initiative and asked if VHA would collaborate to develop national standards for accreditation that could be used for all research programs across the nation (not just within VHA). This additional component further delayed the first accreditation surveys.

All 80 Veterinary Medical Units within the VA Research Program are accredited by the AAALAC (100 percent of goal).

NRC licensure 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. All VA facilities requiring licensure are appropriately licensed by the NRC (100 percent of goal).

Since all standards are now developed and accreditation surveys are underway, we expect to meet the performance goal in 2002.

Means and Strategies

VA complies with federal regulations that have established a system in which responsibility for protecting human subjects is assigned to three separate groups. First, investigators are responsible for conducting research in accordance with regulations. Second, institutions maintain oversight mechanisms, including local committees known as Institutional Review Boards (IRBs). IRBs are responsible for reviewing both research proposals and ongoing research. Third, 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.

The Department requires that each VA medical center (VAMC) engaged in research with human subjects establish its own IRB or secure the services of another IRB at an affiliated university. ORD establishes the policies that promote the ethical conduct of research and manages the NCQA contract. The Office of Research Compliance and Assurance (ORCA) manages matters relating to the effectiveness of research protections, promotion of the ethical conduct of research, and the investigation of allegations of research impropriety.

Within VHA, Veterans Integrated Service Networks (VISNs) must demonstrate full compliance with appropriate regulations in the following ways:

- Quarterly report re-accreditation reviews. 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.
- NCQA 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.
- Network director performance measures. Part of each Network director's annual performance evaluation is based on the completion or outcome of various research compliance measures. This includes information about attainment of all necessary full accreditation and clearly defined plans for any new accreditation.

External Factors

Several external factors created difficulties that resulted in nonachievement of this performance measure. Three factors impeded full implementation of the Human Subjects Protection Program in FY 2001. An unsuccessful bidder protested the initial award of the accreditation contract to NCQA. The protest was resolved in VA's favor but delayed implementation of the contract for more than 3 months. Secondly, VA was asked by the Office of Human Research Protections (OHRP) of the Department of Health and Human Services (HHS) to assist the Institute of Medicine (IOM) in developing recommendations for a single set of national standards for accreditation of human subjects' protections. This

required a modification of VA's contract with NCQA and also diverted some NCQA services (HHS) to complete this task. IOM ultimately endorsed the standards developed by NCQA for VA as the best available for developing national standards for both Federal and private sector institutions. Availability of a single set of national standards will greatly facilitate accreditation of VA human subjects protection programs in the sizeable minority of cases (approximately 40 percent) where the program is shared between a VA facility and an affiliated academic institution, thereby saving time and expense for VA. Finally, a very large number of comments and suggestions for enhancement of the standards were received in response to public posting of NCQA's draft standards in the second quarter. The VA committee overseeing the development of the standards (composed of representatives from the Office of Research and Development, Office of Research Compliance and Assurances (ORCA), and the Ethics Office) decided that a careful and detailed revision of the standards at the front end would save time in the long run by reducing the need for revisions during the course of the accreditation program. This revision was completed during the third quarter and early fourth quarter, permitting initiation of accreditation visits late in the fourth quarter.

Crosscutting Activities

VA research is conducted subject to the regulations of many other Federal agencies as well as VA's own internal 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) regulations and oversight; studies funded by the National Institutes of Health (NIH) and conducted in VA facilities are subject to Department of Health and Human Services 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, ORD is responsible for developing human studies policy in coordination with other federal research regulatory agencies. ORCA is responsible for enforcement activities with other federal research regulatory agencies, including the Food and Drug Administration and the HHS Office of Human Research Protections. As an example, 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.

Data Source and Validation

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. Also, network director performance evaluations include measures related to attaining appropriate accreditations. These accreditations are subject to verification of their validities with the accrediting agency.

Secretary's Priority

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

After the terrorist attacks on September 11, 2001, VA responded on two levels – in support of the Federal Response Plan (FRP) and at VA Central Office, in support of National Continuity of Government and Continuity of Operations requirements.

Immediately following the second aircraft crash into the World Trade Center, VA's Continuity of Operations Plan (COOP) was activated. Alternate sites, serving as command centers, were operational and key personnel were deployed within a few hours.

VA Central Office ensured continuity of operations nationwide, while Veterans Integrated Service Networks (VISNs), headquartered in the Bronx and Baltimore, activated command centers. Personnel from VISN 4, in Pennsylvania, supported the response following the downed aircraft in that state. Under the FRP, VA deployed critical care burn nurses to Cornell Medical Center Burn Unit and the Washington Hospital Center Burn Unit.

In New York, VA deployed staff and shared inventory with other emergency health care facilities. VA facilities in New York provided much needed supplies to emergency workers and the National Guard to help them carry out their jobs in the immediate aftermath. VA also provided support to make certain that emergency pharmaceuticals and medical supplies were delivered to New York City in support of the rescue operations. VA continues to provide medical support to the approximately 3,000 members of the National Guard still providing security to the city and its infrastructure. Since the tragedy, VA outreach teams have staffed family and victim assistance centers around the city and in New Jersey. The Network mental health team is prepared to support the continued emotional needs the event will generate in the months ahead.

On the Saturday following the attacks, staff from VA's National Center for PTSD assisted DoD in its relief efforts at the Pentagon. They provided education for counselors and debriefing and psychoeducational support for relief staff that included Red Cross personnel and DoD Casualty Assistance Officers. They created a Debriefing Facilitators Manual, a computerized self-assessment for the Army Community Support Center staff, and an evaluation questionnaire.

The Department's response was not limited to VHA resources. The Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA) actively assisted victims and their families in the aftermath. The VA regional offices (VAROs) in New York and Washington provided support at the New York City Family Assistance Center and DoD's Family Assistance Center.

In order to expedite claims related to the attack, processing for these claims was centralized in the Compensation and Pension Service at VA Central Office. We processed 39 claims for Dependency and Indemnity Compensation benefits for active duty deaths. VA has streamlined the claims process as much as possible in an effort to support the families. Working with DoD, we obtained direct on-line access to the Defense Eligibility and Entitlement Records System (DEERS) to obtain

data on dependents, allowing us to conduct on-site claims processing. Claims for Servicemembers Group Life Insurance (SGLI) were processed within 24 hours. We paid 88 insurance death claims. We implemented similar procedures for burial claims and headstone or marker applications.

Within NCA, all VA burials resulting from the tragedy were treated as high priority and requests for weekend burials and extended hours were honored when necessary. NCA immediately provided Presidential Memorial Certificates to the families of over 75 active-duty personnel or veterans killed on September 11.

The Department is closely coordinating with the Homeland Security Council, DoD, the Department of Health and Human Services, the Centers for Disease Control and Prevention, the Federal Emergency Management Agency, and state and local authorities to be in a sound position to respond to future threats.

Because of the nature of the terrorist attacks, we did not have a key performance measure in place beforehand, but we will have one in place during 2002.

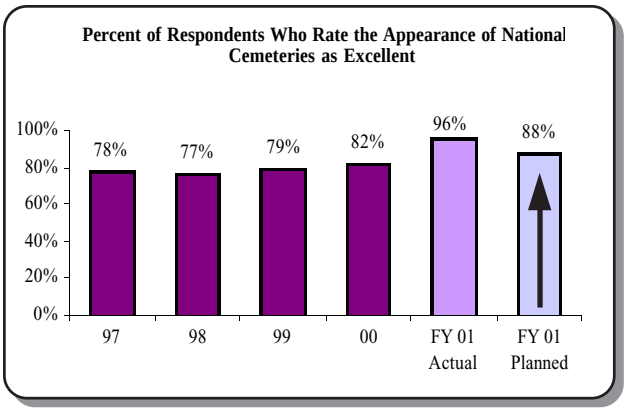
Secretary's Priority

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 88 percent by 2001.**

Each national cemetery exists as a national shrine, a place of honor and memory that provides an enduring memorial to our Nation's veterans, as well as a dignified and respectful setting for their final resting place. Cemetery appearance goals are set consistent with the high expectations of veterans and the general public. The percentage of respondents who rate national cemetery appearance as excellent increased significantly in FY 2001, and was well above our planned performance goal. For FY 2001 and subsequent years, NCA developed a new customer satisfaction survey process. The measure for cemetery appearance is the percent of respondents who agree that the overall appearance of the national cemetery is excellent.



Our Nation's veterans have earned the appreciation and respect not only of their friends and families but also of the entire country. 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. Veterans and their families expect national cemeteries to have well-maintained gravesites, buildings, facilities, and headstones and monuments. In describing one of VA's national cemeteries, a World War II veteran wrote: "The markers are straight and well-aligned, the grass is neatly trimmed around all markers, flags are now at all times flapping in the wind with appropriate flowers to enhance the green grass . . . as a veteran, this care and management is greatly appreciated."

Means and Strategies

To ensure the appearance of national cemeteries meets the standards our Nation expects of its national shrines, VA performs a wide variety of grounds management functions. In FY 2001, headstones were set, aligned, or realigned to maintain uniform height and spacing. Headstones that became soiled were cleaned. In-ground gravesites (casket and cremain) required maintenance to prevent and correct ground sinkage. To preserve columbaria, VA cleaned stains from stone surfaces, maintained the caulking and grouting between the units, and repaired the surrounding walkways. While attending to these highly visible aspects of our national shrines, VA

also maintained roads, drives, parking lots, and walks; painted buildings, fences, and gates; and repaired roofs, walls, and irrigation and electrical systems.

Cemetery acres that have been developed into burial areas and other areas that are no longer in a natural state required regular maintenance. In FY 2001, VA maintained over 6,800 developed acres and over 2.4 million graves.

To ascertain how our customers and stakeholders perceive the appearance of national cemeteries, VA annually seeks feedback from them through surveys and focus groups. This information is used to determine expectations for cemetery appearance as well as specific improvement opportunities and training needs. For FY 2001, VA developed a nationwide mail-out customer satisfaction survey, an improvement over the previous data collection instrument. The information gathered will be used in the NCA 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 appearance of national cemeteries.

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 onetime 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 of 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 spring of 2002.

In advance of the completed report, contracts for National Shrine Commitment projects have been awarded and are underway at four national cemeteries: Fort Sam Houston National Cemetery in Texas; Golden Gate National Cemetery in California; Long Island National Cemetery in New York; and Willamette National Cemetery in Oregon. Over 170,000 headstones and markers will be raised and realigned as well as cleaned where needed. In addition, at Willamette National Cemetery, graves in 24 acres will be completely renovated.

Numerous ceremonies and memorial services were held during FY 2001 at national cemeteries to honor those who made the supreme sacrifice. For example, approximately 150 people gathered at Fort Snelling National Cemetery for the dedication of a memorial monument in memory of our Nation's heroes who served during World War I. Veterans, family members, and members of local veterans service organizations gathered at national cemeteries on Pearl Harbor Day to honor the more than 2,400 Americans who gave their lives in service to their country 59 years ago. Thousands honored America's veterans at ceremonies at national cemeteries across the Nation for Memorial Day 2001. VA, veterans service organizations, and other patriotic groups sponsored ceremonies, supported by volunteers including groups of Boy and Girl Scouts, students, families, community associations, veterans groups, and individuals. A monument honoring women veterans was dedicated at Rock Island National Cemetery. The Medal of Honor Memorial at Riverside National Cemetery was rededicated to honor 26 servicemen whose Distinguished Service Crosses were upgraded to Medals of Honor.

"A Promise Made – A Commitment Kept," NCA's new book on Civil War-era national cemeteries, was published. The new book highlights VA's 59 Civil War-era cemeteries that were accepted in the National Register of Historic Places. The book describes each of the cemeteries and highlights features such as notable burials, monuments and memorials, and the Civil War history of each cemetery.

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.

Crosscutting Activities

VA continued 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 provided for the use of selected prisoners to perform work at national cemeteries. This agreement provided a supplemental source of labor to assist in maintaining the 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. This program provides veterans the opportunity to work for pay, regain lost work habits, and learn new work skills while providing a supplemental work force for the national cemeteries. In FY 2001, the California Employment Development Department selected Riverside National Cemetery as one of nine recipients for Employer of the Year honors. Riverside National Cemetery received the award for the staff's accomplishments in support of veterans' employment and the Compensated Work Therapy Program. While in the program at Riverside National Cemetery, veterans receive on-the-job training and some become permanent employees at the cemetery. To date, 15 of the 125 veterans who have gone through the CWT program at the cemetery were hired as temporary employees. Riverside National Cemetery currently employs nine permanent and two temporary employees who successfully transitioned from the CWT program. The staff is proud to have the opportunity to help men and women who have served our Nation develop the skills needed to return to gainful employment.

Data Source and Validation

From FY 1996 through 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 developed a new customer satisfaction survey process. 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 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 survey information provides a gauge to assess maintenance conditions at individual cemeteries as well as the overall system.

NCA analyzes the information to ensure that we address those issues most important to our customers. This approach provides data from the customer's perspective. These data are critical to developing our objectives and associated measures. VA will continue to conduct focus groups to collect data on stakeholder expectations and their level of satisfaction with the appearance of national cemeteries. 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 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's 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 workforce 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, these activities are critical to our stakeholders as well as the managers and employees who implement VA 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
- ➢ Making greater use of performance-based contracts

Enhancing Accountability for Performance

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, which established the VA Executive Board (VAEB), the Strategic Management Council (SMC), and six strategic management process groups that oversee the planning and operations of VA's major crosscutting management processes. The VAEB is chaired by the Secretary and includes the top leadership. The SMC is chaired by the Deputy Secretary and includes senior leadership at the deputy level. The VAEB meets approximately once a month, and the SMC meets twice monthly. Major policy and management issues will be vetted in an integrated Departmental forum through the VAEB and SMC . 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.

VA continuously strives to improve the quality and delivery of accurate, timely, and courteous service to veterans and their families. By fostering an environment that attracts, retains, and cultivates a dedicated workforce of highly skilled employees, the Department can achieve this goal. In an effort to meet this challenge, a departmentwide survey was conducted to allow employees to voice their perceptions about their work environment. The 2001 VA Employee Survey resulted in the completion of 83,393 surveys. Nearly 38 percent of the employees invested substantial time and effort into providing their views about rewards and recognition, training and career development, customer orientation, fairness and treatment of employees, and quality of worklife. Results are expected in the spring of 2002.

Through the review of the survey data, VA will address top-priority issues and identify creative and innovative ways to enhance the workplace and improve the delivery of high-quality benefits and services to veterans and their families.

Enterprise Architecture

In FY 2001, the Office of the Chief Information Officer accomplished the following in its responsibility for Enterprise Architecture:

- Established the Office of the Chief Architect, whose mission is to develop and implement an evolutionary high-performance *One VA* information technology architecture that (1) is aligned with VA's program/business goals and (2) enables data integration across the enterprise;
- Developed and issued the *One VA* Enterprise Architecture (EA) Strategy and Implementation Plan;
- Developed an EA Communications/Marketing Plan;
- Organized and developed the Information Technology Board;
- Organized the EA Working Group from VA's National Information Technology Board participants;
- Participated in the OI&T Continuity of Operations/Continuity of Government Planning, Command and Control Planning, and Network Redesign;
- Began development of a user's guide for EA field implementation.

Information Security Program

The Office of Cyber Security accomplished the following during FY 2001:

- Developed and issued a revised VA Information Security Management Plan. The Plan identified a number of security enhancement actions that are being accelerated to improve enterprise-wide information security.
- Established a central security fund to consistently pursue departmentwide security efforts, with emphasis on security controls that correspond to significant shared risks across the Department.
- Implemented an enterprise-wide, integrated anti-virus solution that will remove most of the manual interventions that presently plague rapid distribution of new anti-virus updates to more than 150,000 VA desktops and servers at over 800 locations.
- Launched a major contract to develop a certification and accreditation program to bring discipline, formality, and technical excellence to the security planning activities of VA offices during the design of systems and applications.

- Provided all VA facilities 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.
- Established national programs in security training and education of computer professional staff employing commercial sources of Web-based study curriculums and the satellite bandwidth available through the VA Learning University.
- Began revamping security policies into usable frameworks.
- Developed and submitted to the Office of Management and Budget the Government Information Security Reform Act (GISRA) Report and corrective action plans.

Program Evaluation

During FY 2001, Systems Flow, assisted by ORC Macro International, Economic Systems, and Hay Group, completed a comprehensive evaluation of the *Benefits for Survivors of Veterans with Service-Connected Disabilities*. The evaluation, which involved surveying 5,500 servicemembers, veterans, and dependents, focused on the outcomes of the Dependency and Indemnity Compensation (DIC) program and four insurance programs: the Servicemembers' Group Life program (SGLI), the Veterans' Group Life Insurance program (VGLI), Service Disabled Life Insurance (S-DVI), and the Veterans' Mortgage Life Insurance program (VMLI). The 2-year, $1.4 million study addressed issues raised in the Veterans Programs Enhancement Act of 1998, Public Law 105-368, Section 303, and responded to 24 specific research tasks such as comparing VA and non-VA benefit programs, analyzing family household income and expenses before and after a veteran's death, and the effect on the surviving spouse of providing care to the disabled veteran. The evaluation generally concluded that the DIC and insurance programs are meeting the statutory intent of Congress and the income needs of survivors. Nevertheless, the evaluation's findings and recommendations identified the need for several program enhancements already being planned, as well as the implementation of the following initiatives:

- Raising the SGLI coverage amount to $250,000;
- Providing an optional family coverage plan for SGLI;
- Reducing VGLI premium amounts;
- Improving outreach to people eligible for VMLI coverage, including a special outreach to disabled persons leaving military service.

Budget Account Restructuring

VA and OMB established a joint working group to identify options for restructuring the Department's budget accounts. The 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. So as to be able to use the new budget account structure in formulating our FY 2004 budget, we will continue to work with our stakeholders in addressing specific implementation issues associated with this proposal.

The core Financial and Logistics System (coreFLS) will support budget account restructuring. CoreFLS will replace VA's core accounting system (Financial Management System) 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

In July 2001, Secretary Principi established a Department-level capital asset management function, the Office of Asset Enterprise Management (OAEM). Capital asset management is a business strategy that seeks to maximize the functional and financial value of capital assets through well thought out acquisitions, allocations, operations, and dispositions. The OAEM develops and promulgates capital asset policies; establishes and analyzes VA's capital asset portfolio; establishes and coordinates the Department's future investment strategy; and establishes a performance management system to oversee portfolio performance. This comprehensive, corporate-level approach to capital asset management helps ensure VA links its asset decisions closely to its strategic goals, elevates awareness of its assets, and employs performance management techniques to monitor asset performance on a regular basis.

One of OAEM's responsibilities is overseeing VA's Enhanced-Use Lease Program. The Enhanced-Use Lease Authority authorizes VA to find cost-effective alternatives to traditional means of acquiring and managing its facility and capital holdings. It permits the long-term out-lease of underutilized VA property to non-VA users for uses compatible with VA programs in return for obtaining facilities, services and/or money for VA requirements that would otherwise be unavailable or unaffordable.

This program has significantly reduced costs to the Department and provided corresponding benefits to veterans, employees and the local community. To date, 20 Enhanced-Use leases have been awarded and over 150 potential projects have been studied, with 60 currently in development. These projects address a broad array of initiatives including mixed-use development projects, residential care and temporary lodging facilities, energy plants, elder care facilities, child development centers, and parking facilities.

Effective capital asset portfolio and performance management requires that VA establish a comprehensive and integrated capital asset management system (CAMS). Currently, VA has

several non-integrated separate systems, processes, and procedures that serve discrete internal organizational components to track capital assets. In April 2001, the Strategic Management Council initiated the Capital Asset Management Working Group, led by the Office of Information and Technology and the Office of Management, to recommend a single, unified approach to asset control throughout the Department. Findings were reported to the Information Technology Board on the analysis of existing VA systems and the market research of existing and emerging technologies. This research culminated in live product demonstrations of four potential solutions meeting VA requirements. A recommendation and decision for a CAMS solution is expected in FY 2002.

Making Greater Use of Performance-based Contracts

The intent of this management reform is 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. Through this system, the Department will be able to analyze the types of conversions, the dollars obligated, and the level of conversion to performance-based contracts.

In FY 2001, VA prepared and administered contracts for pharmaceuticals, medical equipment and supplies, and subsistence for federal agencies. These contracts are managed as Federal Supply Schedules, national contracts, and competitive contracts for special purchases; all reflect savings from commercial prices. The savings allow VA to best utilize its annual appropriations. Other federal agencies are also able to take advantage of these contracts. In addition to the savings from commercial prices, discounts are negotiated and competed on items VA purchases in high volumes. These contracts reflect the best value available to VA. The general public receives benefits through sound management practices of purchasing the best possible product at the lowest price. VA also provides support to the Centers for Disease Control and Prevention and other agencies in the Department of Health and Human Services in times of emergency. On September 11, 2001, VA provided support to make certain that emergency pharmaceuticals and medical supplies were delivered to New York City in support of the rescue operations.

Procurement Reform

VA spends more than $5 billion annually for pharmaceuticals, medical and surgical supplies, prosthetics, information technology, construction, and services. VA's acquisition system is vital, not

only because of its magnitude, but because of its critical role in ensuring VA can deliver timely services to our Nation's veterans in an efficient and cost-effective manner.

To optimize the performance of VA's acquisition system, the Secretary of Veterans Affairs established a Procurement Reform Task Force in June 2001. Task Force members were charged with reviewing VA's entire acquisition system and processes, and recommending specific improvements to strengthen the system's performance and effectiveness.

To meet this challenge, the Task Force decided to focus its efforts on areas that offer substantial near-term savings and have high potential for sustainable improvements. In addition, the Task Force sought to address key VA-wide issues that affect the effectiveness of the acquisition system. Two areas were excluded from the scope of the Task Force's work: information technology acquisition because this issue is being addressed separately; and pharmaceutical purchases because this area has received considerable management attention and improved so significantly. All other acquisitions fall within the scope of the Task Force's review. To optimize VA's acquisition system, the Task Force established the following five major goals:

- Leverage purchasing power;
- Standardize commodities;
- Obtain comprehensive VA procurement information;
- Improve VA procurement organizational effectiveness; and
- Ensure a sufficient and talented VA acquisition workforce.

Task Force members consulted extensively with other government agencies and private-sector organizations, as well as with VA staff, to identify best practices and innovation opportunities. When finalized and approved by the Secretary in FY 2002, the Task Force's recommendations will provide a solid foundation to improve the efficiency, cost-effectiveness, and accountability of VA's acquisition system. The Task Force has briefed VA's Strategic Management Council, chaired by the Deputy Secretary. Following the Secretary's approval, the Task Force's recommendations will be implemented.

President's Management Agenda

Strategic Management of Human Capital
Competitive Sourcing
Improved Financial Performance
Expanded Electronic Government
Budget and Performance Integration
Improved Coordination of VA and DoD Programs and Systems

At VA, we conduct our operations using sound business principles. The Department has taken a number of steps to support management reforms in the areas delineated in the President's Management Agenda, which will allow us to achieve our goals while managing public resources with prudence.

Strategic Management of Human Capital

The Department has developed a comprehensive workforce planning initiative that will enable VA to remain a competitive employer and provider of quality services to America's veterans. As part of this initiative, VA developed a Departmental Workforce Analysis and 5-Year Restructuring Plan that details demographics, skill assessments, human capital challenges and accomplishments, and strategies that demonstrate VA's commitment to becoming more citizen-centered.

In order to address VA's human capital challenges, we have developed the Department of Veterans Affairs Workforce and Succession Plan. This plan articulates VA's corporate vision for workforce and succession planning and identifies specific strategies to address recruitment, retention, and development issues. Further, VA launched the Departmental Workforce and Succession Planning Intranet Homepage, which is an employee-focused, information-rich communication tool that provides workforce and succession planning data, tools, best practices, and accomplishments.

These efforts supplement the already extensive workforce planning efforts each of VA's business lines have undertaken this year, including an enhanced focus on the recruitment of new employees, leadership development programs at all organizational levels, and the integration of workforce planning into the strategic planning process.

In June 2001, VA established a national veterans employment program to promote the hiring of veterans in both the public and private sector. The program focuses on ensuring that veterans and federal hiring officials are aware of statutory preferences extended to veterans and how special hiring authorities can be used to employ veterans. Information (including bilingual brochures and pamphlets) concerning the veterans' employment program and veterans' preference guidelines is being distributed to veterans service organizations, community-based groups, and military transition centers around the country. Information concerning the program will also be included on VA Web sites.

In an effort to effectively manage its human capital, VA embarked on developing a comprehensive childcare tuition assistance program for all eligible employees effective January 1, 2001. The purpose of the program is to assist lower income employees in offsetting the high cost of childcare. To be eligible for this program, a VA employee must be full-time or part-time with an income of less than $60,000. Children must be age 13 or younger; however, children with disabilities are accepted through the age of 18. The care provider must be licensed by the state and/or regulated by the local regulating authorities. Provider coverage includes center-based care, home care, and before/after school care.

The following chart shows the percentage of the total childcare costs VA will pay based on total family income.

If Total Family Income is:	Then VA Will Pay This Percentage of Child Care Costs:
$60,000 and Over	0
$50,000 - $59,999	25
$35,000 - $49,999	30
$25,000 - $34,999	40
$24,999 and Under	45

Example: Based on the income thresholds in the model above, if a family's total family income is $39,000 and total childcare costs are $6,500, VA will pay 30 percent ($1,950) and the family pays the rest ($4,550).

As of October 1, 2001, over 1,081 employees (with over 1,700 children) have enrolled. The VA program has been showcased by the Office of Personnel Management in its monthly publication of "FOCUS on Federal Work/Life and Wellness Programs" and was noted as having the most comprehensive program across Government. VA leads the Federal Government with the highest number of program participants.

An Intranet survey of agency employees on the VA Web site revealed that 89 percent of the eligible employees indicated that the availability of tuition assistance for childcare is a factor in their "decision" to stay employed with VA. This program makes it possible for VA to attract, recruit, and retain a skilled and competent workforce.

Competitive Sourcing

Over each of the past 5 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 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 5 years. VHA's total contract service expenditures equate to approximately 43,000 full-time employees. One of the key factors

contributing to VHA achievements in competitive sourcing is the transformation of the health care delivery approach, moving increasingly from inpatient to outpatient care and toward the use of community-based outpatient clinics (CBOCs) to improve access for veterans. For each CBOC opened, VA determines whether it is more cost effective to operate the facility with VA employees. Out of 609 operating CBOCs, 146 are staffed with contract personnel.

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.

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 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 competitive sourcing process for VA. The working group identified areas of opportunity for future competitive sourcing and developed a tracking system to assess progress and outcomes. The working group also developed a proposed three-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 the work 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.

Improved Financial Performance

VA received an unqualified opinion on the Department's financial statements from the auditors in FY 2001, continuing the success first achieved in FY 1999. Below are some ways the Department improved its financial performance in FY 2001.

Electronic Business Solution

E-Travel – VA began implementing a new electronic travel system, known as e-travel. This system will allow travelers or travel arrangers to electronically prepare and submit travel information using a Web-based system. They will begin by logging on to the e-travel system through the Intranet from a PC, laptop, or hand-held device to create an online travel request. Through the e-travel system, all VA travelers or travel managers will access an on-line booking engine for trip planning purposes, including access to information on available transportation and lodging options.

Once preliminary travel plans are made, the travel request is electronically routed to the supervisor for authorization and to approving officials for final approval. The electronic routing process includes electronic signature approval and e-mail notification of the request throughout the process. When the travel is approved, travel authority data will be sent from the e-travel system to the Financial Management System. Upon implementation, data will be sent from the e-travel system to the core Financial and Logistics System (coreFLS) to be obligated and to the booking engine for confirmation and ticketing of held reservations. Upon completion of the trip, travelers can easily and immediately submit their travel vouchers.

E-travel will provide a departmentwide system that will reduce cycle time for the travel management process, centralize travel and budget information

online, reduce delinquency rates, increase dollar savings from prompt payment of travel card bills, and reduce paper with an end-to-end process.

Debt Management Center (DMC)

Cross-servicing Program – During FY 2001, the DMC began referring debts over 180 days delinquent to the Department of the Treasury (Treasury) in compliance with the Debt Collection Improvement Act of 1996. Throughout the year, the DMC referred 83,663 accounts valued at $303 million for collection by Treasury and their private collection agencies. Collections from cross-servicing efforts totaled $7,874,164 for FY 2001. Treasury recognized the DMC with a Certificate of Appreciation for their efforts in developing an automated process for referring and updating accounts for cross servicing.

The DMC increased collections/offsets by 3 percent over last fiscal year. Collections/offsets increased from $302 million in FY 2000 to $312 million in FY 2001, despite a decrease of 19 percent in new debt established (from $506 million in FY 2000 to $426 million in FY 2001). Operating expenses were reduced from $6,143,452 in FY 2000 to $6,031,945 in FY 2001.

Successful initiatives achieved in FY 2001 include:

Treasury Offset Program – The Debt Collection Improvement Act of 1996 requires agencies to refer delinquent debts to Treasury for offset under the Treasury Offset Program. Under this program, most federal payments can be offset to satisfy delinquent federal debts. VA's Debt Management Center referred 445,017 accounts valued at $229 million to Treasury for offset during FY 2001. Collections from the effort totaled $39 million through October 2001 as compared to $16 million through a comparable period in FY 2000.

Enhanced Imaging/Retrieval System – The DMC has moved from film/fiche media to magnetic media for storage of archived material. With film/fiche, retrieval of images was largely a manual task, sometimes taking hours or days for a clerk to find a particular image and print it. Through investments in hardware and software, the bulk of the imaging and retrieval system has evolved into a largely automated system with desktop retrieval for most employees. Hours of time simply walking to the former retrieval devices have been saved. Thousands of dollars are saved each year in filming costs and more will be saved when the DMC completes a project to convert audit trail records from the Benefits Delivery Network.

Remittance Processing – Until June 2000, the St. Paul Regional Office with older, generally unserviceable equipment, was in the business of processing collections. Regional office costs for rent and FTE made the DMC's process more cost beneficial. The DMC assumed responsibility for remittance processing in June 2000. The DMC estimates that it saves fifteen to twenty thousand dollars each month in what it would have paid for similar services provided by the regional office.

Expanded Electronic Government

VA's goal is to develop an agency-wide architecture with a uniform approach addressing electronic forms development, Web-based user interface, identification and authentication, authorization and access control, electronic signature, security, and data interchange with internal business processes and systems. Within the next 2 years, VA's Enterprise Architecture should be complete with secure computer and information infrastructure, and VA's currently fragmented telecommunication network will be integrated and modernized. VA expects to use the Internet as a primary means for conducting business with VA customers as well as other electronic media, including telephones, kiosks, and various information call response centers.

In December 2000 and October 2001, VA submitted status reports to OMB on implementation of the Government Paperwork Elimination Act (GPEA). In the December report, VA provided a list of over 216 OMB-approved forms with indicators of which forms were feasible or practicable for electronic conversion including those that were: 1) at high-risk, 2) inter-agency related, and 3) forms requiring electronic signatures. The October 2001 report reflected VA's progress, as follows:

- VA conducted a departmentwide assessment of business practices and drafted a GPEA implementation plan. The plan outlined preliminary findings and recommendations to increase the probability of a successful GPEA implementation. It also provided strategic direction on how VA should: 1) establish information collection priorities, 2) develop data and form standards, 3) select technologies for electronic signatures and authentication, 4) use Public Key Infrastructures, and 5) develop policies for electronic records management, electronic data interchange standards, and electronic rule-making.

- In September 2001, VHA initiated a study to find a Web-enabled commercial product that could support the delivery and management of on-line electronic forms via the Internet and VA's Intranet. Staff from VA's Office of Information and Technology, Veterans Benefits Administration, and Office of Acquisition and Materiel Management reviewed the results and recommended drafting a concept paper for departmentwide concurrence and approval. Implementation of this enterprise-wide software solution for electronic submission and receipt of information (on VA's 4,294 internal and public use forms) will be the primary means for conducting business with VA customers over the Internet.

- VA has taken steps to expand the use of Public Key Infrastructure (PKI) as an identification and authentication, digital signature, and encryption solution for the VA enterprise. VA's current PKI uses a commercial Certificate Authority. In the near term, VA will integrate PKI into evolving enterprise-wide applications upon deployment. Additionally, PKI functionality will be incorporated into VA applications accessed by veterans to provide digital certificates for veterans. These initiatives will focus on eliminating fraud and improving privacy of veteran data.

- A technical report was completed in August 2001, which will assist VA administrations and staff offices in formulating a set of evaluation criteria and a method to rank and prioritize information collections. A business process mapping schema and techniques for identifying migration and risk analyses were also developed. The model will be prototyped within VHA using an initial set of transaction forms.

- The CIO's office participated in the OMB Quicksilver Task Force Project, which resulted in the selection of over 23 electronic government initiatives. VA is partnering with several lead agencies to plan, develop, and implement the following electronic government initiatives: 1) USA Services, 2) E-Loans, 3) Eligibility Online, 4) Federal Asset Sales, 5) HR Integration, 6) e-Records Management, 7) Health Informatics, 8) Integration Acquisition, and 9) e-Vital. These initiatives are closely aligned with VA management and agency performance. As a result, VA offices are developing e-government and system modernization strategies categorized under OMB's customer groupings: Government to Citizen (G2C), Government to Business (G2B), Government to Government (G2G), and Internal Effectiveness and Efficiency (IEE).

Budget and Performance Integration

During FY 2001, VA made three significant advances toward integrating budget and performance information. First, we achieved agreement with our stakeholders on a revised budget account structure that will allow us to more readily determine full program costs. Second, the Department progressed in design of the core Financial and Logistics System (coreFLS), which will allow us to better align resources with program activities and improve automated analytical and reconciliation tools. Third, we worked with OMB to identify three performance-based budget pilots to test the concepts of integrating performance and budget information.

Improved Coordination of VA and DoD Programs and Systems

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 of the two Departments have been meeting for several years to improve and expand sharing. Results of this national cooperation include progress in the joint development of clinical practice guidelines; promotion of patient safety; and combining the military's discharge physical with VA's disability compensation examination for servicemembers applying for VA compensation benefits. We are also pursuing several joint medical technology assessment initiatives.

VA is planning to conduct an analysis of alternatives to determine the best way to use the Defense Eligibility and Enrollment System (DEERS) to create a central enrollment and eligibility database for VA. The Deputy Secretary met with the Under Secretary of Defense in February 2002 to discuss how to improve coordination and maximize resources for the two departments.

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 interactions and recommending changes.

The two Departments have made substantial progress in increasing joint procurement activities. The foundation for this progress was established in December 1999 when VA and DoD signed a Memorandum of Agreement (MOA) to combine their purchasing power to eliminate redundancies. As of November 1, 2001, there were 55 joint VA/DoD contracts and 3 blanket purchase agreements (BPAs) for pharmaceuticals. VA's cost avoidance resulting from these contracts and BPAs was approximately $85 million in 2001. DoD cost avoidance resulting for all national contracts was over $100 million in 2001. An additional eight contracts were awarded with discounts off the lowest VA Federal Supply Schedule (FSS) price, ranging from 0.19 percent to 53.75 percent 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;
- 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.

Assessment of Data Quality

Due to diligent efforts over the past several years, the quality of VA performance 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; 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 its 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 cross-cutting task force on data quality and standardization whose membership includes the Chief Officers from the Office of Quality and Performance, Office of Policy and Planning, Chief Network Office, and the Office of Information. 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. The members will seek collaboration with other parties including the Department of Defense, Indian Health Service, private sector health care providers, and standards organizations.

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..."

The VHA Data Consortium addresses organizational issues and basic data quality assumptions. The 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.

The VHA data quality 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^{tm} for use within the Veterans Health Information Systems and Technology Architecture (***VistA***). 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 Central Office 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:

Replacement of VistA 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.

Overall, VBA has emphasized the establishment of a viable and acceptable information security program. An organized, centralized effort has been underway since the completion of the Year 2000 initiative. VBA has established a Security Infrastructure Protection Office (SIPO) within the Office of Information Management. We will further strengthen this program by continued coordination with the VA Office of Cyber Security and by providing (1) increased oversight at SIPO, (2) enhanced technical security at VBA's Hines Information Technology Center, and (3) enhanced VBA Internet Security.

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, Central Office 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 (Memorial Service Network) 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 Central Office 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. In FY 2001, NCA implemented 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.

Efforts continue in expanding the use of information technology to collect performance data for the timeliness of marking graves at national cemeteries. NCA has developed a new data collection instrument and is currently validating the accuracy and integrity of the data collected.

Following the collection and analysis of baseline data, NCA will identify future performance goals.

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 of FY 2002 to determine which key measures should be the next ones to audit.

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 report presents each of these challenges and outlines what steps VA has taken to resolve them.

Major Management Challenges Identified by VA's Office of Inspector General

The following is an update prepared by VA's Office of Inspector General (OIG) summarizing the most serious management problems facing VA, and assessing the Department's progress in addressing them. Although VA does not have specific quantifiable goals and performance measures in place to help resolve these issues, the Department does have corrective action plans in various stages of implementation. Progress will be monitored until each management challenge has been successfully addressed. Department officials have stated their agreement with the conditions the OIG reported. (On these pages, the words "we" and "our" refers to the OIG.)

1. Health Care Quality Management and Patient Safety

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 Central Office 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 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 it expeditiously conclude its 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

[1] Through this program, auditors, investigators, and health care inspectors collaborate to assess key operations and programs at VA health care systems and VA regional offices on a cyclical basis.

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.

VA's Program Response

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, Community Nursing Home Evaluation and Monitoring. Plans are also underway to establish annual review protocols and follow-up training for VA staff who conduct nursing home inspections. Progress is also being made to revitalizing the information system that monitors facility compliance with the annual review of community nursing homes. A new report is designed to monitor compliance with the monthly visit standard.

VHA continues to finalize actions to address the one remaining OIG recommendation on the state veterans home inspection process, involving revision and update of the policies and procedures included in the annual inspection guidance issued to VA medical centers 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. Recommendation will be implemented in FY 2002.

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 January 2004.

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. Streamlining of the system will continue.

2. Resource Allocation

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 which 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 to VISNs using the VERA system. The system provides some 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 were 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 Central Office 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

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.

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 number of veterans enrolled and treated is 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. Other facilities ignored DSS, and management at those 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.

VA's Program Response

VHA has adequately responded to recommendations in the OIG reports on the Decision Support System and the VERA allocation system and no further reporting is required. A final decision has not yet been made about the extent of inclusion of Priority 7 veterans, the lowest priority in the VERA funding distribution. OIG has been provided with a draft of the VHA study on utilization of a variable geographic means test, one option that is being considered. Legislation addressing application of the geographic means test is currently pending. If passed, the legislation will directly impact eligibility status of many veterans, including those now in the Priority 7 category. Such considerations will be inherent in VHA's final determination about the scope of VERA inclusion of Priority 7 veterans.

The proposed directive on Diagnostic Radiology Staffing has been completed, as well as a handbook on Nuclear Medicine and Radiation Safety. 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

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 an inventory 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) which 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) require the Board of Veterans' Appeals to develop and process the current workload of appeals rather than issuing remands, (ii) establish appeals claims processing teams, (iii) improve record recovery from the VA Records Management Center, and (iv) 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 benefits; 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. The OIG plans to continue conducting CAP reviews at VAROs and plans to summarize program findings in FY 2002.

Inappropriate Benefit Payments

VBA needs to develop and implement an effective method of identifying 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 6 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 by 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) also 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 one of four 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.

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 seven of eight 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 the Social Security Administration remains unimplemented. This recommendation was a repeat recommendation from our 1990 OIG report.

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.

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 two of three 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 onetime 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 multi-part recommendations identified in the St. Petersburg audit. Implementation action on these recommendations is currently in progress.

VA's Program Response

Timeliness and Quality

VBA established five teams to address the major recommendations in the report issued by the Claims Processing Task Force. The reports from all the teams have been completed and are being reviewed by senior management. VBA has taken action on many of the recommendations, and the Secretary was briefed in late December 2001.

In addition, a working unit comprised of six VBA employees and five Board of Veterans' Appeals (BVA) employees has been established. The BVA employees are currently receiving training on VBA's evidence-gathering process and systems. Previously, BVA would refer all remand actions to the field stations for completion. The current agreement between VBA and BVA states that BVA employees will now process remand actions instead of referring the requests to the field stations. The six VBA employees will make decisions and generate payments on the appeals.

VBA has begun the process of centralizing work processes. The Tiger Team, located in Cleveland, OH, is fully operational at this time. It has been processing claims for veterans over the age of 70 who have been awaiting a decision for over 1 year.

In addition, three Pension Maintenance Centers have been established and have begun processing Eligibility Verification Reports. They are expected to begin processing matching programs in April 2002. Training is currently underway in all three sites.

Inappropriate Benefit Payments

Payments to Incarcerated Veterans

Federal Prisons

Since April 1998, VA has been receiving files from the Federal Bureau of Prisons (BOP) identifying VA beneficiaries who are incarcerated by BOP. Every month VA receives a file of accessions to the BOP population. That file is matched with the file of C&P master records on Social Security Numbers (SSN). If there is a match, a worksheet and listing are generated to the VA regional office of jurisdiction for appropriate action. The BOP match is working very well with a low percentage of bad hits. However, the match will fail if the BOP has the wrong SSN for the prisoner or if VA has the wrong or no SSN for the VA beneficiary.

State & Local Prisons

VA entered into a Memorandum of Understanding (MOU) with the Social Security Administration (SSA) to get access to SSA's file of individuals

incarcerated by state and local governments. In March 2001, VA received a test file from SSA. Based on the output, it was necessary to refine criteria for the match. VBA has prepared a Project Initiation Request (PIR) to modify the programming necessary to conduct the match. It is anticipated that the match will be run on or about April 30, 2002.

We are unable at this time to estimate when we will release output from the state/local prisoner match to regional offices. We expect that the results of the next test run will be received by May 23, 2002. If the results do not reveal significant problems with the match, VBA will start releasing output to field stations within 60 days of the test.

The establishment and collection of overpayments for released veterans and dependents after the beneficiary was incarcerated by state or local governments who did not have their benefits adjusted were contingent upon VA getting acceptable output from the match with SSA.

Benefit Overpayments Due to Unreported Beneficiary Income

In order to implement the final recommendation, the Social Security Administration (SSA) recommended that VA use the "no surname match" routine in its State Verification and Exchange System (SVES) to more accurately conduct Social Security number verification. Using this routine, SSA will verify a payee's SSN if the SSN and date of birth and first initial of the first name match in VA and SSA records. If these elements do not match, the case will be identified as unverified. The individual's sex and last name will no longer be considered in determining whether there is a match. A PIR to modify the programming is being prepared. The intent of program changes is to get accurate SSNs into the system so we can better match data for the Income Verification Match and all other matches. It is not possible to provide an estimated date of installation until the PIR has been evaluated at the Hines Benefits Delivery Center (BDC), but we expect that it will be operational before the end of FY 2002.

Disability Compensation Benefits for Active Military Reservists

Allegations of problems with drill pay files from DoD date back to 1989 when VA attempted to move from annual waivers to a onetime waiver. After a hiatus of several years when no computer matching agreement was in place to support the match, VA and the Defense Manpower Data Center (DMDC) started matching again in 1999. The BDC sent a file of 2,660,266 active C&P records to DMDC to be matched for reservist drill days. On June 23, 1999, the return file was received from the DMDC with 56,884 matches covering fiscal years 1993-1998.

Because of concerns about the accuracy of DMDC files, VBA decided to test the accuracy of the data by doing a limited mailing to selected test stations. On January 26, 2000, Hines released fiscal year 1999 drill pay cases from four regional offices. A total of 751 waiver forms were released. However, review of copies of the waiver forms uncovered anomalies in the reported training days for reservists. Work to resolve this issue is ongoing, and release of the national review data will be done as soon as a solution is deployed.

VA received a letter dated June 13, 2001, from DMDC in which the Director explained that the Defense Finance and Accounting Service (DFAS) office in Denver discovered an error in its reporting of drill information to the DMDC affecting Army, Navy, and Air Force

pay data. The large majority of reservists served in these branches of the military. DMDC reports that Denver DFAS is unable to provide corrected submissions for drill data prior to April 2001. Hines currently has the FY 2001 drill pay file from DMDC, and it will be run before the end of FY 2002.

4. Government Performance and Results Act (GPRA) - Data Validity

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.
- Unique Patients – VHA overstated the number of unique patients by 7 percent.

Deficiencies were identified in each performance measure audited. VBA, VHA, and NCA have taken action to correct the deficiencies and have implemented all the recommendations in the OIG reports related to these 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 departmentwide 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

[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.

care index, and the accuracy of the VBA veteran rehabilitation rate – are in process.

5. Security of Systems and Data

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 September 30, 2000 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.

VA's Program Response

The OIG, the General Accounting Office, and VA security staff members have, for the past several years, reported on core deficiencies existing in the Department's segmented information security programs. Although some identified weaknesses were the result of insufficient funding being available to upgrade IT assets to more secure hardware and software configurations, most deficiencies were attributed to the lack of centralized security management, oversight, and control. During the past year, a number of aggressive actions have been initiated to develop a comprehensive, departmentwide security program targeted toward enhancing VA's overall IT security posture, including ensuring compliance with related OMB and Congressional directives.

This year, the Secretary realigned departmentwide IT security responsibilities under a single focal point. The Chief Information Officer (CIO) has been vested with authority to provide guidance and direction for all IT technical and security issues. The CIO manages the Department's security program through the newly established Office of Cyber Security (OCS). The office is serving as the focal point for leveraging existing resources and implementing security initiatives on a global basis within the Department.

During the past year, IT security has received priority attention at all Department levels. The focus on security has been revitalized in VA's Information Technology Board through establishment of a Cyber Security Subcommittee to identify areas of concern, coordinate policy issues, and share concepts for related best practices. Successes in FY 2001 include:

- Remote penetration testing has been conducted to support the Department's commitment to conduct active compliance monitoring and identification of continuing security weaknesses.

- Intrusion detection systems have been fielded at a number of locations within the Veterans Health Administration and the Veterans Benefits Administration as a precursor to implementing global intrusion detection capability.

- The VA Computer Incident Response Capability has been expanded to operate on a 24/7 basis to coordinate data on threat and vulnerability issues, cyber security incidents, and appropriate countermeasures.

- A departmentwide anti-virus regime is currently being deployed to better prevent and contain virus outbreaks that continue to occur

in VA, disrupt services and divert the efforts of technical staff.

In addition to these initiatives, the CIO initiated the first-ever departmentwide cyber security program review. This review coincided with VA's implementation of provisions of the Government Information Systems Reform Act (GISRA). During the review, a self-assessment survey containing 247 security-related elements was completed by respective IT and security staffs providing logistical support for each of VA's 995 systems and major applications.

As expected, the results of the GISRA self-assessment survey confirmed the lack of security management for IT assets. Overall, less than 70 percent of VA systems and major applications had effectively implemented IT security controls in such areas as segregation of duties, access controls, and entity-wide security program planning and management. Even for those systems reporting that controls were in place, there was almost no independent validation to ensure compliance with previously established security procedures. Correspondingly, many of the deficiencies identified in the surveys were cited in prior audits, and had not been adequately remedied. Although this process identified deficiencies in great detail, it was used as an effective management tool to identify and address the underlying lack of line management accountability, a contributing factor to VA's current security weaknesses.

Upon receipt of the Department's first GISRA Report, OMB commented in a November 16, 2001, memorandum to the Secretary, "On IT security, the CIO's security report is clear, coherent and shows that a comprehensive Department-level security program is developed and has begun. It is not clear how the Department-level program will be implemented at lower level. Specifically, it does not describe how the approach will correct the security issues that have long plagued the operating administrations, i.e., the Veterans Health Administration and the Veterans Benefits Administration."

The momentum for change established this year will be carried forward. The CIO's near-term focus is to build upon current initiatives including:

- Preliminary intrusion detection projects will be expanded to a departmentwide capability.
- Capabilities for compliance support and independent validation for GISRA remediation efforts will be established.
- Comprehensive policies for authentication, certification, and accreditation will be developed and implemented.

The success of current initiatives, future initiatives, and the extensive direction and support provided by the Secretary, the VA CIO, and Administration CIOs, reaffirm that this program is one of VA's highest priorities.

6. Federal Financial Management Improvement Act (FFMIA) and VA's Consolidated Financial Statements (CFS)

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 Governmentwide CFS prepared by the Department of the Treasury and audited by the GAO. VA's FY 2000 CFS reported assets totaling $44 billion, liabilities totaling $583 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 (FFMIA). 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 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.

VA's Program Response

During the past year, the Department has directed priority attention to remediating material weaknesses in IT security controls reported under the Federal Financial Management Improvement Act (FFMIA). In August 2001, the Chief Information Officer (CIO) initiated the first-ever departmentwide cyber security program review. This review coincided with VA's implementation of the Government Information Systems Reform Act (GISRA). A GISRA self-assessment survey containing 247 security-related elements was completed by respective security and IT staffs providing logistical support for each of VA's 995 systems and major applications.

The results of the GISRA surveys were analyzed under the six specific control categories identified in the General Accounting Office's Federal Information System Controls Audit Manual (FISCAM). The use of these FISCAM categories was deemed particularly appropriate, since FISCAM provides guidance for reviewing information system controls that affect the integrity, confidentiality, and availability of data. These are the specific areas that require significant improvement in order to remediate the FFMIA material weakness.

7. Debt Management

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 Income Verification Match (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 the Treasury. VA has reported it has met or exceeded Department of the 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 previously 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.

VA's Program Response

VHA continues to implement the outstanding recommendations for the report on the Income Verification Match (IVM) program. The Health Eligibility Center (HEC) has established mechanisms to ensure that IVM conversion 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. The 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.

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 OIG are addressed in the plan, as are recommendations that were made by reviews conducted by the Financial and Systems Quality Assurance Service (FSQAS).

8. Workers' Compensation Costs

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 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 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 its efforts to reduce WCP costs and identify WCP fraud. The OIG identified 82 claims during its FY 1999 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 were needed. The OIG staff discussed these cases with VHA staff. VHA is working to provide documentation to the OIG.

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.

VA's Program Response

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.

9. Procurement Practices

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 supplies are available to satisfy demand. Excess inventory should be avoided so funds that could be used to meet other needs are not tied up.

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 VA's 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 procurement 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 and 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 review. The group suggested 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.

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. An 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. An 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 used for maintaining and repairing buildings, equipment, furnishings, utility systems, and grounds 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.

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.

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 that the contracting officer should negotiate reductions of over $2 million to the proposed contract costs.

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.

VA's Program Response

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 Task Force. This work group was formed in July 2001 and was tasked to look into similar procurement issues.

Inventory Management

Inventory management problems noted in two OIG reports 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. An Information Letter (IL) 17-01-01 to address one recommendation in OIG report, *Audit of VAMC Management of Engineering Supply Inventories* (Report No. 99-00192-65), and an amendment to VHA Handbook 1761.2 to address four recommendations in OIG report, *Audit of VAMC Management of Pharmaceutical Inventories* (Report 99-00186-86), are currently in concurrence.

Government Purchase Card Use

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" that is found in OIG report *Audit of VA's Purchase Card Program (*Report No. 9R3-E99-037). VHA requirements have been provided to the coreFLS analysts at 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 the 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

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

VHA has implemented all but one of the recommendations from the June 1997 report, *Audit of Internal Controls over the Fee-Basis Program.* 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

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 workforce, there are also significant dollar outlays associated with addressing this challenge effectively. GAO has also identified strategic HCM as a Governmentwide "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."

- 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...."

- 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."

- 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 workforce. 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.

VBA Claims Processing

The 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 increase in funding to pay for 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 Employee 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 its 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 Combined Audit Program (CAP) reviews.

VA's Program Response

VHA Nurses

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.

In response to this challenge, the Department established the Office of Workforce Planning in FY 2001 in order to devote full-time resources to developing and implementing a comprehensive workforce planning initiative that will enable VA to remain a competitive employer and provider of quality services to America's veterans. As part of this initiative, VA developed a Departmental

Workforce Analysis and 5-Year Restructuring Plan that details demographics, skill assessments, human capital challenges and accomplishments, and strategies that demonstrate VA's commitment to becoming more citizen-centered.

In order to address VA's human capital challenges, we have developed the Department of Veterans Affairs Workforce and Succession Plan. This plan articulates VA's corporate vision for workforce and succession planning and identifies specific strategies to address recruitment, retention, and development issues.

VBA Claims Processing

In response to the challenges in the areas of claims processing and succession planning, VBA has undertaken a number of initiatives designed to build human capital across the organization. A highly successful multi-year nationwide recruitment program yielded over 2,000 entry-level employees primarily in the Compensation and Pension business line. The influx of new employees in advance of expected high retirement levels among senior employees has ensured adequate time for skills development and knowledge transfer through training and mentoring. To support training and mentoring programs, VBA has obtained a regulatory flexibility from the Office of Personnel Management allowing reemployment of experienced retirees without reduction in their annuities. This initiative has reduced the need to move experienced employees into training roles from direct claims work. A third approach involved a study (begun summer 2001) to develop a system of leadership competencies for use in selection, development and succession planning for executive, mid-level management, and first-line supervisory positions. Initiatives involving VBA's human resources capacity included a 2001 contractor study of the human resources function, structure, and alignment; and week-long training conferences for the entire VBA human resources community in August 2000 and 2002. Finally, the annual Directors' Conference in September 2001 focused on "High Performance in Leadership Development," through a week-long program of learning, discussion, and study of recruitment, change management, information technology, development, succession planning, performance management, employee satisfaction, and recruitment.

A Training Task Team convened to respond to the 13 Task Force recommendations and recently briefed VBA management on a series of findings and action recommendations. The team's recommendations were divided into five categories: evaluating current training; instructor selection and certification; establishing skill competency and job certification criteria; delivering training; and structure. The Office of Employee Development and Training (ED&T) completed milestones in several of the categories. These include completion of an assessment of previous training, establishment of an instructor certification process and the training of a first class of instructors, and completion of a design plan for broadcasting capability at the Veterans Benefits Academy. Milestones completed by the Compensation and Pension Service and ED&T include submission of proposed organization structures for training and a schedule to review the skill requirements and competencies for each grade level within the VSR and RVSR job series, which will establish the foundation for a training plan for each employee.

VBA successfully concluded an 18-month SES Candidate Development Program for 16 new senior leaders. The program was endorsed by the U.S. Office of Personnel Management and was adopted by the Department as the framework for a departmentwide program announced late in 2001. Completion of a systematic path of leadership training continues. VBA led a VA-wide team to produce an Assistant Director Development Program.

Management Challenges Identified by the General Accounting Office

1. Access to Quality Health Care

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, 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. For the period October 1, 2000 through September 30, 2001, a total of 67 community-based outpatient clinics (CBOCs) were opened across the country to maintain the emphasis on outpatient primary care. VHA has also placed a high priority on full implementation of telephone access to care (nurse advisor). In FY 2001, all but one VISN achieved full Network-wide implementation of this important facet of access. The remaining VISN plans to provide "24/7" telephone care by March 2002.

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 (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 with the quality of their health care.

Quality and Patient Safety

Quality management leadership at all levels has been strengthened. The Office of Quality and Performance is now fully staffed. Network Quality Management program personnel qualifications, responsibilities, and functions have been clearly delineated in standardized position descriptions and consistent position titles.

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

VHA's establishment of the National Center for Patient Safety (NCPS) and national training on the principles of root-cause analysis represent an

aggressive response to previous concerns. The focus that NCPS has placed on the issue of patient safety and on resolving long-time patient vulnerabilities provides sentinel capabilities toward making sure that VA patients receive proper care in a safe environment.

In FY 2001, VHA met the performance goal for having root cause analyses in a correct format and completed within the appropriate time (45 days). Timeliness is important, because the longer it takes to complete an RCA, the longer it is before preventive corrective actions can be implemented. In FY 2002, to continue emphasizing new methods in ensuring patient safety, this performance measure will be replaced with one that will measure the success of implementing bar code medication administration.

VHA achieved its goal of providing 20 hours of continuing education on patient safety to front-line providers of patient care. This goal, included in each Network director's performance standards, was achieved through satellite video and computer-based self-teaching modalities, which maximized cost effectiveness.

Treating Veterans with Special Disabilities

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). Similarly, 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. Performance in FY 2001 was 98 percent.

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 illnesses. P.L.104-262 also required the publication of data in an annual report (the "Capacity Report") to Congress demonstrating VA's compliance with the provisions of this mandate.

On November 2, 2000, a coordinator for special disabilities was appointed by the Under Secretary in response to a General Accounting Office recommendation to:

- Address underlying dissatisfaction from stakeholders and oversight groups with VA's annual Eligibility Reform report to Congress.

- Structure and develop a rational, viable action plan to improve database accuracy and nationwide reporting consistency for special disability patient care, staffing and demographic data for inclusion in the OIG's annual report to Congress.

In addition, in May 2001, the FY 2000 Capacity Report was published in a new narrative format designed to place the accountability for interpretation of data for each special disability with program officials in VHA and their clinical service chiefs in the field. Data table formats remained the same to maintain continuity between FY 1996 (the year required by Congress) and FY 2000.

In July 2001, eight work groups representing each special disability category were created, co-chaired by a VISN clinical manager and a Patient Care Services Program director/Strategic Health Group chief consultant. Work groups are responsible for explaining the reason for incomplete data capture

in VHA databases regarding clinical care provided for special disability patients.

General Findings and Conclusions - Capacity Report 2000

Nationwide capacity has been maintained or improved for workload measures in seven of eight specialties. Analysis of Allocation Resource Center (ARC) data from all VISNs shows evidence of a wide variation in capacity for special disabilities among VISNs.

- VHA's corporate database from FY 1996 to FY 2000 published by ARC is not considered to be accurate by certain VSOs and VA's federal advisory committees. The data for mental health specialties, especially substance abuse, is considered to be incomplete and reflects negatively upon these high-volume, high-cost specialties.

- Significant advances in data-gathering and recording processes since September 30, 2000, have substantially improved the validity of capacity data (beds and FTE) for the Spinal Cord Injury and Disorders (SCI&D) program.

- However, in other specialties, the implementation of VHA policies, current definitions, and "counting rules" for workload makes it difficult to ensure that special disability patient care data are correctly and uniformly entered into local hospital/clinic databases.

- More work is needed to better capture data on special disability patients. Patient Care Services is actively working with clinical managers to preclude this problem.

Positive Actions and Accomplishments Since the Last Capacity Report

- The Paralyzed Veterans of America (PVA), in general, has expressed satisfaction with the effectiveness of programmatic directives from the Under Secretary for Health and the compliance of field sites with the directives. Stakeholders such as the PVA have worked closely with VHA during the past year to improve the accuracy of Spinal Cord Injury data submitted from the SCI&D program using a joint VHA/PVA survey.

- For all other programs except Substance Abuse, VHA can document that it has maintained or improved its workload capacity for its special disability programs. For example, a decrease in amputation rates indicates more aggressive treatment and better preventive care for veterans.

- Appointment of a clinical coordinator in Patient Care Services has created a new dialogue and a bi-directional information exchange between VISN clinical managers and VA Central Office to identify the causes of data differences among and within VISNs.

- VHA has issued policy establishing centralized review of proposed changes in mental health and SCI&D programs in the field. This has markedly improved oversight of these special disability programs by the national program offices as well as the accuracy of available information.

Shifting Health Care Needs and Workforce Issues

Substantial planning, effort, and resources will be required as VA positions itself to meet the increasing health care needs of the expanding population of elderly veterans. As noted, the population projections emphasize our demographic

imperative. According to the Long-Term Care Planning Model, the enrolled population over age 85 will triple between fiscal years 2000 and 2010.

As authorized in PL 106-117, VA is conducting a 3-year pilot study of assisted living for veterans. The pilot site, selected through a competitive process, includes the four states within VISN 20, Pacific Northwest. A report on the outcomes of the pilot will be prepared for Congress in 2004.

VA officials estimate that as much as 6.6 percent of its health care enrollees are infected with the hepatitis C virus. This rate is three times higher than 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. In addition, VA adopted appropriate performance measures for screening and testing patients evaluated for risk factors for hepatitis C.

In response to concerns about a national nursing shortage, VA is engaged in multiple efforts to assess the adequacy of its current nursing workforce and plan for the future. Recent legislation authorizing higher salaries for VA nurses could help in these efforts. The Nursing Workforce Planning Group (whose members include representative nurses from a variety of roles, a Nurses Organization of Veterans Affairs representative, labor partners, hospital administrators and human resources experts) completed a report that examines the impact of the nursing shortage on VA and current barriers to VA medical center recruitment and retention of nurses in a competitive marketplace. The report contains a reference guide for the optimal use of current hiring and pay authorities and also makes recommendations for both legislative and non-legislative initiatives to address the nursing shortage.

VHA employs a diverse and knowledge-based workforce comprised of individuals with a broad spectrum of technical and program skills and institutional memory; a large proportion of this workforce is reaching retirement age. VHA has begun a substantial succession planning effort – encompassing all processes and activities – to ensure that current and future missions are supported by the highest quality workforce. To this end, VHA's Succession Planning Committee has analyzed current and future workforce needs and capacities and recommended actions to address immediate and long-term issues and institute Human Resources strategic planning as an integral component of VHA's annual strategic planning process.

A Web site (http://vaww.va.gov/succession/) was established to allow all VA employees access to information on succession planning in VHA. The site includes the results of a survey on succession planning activities in every VISN and in the Central Office; tools for conducting analyses; information on the Succession Planning Committee; study results; a library of documents; and links to other related sites.

2. Health Care Resource Utilization

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

VA's capital infrastructure has been designed, for the most part, as a "hospital-based" delivery system with a focus on inpatient acute care and supporting services. This configuration no longer reflects VHA's current delivery of care, as VA health care delivery has evolved into an integrated delivery system with greatly expanded outpatient services. The costs to maintain and operate the existing VA capital infrastructure are substantial, diminishing the availability of resources that could be devoted to direct patient care services. Future realignments of VA's capital infrastructure, including contracting for acute hospital care in locations where there is not sufficient workload and establishing new facilities for provision of outpatient care, will yield improved access, efficiencies and service to veterans.

The Capital Asset Realignment for Enhanced Services (CARES) program is designed to assess veteran health care needs in VHA VISNs, identify service delivery options to meet those needs for the future, and develop an associated capital asset realignment plan that ensures the availability of high-quality health care in the most accessible and cost effective manner, while minimizing impacts on staffing and communities and on other VA missions. Through the CARES process, VISNs will develop plans for capital asset restructuring that are based on practices in health care delivery, demographics, strategic plans, and assessments of the existing as well as future capacity of physical plants to deliver accessible, quality health care.

VA also has an on-going infrastructure maintenance program (for VHA it is non-recurring maintenance; while in VBA and NCA it is general operating expense) to address periodic system renovations and replacements. In addition, the Facility Condition Assessment evaluation (approximately 50 percent complete at this time) will provide current information on VHA's physical plant condition. This information will be a valuable tool for medical centers to use in strategic planning for future capital investments.

DoD and VA Cooperation

In FY 2001, President Bush established a top-level VA-DoD Task Force designed to find ways to improve health care in both agencies and to determine the existence of greater opportunities for sharing as well as buttressing a VA mission to serve as primary backup to DoD in times of national emergency. To date, the Task Force has developed a working agenda in response to the President's Executive Order. The Task Force meets monthly and has developed a working agenda in response to the President's Executive Order to identify ways to improve benefits and services, and review barriers and challenges that impede coordination between the Departments. Seven work groups have been formed to review a variety of issues: Benefit Services, Acquisition and Procurement, Facilities, Information Management/Information Technology, Leadership and Productivity, Pharmaceuticals, and Resources/Budget Process.

Ongoing activities that predate this Executive Order include:

- The Persian Gulf Veterans Coordinating Board was established in January 1994 under the authority of United States Code (U.S.C.) Title 31, section 1535. This Board has established three subgroups – focusing on research, clinical issues, and disability compensation.

- The Military and Veterans Health Coordinating Board (MVHCB) was established in December 1999, with three working groups – focusing on research, health and health risk communications. The second work group is tasked with monitoring and coordinating interagency activities related to force health protection and medical surveillance. The last of these has developed a public-academic partnership with The George Washington University and the Centers for Disease Control and Prevention, which are in the forefront of disseminating needed information regarding anthrax and other biological contaminants.

- Force Health Protection Initiative: On November 8, 1997, President Clinton directed the "...Departments of Defense and Veterans Administration to create a new Force Health Protection Program...." This initiative has been enfolded in the MVHCB's subgroup described above and will "...provide every soldier, airman and marine with comprehensive, life-long medical record of all illnesses and injuries they suffer, the care and inoculations they receive and their exposure to different hazards."

- Joint Ventures: (a) the New Mexico VA Health Care System partners with the 377th Air Force Medical Treatment Facility in Albuquerque; (b) the El Paso VA Health Care System operates an outpatient facility adjacent to the William Beaumont Army Medical Center; (c) the Mike O'Callaghan Federal Hospital in Las Vegas, Nevada, provides services to both VA and Air Force beneficiaries; (d) Alaska VA Health Care System and Anchorage Regional Office and the 3rd Medical Group from Elmendorf Air Force Base (AFB) operate a VA/DoD replacement hospital; (e) Navy and VA occupy an outpatient care facility in Key West, Florida; (f) VA operates an ambulatory care center and leases a psychiatry ward from Tripler AFB in Honolulu, Hawaii. Tripler also provides inpatient medical, surgical and specialty outpatient care for DoD and VA beneficiaries while VA's Center for Aging provides both with long-term care, rehabilitation and home-based primary care. In addition, an enhanced-use lease with US Vets provides shelter and programs for homeless veterans at Barber's Point Naval Station (which VA obtained through DoD's Base Closure Program); and (g) in Fairfield, California, Travis AFB provides care to VA inpatients and provides same-day surgery within the David Grant Medical Center. The Air Force also provides outpatient specialty and ancillary support services. VA was leasing outpatient space until late 2000 when it opened its own outpatient clinic. The Air Force also operates two TRICARE satellite clinics in the Sacramento area, both of which are located in VA facilities.

- VA/DoD Medical Research: Historically this program has supported biomedical research for a wide variety of health problems experienced by active duty and veteran military personnel. The currently funded collaborative research program includes a multi-site clinical study exploring the epidemiology of amyotropic lateral sclerosis (Lou Gehrig's Disease) among Persian Gulf Veterans, as well as other studies.

- Health Information Management and Technology: Chief Information Officers from the Military Health System and VHA meet on

a continuing basis to explore, assess, develop, and monitor sharing initiatives. Both CIOs are members of and report to the VHA/DoD Executive Council. These officers are also engaged in a host of other interagency efforts.

- Other sharing activities: (1) the Army established an infirmary service at the VAMC in Richmond, Virginia; (2) the 81st Army Reserve Regional Support Command has negotiated regional agreements with more than one-third of VHA's VISNs to provide physical examinations, dental screenings and immunizations to reservists; (3) the Military Medical Support Office in Great Lakes, Illinois, assumed responsibility for managing the Remote Dental Program for Air Force, Army, Navy, Marines and Air National Guard personnel as well as four VISNs' beneficiaries; (4) VHA CBOCs occupy clinic space provided by military facilities in Louisville, and Fort Knox, Kentucky, among other locations (see above); (5) the Walter Reed Army Allergen Extract Laboratory in Washington, D.C. provides delivery of diagnostic and therapeutic allergen extracts to 29 VAMCs and outpatient allergy clinics; (6) VA and TRICARE – by prior agreement, over 71 VAMCs utilize funds generated by TRICARE patients to help provide benefits to VA beneficiaries, and VA has signed agreements with all 5 TRICARE mental health subcontractors; (7) there are over 155 VA/DoD agreements involving education and training support to DoD units and reservists.

Third-Party Collections

VA Secretary Principi directed the Under Secretary for Health to develop a revenue cycle improvement plan. The plan describes the vision of the VHA Revenue Program, outlines an action plan for improved performance, and defines performance measures and goals that stress standardization of policy, technology, data capture, measurement, training and education, accountability, and achievement. This plan also outlines recommended actions required to improve the core business processes of the revenue cycle. These action items fall within five process areas: Patient Intake, Documentation, Coding, Billing, and Accounts Receivable.

The Revenue Enhancement Work Group and Steering Committee have identified 24 major recommendations that require action in order to bring VHA's revenue operation to the next level of success in improving collections. VHA will actively and aggressively monitor these identified areas to ensure that all possible areas of improvement have been achieved. VHA will take prompt action to provide assistance to any Network or medical center that is not performing consistent with these expectations. Based on the collection performance experienced in FY 2001, with collections totaling over $770 million, we anticipate being able to meet or exceed the collection estimate of $1.05 billion in FY 2002.

3. Compensation and Pension Claims Processing

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

VBA is currently addressing the Compensation and Pension Claims Processing issues as noted on above response (item number 3), under the challenges identified by VA's Inspector General.

4. Management Capacity

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; and (4) to improve planning, simplify systems, enhance tracking, and focus on accountability. We are on track to implement the new structure with the FY 2004 budget.

Financial Management

In FY 2000, VA again received an unqualified opinion on the consolidated financial statements for FY 2000 and 1999. In addition, VA continued to make substantial progress in correcting material internal control and other management and operational controls reported by GAO. The material internal control relating to fund balance with Treasury was removed. VA continued to implement significant improvements in accounting for the Housing Credit Assistance program, which was converted to VA's core financial management system, FMS. In addition, to correct material weaknesses in information technology security, the Secretary is personally setting expectations for improvement at all levels; funding for cyber security initiatives that cross Administrations is beginning. Individual and collective cyber security responsibilities and accountability are being identified and assigned. While major improvements in financial management have been achieved, VA is committed to addressing and correcting the remaining areas identified by GAO.

PERFORMANCE MEASURES

BY ORGANIZATION AND PROGRAM

In addition to VA's key performance goals, there are other performance measures, identified and discussed in the following tables, by which VA evaluates its success. The tables show trend data for a 5-year period and associated target levels of performance grouped by organization and program, including the total amount of resources (number of full-time equivalent employees and obligations) for each program. Within each group, the performance measures are structured as follows:

1. *Target was met or exceeded (green);*

2. *Target was not met, but the deviation did not significantly affect goal achievement (yellow);*

3. *Target was not met, and the difference significantly affected goal achievement (red).*

For each measure that resulted in non-achievement of a performance target (highlighted in red), we provide a brief explanation as to why there was a significant deviation between the actual and planned performance level, and identify what steps are being taken to ensure goal achievement in the future.

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 a balanced family of measures, the specific measures vary somewhat from organization to organization, and thus, from program to program. The performance measures for each organization have been tailored to fit the strategic goals of the programs for which each organization is responsible.

For example, VHA has developed performance measures corresponding to their "6 for 2007" strategic goals:

- put quality first until first in quality;
- provide easy access to medical knowledge, expertise, and care;
- enhance, preserve, and restore patient function;
- exceed patients' expectations;
- maximize resource use to benefit veterans;
- build healthy communities.

VBA has implemented a system of balanced performance measures. This system contains the major service delivery performance measures that mean the most to the veterans we serve, our stakeholders, and our employees:

- timeliness of claims processing;
- accuracy;
- customer satisfaction;
- unit cost;
- employee development.

NCA evaluates its performance in those areas identified by veterans and their family members as being most important to service delivery:

- reasonable access to a burial option in a national or state veterans cemetery;
- quality of service provided;
- satisfaction with the appearance of national cemeteries as national shrines;
- quality and accuracy of headstones, markers, and Presidential Memorial Certificates;
- access to information about burial benefits and services provided.

Taken together, the measures in the following tables and the Department's key measures demonstrate the balanced view of performance VA uses in assessing how well we are doing in meeting our strategic goals, objectives, and performance targets.

The GPRA program activity structure is somewhat different from the program activity structure shown in the program and financing (P&F) schedules of the President's Budget. However, all of the P&F schedules (budget accounts) have been aligned with one or more of our programs to ensure all VA program activities are covered. The program costs (obligations) represent the total resources available for each of the programs, regardless of which organizational element has operational control of the resources. The performance measures and associated data for each major program apply to the entire group of schedules listed for that program.

Veterans Health Administration Performance Measures

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; 36-5014-0-2-703; 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

Resources

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
FTE	186,135	184,768	186,595	183,396	186,832	185,553
Medical care costs ($ in millions)	$17,149	$17,441	$17,859	$19,434	$21,653	$21,685

Performance Measures

					Goal Achieved	
Percent of full-time employees receiving 40 hours of continuing education or training annually; as part of the 40 hours, all front-line providers will have 20 hours directly related to patient safety	N/A	N/A	N/A	74%	77%	50%
Percent of patients who report problems in the following categories regarding their participation in health care decisions:						
- patient involvement in decision-making	N/A	34%	33%	33%	32%	32%
- information on condition / treatment	N/A	37%	37%	36%	35%	35%
Number of VISNs that perform CARES studies seeking to assess and realign the VA health care system in order to provide cost-effective care to veterans	N/A	N/A	N/A	N/A	1	1
Dollars derived from alternative revenue generated from health care cost recoveries	N/A	$560.1M	$573.6M	$572.9M	$771.0M	$675.0M
Increase the number and dollar volume of sharing agreements by 10% over the previous year (Baseline = FY 2000):						
Non-DoD Agreements						
Number	N/A	N/A	N/A	1136	2506	1249
$ Purchased	N/A	N/A	N/A	$290M	$379M	$310M
$ Sold	N/A	N/A	N/A	$32M	$49M	$36M

					Goal Not Achieved - - Minimal Difference	
Implement and maintain patient access to telephone care 7 days a week, 24 hours a day, in all VISNs	N/A	N/A	N/A	N/A	21	22

The performance goal for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Veterans Health Administration Performance Measures

Medical Care (continued)

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
	Goal Not Achieved -- Significant Difference					
Percent of patients who use tobacco products	32%	29%	27%	25%	27%	22%

In FY 2001, Veterans Health Administration (VHA) expanded the sampling methodology to include established patients, defined as having been seen at least once, 12 - 24 months ago, and again within the current year. The previous methodology included only patients who had been seen at least three times in the 12 months prior to the review. The change was made to enable comparison to external measures that require at least two years of continuous enrollment. The baseline using the previous methodology was 25% using tobacco; using the new methodology, the baseline is 30% using tobacco. Those patients seen in VHA at least 3 times in the previous 12 months were less likely to smoke. Although the baseline was recalculated to reflect the more liberal sample and additional smokers, the FY 2001 target of 22% was not changed, thus requiring a reduction of 8% instead of the original 3%. The efforts in tobacco cessation resulted in a 3% decrease nationally. Smoking cessation will continue to be a top priority in preventive measures in FY 2002.

Percent of VA-managed Federal Coordinating Centers that complete at least one NDMS casualty reception exercise every three years	N/A	N/A	50%	66%	63%	70%

Prior to September 11, 2001, efforts to focus attention on VA's responsibilities for contingency support during war or national emergencies were sometimes overshadowed by requirements of other VA missions. Already stretched thin, staffing levels sometimes drove contingency support commitments to a lower priority. As a result, participation in casualty reception and other exercises was not as robust as desired. Nevertheless, while our goal of 70 percent was not fully achieved in our first year of measuring our performance against this target, we did approximate the target by achieving 63 percent and anticipate that this rather ambitious initial target level will be exceeded in FY 2002. No new strategies are as yet planned (although revised planning guidance is being discussed internally) since we are well on our way toward meeting the targeted achievement level of 75 percent in FY 2002.

Increase the number and dollar volume of sharing agreements by 10% over the previous year (Baseline = FY 2000):						
DoD Agreements						
Number	N/A	N/A	N/A	717	604	788
Revenue	N/A	N/A	N/A	$35.4M	$37.7M	$ 38.0M

The decrease in sharing agreements has been due largely to a change in policy at DoD to focus on managed care support TRICARE networks at the expense of direct VAMC-military treatment facility relationships. VA and DoD are attempting to increase sharing activities through the VA-DoD Executive Council, which meets on a regular basis and has work groups developing recommendations in the following areas: information management and technology; clinical practice guidelines; patient safety; pharmacy; medical/surgical supplies; benefits coordination; financial management; geriatric care; and joint facility utilization/resource sharing.

Of those who are Hepatitis C positive and for whom treatment is medically appropriate and desired, percent of patients treated	N/A	N/A	N/A	N/A	Being replaced by new measures in FY 2002	N/A

This measure will be replaced by three new measures in FY 2002. Current viral treatment has significant side effects and is successful only among a minority of patients. Due to the risk-benefit ratio of treatment as compared to supportive care and watchful waiting, many patients have opted to defer therapy or have been unable to tolerate treatment-associated side effects. If and when dramatically improved therapy for treating Hepatitis C becomes available, it is expected that a significantly large number of persons with infection will be treatment candidates and accept treatment. The new measures are: 1) percent of patients screened and/or tested for the risk factors of Hepatitis C; 2) percent of patients tested for Hepatitis C subsequent to a positive Hepatitis C risk factor screening; and 3) percent of patients with Hepatitis C who have annual assessments of liver function.

Percent of C&P transmissions between VBA and VHA that are electronic	N/A	N/A	N/A	N/A	N/A	90%

VHA is continuing to identify the best way to ensure accuracy of counting the number of transmissions and is in discussion with VBA regarding this measure to ensure that double counting or duplicative work is minimized or eliminated.

Veterans Health Administration Performance Measures

Special Emphasis Programs

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
	Goal Achieved					
Percent increase in number of enrolled veterans who have access to home and community-based care when clinically appropriate (2000 baseline = ADC of 14,111)	N/A	N/A	N/A	Baseline	14%	14%
Percent of veterans who acquired independent living at discharge from a Domiciliary Care for Homeless Veterans (DCHV) program or a community-based contract residential care program	N/A	52%	50%	48%	51%	48%
Percent of veterans who obtained employment upon discharge from a DCHV program or a community-based contract residential care program	N/A	54%	55%	51%	51%	51%
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	N/A	64%	64%	63%	63%	63%
Percent of veterans using Vet Centers who report being satisfied with services and say they would recommend the Vet Center to other veterans	N/A	N/A	100%	100%	99%	95%
Percent of hospitalized first admission traumatic brain injury (TBI) patients discharged to the community setting (FY 1997 baseline = 305 patients)	N/A	60%	63%	66%	68%	66%
Blind Rehabilitation - Percent change in functional status from admission to discharge from a blind rehabilitation program or unit	N/A	N/A	N/A	N/A	108%	90%
Amputees (PACT) - Average Length of Stay Efficiency of veterans undergoing rehabilitation for a lower extremity amputation in a medical rehabilitation bed unit	N/A	N/A	N/A	N/A	50%	50%
Percent of prosthetics orders delayed	N/A	2%	2%	1%	1%	2%
Percent of randomly selected admissions from Special Intensive PTSD Programs (SIPPs) that are enrolled in the Outcomes Monitoring program	N/A	N/A	N/A	N/A	85%	65%

Veterans Health Administration Performance Measures

Special Emphasis Programs (continued)

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
	Goal Not Achieved -- Significant Difference					
Percent of spinal cord injury (SCI) respondents to the Performance Analysis Center of Excellence (PACE) Surve who rate their care as very good or excellent - Inpatient	55%	55%	55%	52%	53%	60%

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. Balancing of resources in constrained economic times and dealing with key st shortages in the national health care arena continue to be challenges. Improved staffing to maintain capacity may increase patie satisfaction. VHA will conduct focused review of results and problem scores.

The following recent interventions were initiated: designation of bed and staffing levels as described in VHA Directive 2000-022; 2001, increased staff at SCI Centers (increase full time equivalent of 275 in FY 2001); distribution and implementation of clinical guidelines from the consortium for spinal cord medicine; annual national SCI primary care team training; improvements in the S Registry to improve coordination of care; achievement of CARF (Commission on Accreditation of Rehabilitation Facilities) accre for acute Spinal Cord Injury and Disorders (SCI&D) rehabilitation programs at 19 of 20 SCI Centers; continued identification an translation of best practices in spinal cord injury and disorders by quality enhancement research initiative for spinal cord injury; outreach to patients with SCI&D to increase influenza and pneumococcal vaccinations; distribution of SCI, continuing medical project to enhance primary care knowledge of SCI&D issues; improved access to care within patients' community. Improvement satisfaction scores is anticipated as patients with SCI&D are affected by these initiatives.

Percent of spinal cord injury (SCI) respondents to the Performance Analysis Center of Excellence (PACE) Surve who rate their care as very good or excellent - Outpatient	57%	55%	55%	57%	Not available*	58%

*Due to delays in contract award negotiations, the data for FY 2001 will not be available until the fourth quarter of FY 2002, contingent on the availability of funds.

Medical Education

P&F ID Codes: 36-0160-0-1-703

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
Resources						
Education costs ($ in millions)	$919	$933	$902	$884	$898	$914
Performance Measure						
	Goal Achieved					
Medical residents' and other trainees' scores on a VHA survey assessing their clinical training experiences	N/A	N/A	N/A	N/A	84	81

Veterans Benefits Administration Performance Measures

Compensation and Pension

P&FID Codes: 36-0153-0-1-701; 36-0153-2-1-701; 36-0153-1-1-701; 36-0153-4-1-701; 36-0154-0-1-701; 36-0155-0-1-701; 36-0151-0-1-705; 36-0110-0-1-703; 36-0111-0-1-703

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
Resources						
FTE	6,931	6,770	6,841	7,123	8,035	7,791
Benefits costs ($ in millions)	$19,352	$20,242	$21,112	$22,054	$23,277	$23,389
Administrative costs ($ in millions)	$495	$491	$549	$586	$706	$685
Performance Measures						
Goal Achieved						
Rating-related actions - average days pending	94	119	144	138	182	220
National accuracy rate (authorization work)	N/A	70%	63%	51%	62%	62%
National accuracy rate (fiduciary work)	N/A	51%	48%	60%	68%	65%
Telephone activities - abandoned call rate	9%	13%	9%	6%	6%	7%
Telephone activities - blocked call rate	45%	52%	27%	3%	3%	4%
Fiduciary activities -initial appeals and fiduciary beneficiaries - percent of initial appointments > 45 days	N/A	N/A	N/A	6%	12%	12%
Appeals ratio	N/A	N/A	N/A	N/A	8%	8%
Goal Not Achieved - - Minimal Difference						
Customer orientation (customer satisfaction)	N/A	N/A	N/A	67%	67%	68%
Non-rating actions - average days to process	23	32	44	50	55	54
One VA survey (C&P)	N/A	N/A	N/A	3.3	3.0	3.6

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Goal Not Achieved -- Significant Difference						
Overall satisfaction	58%	57%	57%	56%	56%	60%

This measure is a lagging indicator that reflects our level of timeliness and quality. Although quality improved during the year, timeliness did not. We expect satisfaction to improve as we realize the positive effects of initiatives to reduce claims processing times. For more information see the narrative on timeliness and quality of claims processing.

Non-rating actions - average days pending	56	74	94	84	117	85

Changes in staffing, with new staffing added and experienced staffing promoted from the position, resulted in fewer claims being processed. The loss of production was not off-set by changes made by the C&P Service that reduced the number of income match claims that were added to the pending claims inventory. The added focus given to rating-related cases impacted on these types of claims. It is expected that an increase in staffing experience and time to spend processing claims should result in improved performance.

Veterans Benefits Administration Performance Measures

Compensation and Pension (continued)

The indicators below are the component end-products for the measure on average days to complete rating-related actions. We do not establish separate performance goals for these indicators. For a detailed discussion of rating-related actions timeliness, see the narrative on pages 27-30.

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	Claims Completed in FY 2001
Average days to process rating-related actions	94	128	166	173	181	481,117
Initial disability compensation	133	168	205	212	219	86,549
Initial death compensation/DIC	66	89	111	122	133	19,898
Reopened compensation	101	141	182	189	197	261,583
Initial disability pension	77	94	112	115	130	29,050
Reopened pension	67	88	113	111	126	54,561
Reviews, future exams	41	61	104	108	119	22,252
Reviews, hospital	33	52	73	78	91	7,224

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

Resources

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
FTE	1,051	927	849	781	852	774
Benefits costs ($ in millions)	$914	$891	$1,210	$1,197	$1,387	$1,768
Administrative costs ($ in millions)	$72	$66	$70	$66	$64	$73

Performance Measures

	Goal Achieved					
Compliance survey completion rate	82%	80%	98%	94%	92%	90%
Customer satisfaction-high ratings (Education)	76%	76%	78%	78%	82%	80%
Telephone Activities - Abandoned call rate (Education)	N/A	N/A	N/A	17%	13%	18%
Employee job satisfaction (Education)	56%	N/A	2.8	3.3	3.3	3.3

	Goal Not Achieved -- Significant Difference					
Telephone Activities - Blocked call rate (Education)	45%	60%	16%	39%	45%	30%

There were very high blocked call rates during the early part of the fiscal year due to the higher than normal number of calls. In addition, the St. Paul Overflow call unit was discontinued, effective September 30, 2000, resulting in calls blocked instead of being diverted to St. Paul. Furthermore, equipment limitations in Buffalo added to the problem. The blocked call rate improved toward the middle of the fiscal year. Muskogee is due to get new equipment in fiscal year 2002 which will help. Meanwhile, seasonal employees and Education Service Unit personnel have been answering the phones.

Payment accuracy rate	93%	94%	94%	96%	92%	96%

The backlog and influx of new hires created a sense of urgency in claims processing which caused a deterioration in quality. Further, training and experience will raise the quality level. Continuing improvement in Enrollment Certification Automated Processing will result in fewer errors as more cases are processed without human intervention.

Veterans Benefits Administration Performance Measures

Education (continued)

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
	Goal Not Achieved -- Significant Difference (continued)					
Administrative cost per trainee	N/A	$156	$171	$166	$177	$165

This measure may be higher than desired due to the hiring of 100 new employees. Information Technology (IT) costs were also higher than expected. A redistribution of IT overhead costs will bring our cost per trainee down. We project an increase in trainee counts as more Licensing & Certification and Top-Up claims are received. As trainee counts go up, cost per trainee will go down.

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

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
Resources						
FTE	1,099	919	972	940	1,061	971
Benefits costs ($ in millions)	$402	$406	$412	$439	$427	$419
Administrative costs ($ in millions)	$78	$68	$72	$81	$109	$116
Performance Measures						
	Goal Achieved					
Speed of entitlement decisions in average days	N/A	88	88	78	62	66
Employment timeliness in average days	N/A	83	53	42	38	50
Accuracy of decisions (entitlement)	N/A	N/A	86%	89%	93%	91%
Serious Employment Handicap (SEH) rehabilitation rate	N/A	N/A	49%	62%	64%	63%
	Goal Not Achieved -- Significant Difference					
Accuracy of decisions (services)	N/A	85%	87%	86%	79%	89%

The methodology for performing this quality review changed during FY 2001 after the target was set. The target was not adjusted based on the change in the methodology for conducting the review.

Accuracy of decisions (fiscal)	N/A	N/A	94%	94%	86%	96%

The methodology for performing this quality review changed during FY 2001 after the target was set. The target was not adjusted based on the change in the methodology for conducting the review.

Customer satisfaction (Survey)	N/A	N/A	N/A	76%	76%	80%

At the time the 80% target was set, it was perceived to be a stretch goal. However, many factors such as the hiring of new employees (due to the renewed focus on veterans), the reduction in contract services, and utilization of the annual survey (which was not regional office specific) are key factors that affected this measure.

Veterans Benefits Administration Performance Measures

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

Resources

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
FTE	2,254	2,075	2,108	2,057	1,759	1,827
Benefits costs ($ in millions)	$1,368	$1,676	$1,811	$1,866	$540	$722
Administrative costs ($ in millions)	$139	$161	$160	$157	$162	$162

Performance Measures

Goal Achieved						
Veterans satisfaction	N/A	90%	93%	93%	93%	93%
Property holding time (months)	N/A	N/A	6.7	N/A	8.2	10
Statistical quality index	N/A	N/A	N/A	94%	96%	93%
One VA survey (Housing)	N/A	N/A	N/A	3.3	3.3	3.0
Telephone activity for abandoned calls (Housing)	N/A	N/A	N/A	TBD	4%	5%
Return on investment	97%	99%	101%	N/A	108%	98%
Goal Not Achieved -- Minimal Difference						
Lender satisfaction	N/A	67%	67%	74%	74%	76%
Processing time for eligibility certificates (days)	N/A	N/A	N/A	4.8	7.4	5.0

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

Goal Not Achieved - - Significant Difference						
Administrative cost per loan	$291	$233	$111	N/A	$177	$120

Accurate data were not available for setting the FY 2002 target. The status of unit cost as a measure is under review.

Administrative cost per default	$212	$304	$338	N/A	$351	$340

Accurate data were not available for setting the FY 2002 target. The status of unit cost as a measure is under review.

Telephone activity for blocked calls (Housing)	N/A	N/A	N/A	N/A	15%	5%

Blocked calls were at 14.8% in FY 2001 compared with the plan of 5%. On May 16, 2001, Loan Guaranty Service implemented the Loan Guaranty National Automated Response System (LGY NARS) telephone module. As a result of the implementation, the fiscal year to date Blocked Call Rate fell from 20% to 15%. Although we did not meet our goal of 5% in FY 2001, the Blocked Call Rate from June 2001 has ranged from 2.5% to 3.75%. We anticipate meeting our goal of 4% in FY 2002.

Veterans Benefits Administration Performance Measures

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
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	584	563	548	525	507	523
Benefits costs ($ in millions)	$2,778	$2,687	$2,559	$2,458	$2,534	$2,554
Administrative costs ($ in millions)	$38	$40	$40	$40	$41	$42
Performance Measures						
	Goal Achieved					
High customer ratings (Insurance)	90%	95%	96%	96%	95%	95%
Low customer ratings (Insurance)	5%	2%	1%	2%	2%	2%
Percent of blocked calls (Insurance)	44%	17%	6%	4%	3%	5%
Average hold time in seconds	70	35	20	20	17	20
Percent of insurance disbursements paid accurately	98%	99%	99%	99%	99%	99%
Cost per policy maintained	$9.96	$10.34	$11.25	$11.34	$11.88	$13.00
Cost per death award	$87.55	$88.15	$78.18	$79.45	$83.95	$85.00
Employee skills matrix (Insurance)	N/A	N/A	N/A	N/A	88%	85%
Favorable IG audit opinion (Insurance)	Y	Y	Y	Y	**Y**	Y
	Goal Not Achieved - - Minimal Difference					
Employee satisfaction (Insurance)	N/A	N/A	N/A	3.3	3.3	3.7

The performance goal for this measure was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

National Cemetery Administration Performance Measures

Burial

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

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
FTE	1,283	1,328	1,357	1,399	1,385	1,466
Benefits costs ($ in millions)	$113	$114	$106	$109	$111	$130
Administrative costs ($ in millions):						
Operating costs	$77	$84	$92	$103	$116	$116
State cemetery grants	$5	$6	$5	$19	$24	$40
Capital construction	$19	$79	$21	$30	$33	$37

Performance Measures

Goal Achieved						
Percent of veterans served by a burial option in a national cemetery within a reasonable distance (75 miles) of their residence	N/A	N/A	56.7%	67.5%	66.0%	63.3%
Cumulative number of kiosks installed at national and state veterans cemeteries	2	6	14	24	33	32
Percent of monuments ordered on-line by other federal and state veterans cemeteries using AMAS-R	N/A	N/A	65%	87%	89%	88%
Percent of individual headstone and marker orders transmitted electronically to contractors	68%	85%	88%	89%	92%	91%
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%	95%	95%	97%	97%	97%
Goal Not Achieved -- Significant Difference						
Percent of veterans served by a burial option only in a state veterans cemetery within a reasonable distance (75 miles) of their residence	N/A	N/A	10.3%	5.1%	6.6%	12.5%

VA did not meet the FY 2001 performance goal, which 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 to serve 12.5 percent of veterans with a burial option only in a state veterans cemetery within a reasonable distance of their residence.

Board of Veterans' Appeals Performance Measures

P&F ID Code: 36-0151-0-1-705

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
Resources						
FTE	492	483	478	468	455	480
Administrative costs ($ in millions)	$36	$38	$40	$41	$44	$45
Performance Measures						
	Goal Achieved					
Appeals resolution time (days)	628	686	745	682	595	650
Response time (days)	334	197	195	220	90	202
	Goal Not Achieved -- Minimal Difference					
Deficiency-free decision rate	N/A	89%	84%	86%	87%	90%
Appeals decided per FTE	88.1	80.5	78.2	72.7	69.3	71.3
Cost per appeals case	$839	$965	$1,062	$1,219	$1,401	$1,327

The performance goal for these measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance.

	Goal Not Achieved - - Significant Difference					
Court remand rate	64%	58%	65%	61%	97%	55%

The impact of the Veterans' Claims Assistance Act of 2000 was the primary reason why this goal was not met. Cases pending at the Court were remanded to the Board for further remand to the appropriate regional offices in order to ensure claimants' due process rights under the new law. Because of the enormous backlog of cases at the regional offices, the Secretary in April 2001 directed the General Counsel to prepare regulations which would permit the Board to develop evidence of cure procedural defects without a remand. As a result of the Secretary's memorandum, the Board of Veterans' Appeals has been working with VBA, VHA and General Counsel to enable the Board to perform evidence development and not remand cases to the regional offices for development. It is intended that this will speed up the process and provide a decision to the appellant in a shorter period of time. This will fundamentally change how the Board of Veterans' Appeals does business.

Departmental Management Performance Measures

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

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
FTE	2,170	2,216	2,483	2,564	2,674	2,871
Administrative costs ($ in millions)	$281	$327	$357	$416	$449	$473

Performance Measures

Goal Achieved						
Percent of cases using alternate dispute resolution (ADR) techniques	N/A	11%	12%	13%	29%	14%
Number of audit qualifications identified in the auditor's opinion on VA's Consolidated Financial Statements	2	2	0	0	0	0
Percent increase of EC/EDI usage over 1997 base year	N/A	16%	48%	86%	178%	90%
Percent of statutory minimum goals met for small business concerns	N/A	36%	37%	33%	23%	23%
Percent implementation of the Department-wide IT Security Program	N/A	N/A	N/A	N/A	20%	20%
Goal Not Achieved -- Significant Difference						
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	N/A	N/A	75%

The intent of this measure is to develop some measure of satisfaction with VA's planning process among VA's stakeholders. The method for obtaining this data is to survey the participants of VA's Four Corners meetings, which include representatives from VA, Congress, OMB, and veterans service organizations. Because no Four Corners meetings were held in FY 2001, VA has no actual data associated with this target. VA intends to resume its Four Corners meeting in FY 2002 and will collect data from the participants.

Percent of employees who are aware of ADR as an option to address workplace disputes	N/A	N/A	N/A	N/A	28%	50%

The percentage of employees who are aware of ADR as an option is being determined by the percentage of employees who have received ADR/mediation awareness training. Overall, 28 percent of VA employees have received mediation awareness training. It is fully anticipated that these numbers will increase during FY 2002. Currently, 53 percent of new VA employees are receiving ADR/mediation awareness training as part of their employee orientation.

Number of interactive points of contact on VA Web site available to veterans	N/A	N/A	N/A	100	N/A	110

FY 2001 goals were not met due to the implementation of VA's new Inquiry Routing and Information System (IRIS). IRIS quickly routes complaints, inquiries and compliments directly to the concerned office. IRIS also provides the means to quantify the number of such contacts and extract evaluative information. Therefore, this performance goal is no longer needed.

Office of Inspector General Performance Measures

P&F ID Code: 36-0170-0-1-705

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual	FY 2001 Plan
Resources						
FTE	339	322	342	354	370	393
Administrative costs ($ in millions)	$32	$33	$38	$45	$48	$49
Performance Measures						
	Goal Achieved					
Number of indictments, arrests, convictions, and administrative sanctions	395	366	696	938	1,655	1,355
Value of monetary benefits ($ in millions) from:						
- IG investigations	$18	$17	$24	$28	$52	$29
- IG audit and health care inspection reviews	$104	$468	$610	$254	$4,088	$615
	Goal Not Achieved -- Significant Difference					
Number of reports issued	181	171	162	108	136	176

During the year we did a number of exceptionally broad nationwide audits, which produced few reports, although one generated large monetary benefits. In addition, the VA Secretary requested a special VBA fraud review late in the year, which caused us to suspend ongoing projects and refocus resources.

In light of continuing requests by the Secretary to do specific, broad, nationwide reviews that will produce a limited number of reports, we have reassessed our FY 2002 goal and believe that it is still challenging.

Value of monetary benefits (in millions) from:						
- IG contract reviews	$99	$250	$47	$35	$42	$57

It should be noted that the total FY 2001 goal for OIG monetary benefits was $701 (million) from all sources; OIG's achievement was record setting at a total of $4,189 (million) - almost 6 times the original total goal.

More specifically, contract reviews have an inherently cyclical nature, wherein some contracts cover a multi-year period and may have no impact on the year covered by the goal. Most of this work is reactionary in nature, either assigned by the Department or responding to self-disclosures by contractors; consequently OIG has no control over the volume of work that comes in. Consequently, next year we plan to consolidate the sources for the monetary benefits goal.

DEFINITIONS

AAALAC - Association for Assessment and Accreditation of Laboratory Animal Care
An accrediting body that provides oversight for research programs that include animal research. (Medical Research)

Abandoned call rate
Nationwide, the percentage of call attempts for which the caller gets through, but hangs up before talking to a VA representative. (C&P, Education)

Accuracy of decisions (entitlement)
Percent of entitlement determinations completed accurately. Accuracy is determined through case reviews. (VR&E)

Accuracy of decisions (fiscal)
Percent of vendor fiscal transactions and subsistence award transactions that are accurate and consistent with laws and regulations. The measure, calculated by determining the number of completed cases reviewed that were correct compared to the total number of cases reviewed, is expressed as a ratio. (VR&E)

Accuracy of decisions (services)
Percent of cases completed accurately of veterans who receive Chapter 31 (disabled veterans receiving vocational rehabilitation) services and/or educational/vocational counseling benefits under several other benefit chapters. Accuracy of service delivery is expressed as a percent of the highest possible score (100) on cases reviewed. (VR&E)

Administrative cost per default
The average administrative costs of all defaults processed. (Housing)

Administrative cost per loan
Administrative unit cost for each guaranty issued, including direct labor, indirect labor, and non-payroll costs. (Housing)

Administrative cost per trainee
The average annual cost, including direct labor and overhead, to serve an education beneficiary. (Education)

Alternate Revenue Sources
A generic description of revenue over and above VA's yearly Congressional budget appropriation. Examples of these revenues include medical cost recoveries, Medicare, and other sharing revenues including income from fee-for-service payments or third-party payments for care received by veterans covered by a medical insurance policy. (Medical Care)

Appeals decided per FTE
A basic measure of efficiency determined by dividing the number of appeals decided by the total BVA full-time equivalent staff. (BVA)

Appeals resolution time (in days)
The average length of time the Department takes to process an appeal, from the date a claimant files a Notice of Disagreement until a case is resolved, including resolution at a regional office or by a final decision by the Board. (BVA)

Average days to complete education claims
Elapsed time, in days, from receipt of a claim in the regional office to closure of the case by issuing a decision. Original claims are for first-time use of this benefit. Supplemental claims are for any re-enrollment. (Education)

Average days to process insurance disbursements
The weighted composite average processing days for all disbursements, including death claims and applications for policy loans and cash surrenders. (Insurance)

Average days to process non-rating actions
Elapsed time, in days, from receipt of a claim in

the regional office to closure of the case by issuing a decision by a regional office. Non-rating actions include the following types of claims: original death pension, dependency issues, income issues, income verification matches, income verification reports, burial and plot allowances, claims for accrued benefits, and special eligibility determinations. (C&P)

Average days to process rating-related actions
Elapsed time, in days, from receipt of a claim in the regional office to closure of the case by issuing a decision by a regional office. Rating-related actions include the following types of claims: original compensation, original disability pension, original dependency and indemnity compensation (DIC), reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization. (C&P)

Average hold time in seconds
The average length of time (in seconds) that a caller using the toll-free service number waits before being connected to an insurance representative. (Insurance)

Average length of stay efficiency of veterans undergoing rehabilitation for a lower extremity amputation in a medical rehabilitation bed unit
Lower extremity amputations produce significant life changes for a veteran's functional status, and effective rehabilitation intervention represents an opportunity to achieve maximal benefit for the patient. This measure is part of the evaluation of rehabilitative interventions. In the FY 2001 baseline, this measure was based on inpatient medical rehabilitation beds. Beginning in FY 2002, a new measure will be based on the full continuum of rehabilitative care. The new measure expands the patient cohort to include amputees at all facilities, both inpatient and outpatient, across the continuum of care (i.e., includes care outside of a medical care rehabilitation unit). (Medical Care)

Balanced Scorecard/Value Index
The Quality-Access-Satisfaction (QAS)/Cost VALUE 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 VHA Balanced Scorecard provides a framework for translating VHA's 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 identification of areas where the goal is exceeded.

The sources of data for these performance measures 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 and specialty clinics; and wait times to see a provider. The cost element is obligations per unique patient in constant dollars. (Medical Care)

Blocked call rate
Nationwide, the percentage of call attempts for which callers receive a busy signal because all circuits were in use. (C&P, Education)

BVA response time (in days)
A future-oriented timeliness indicator that, based upon BVA's appellate processing rate of the immediately preceding 1-year time frame, projects the time BVA will take to decide a new appeal added to its docket. (BVA)

CARES - Capital Asset Realignment for Enhanced Services
The program to assess veteran health care needs in VHA Networks, 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. (Medical Care)

CDCI II-Chronic Disease Care Index II
The index consists of 23 medical interventions assessing how well VA follows nationally recognized guidelines for 7 high-volume diagnoses. Within each of the seven diagnoses, one to eight medical interventions are measured as follows: (Medical Care)

Diagnosis	Medical Interventions
Ischemic heart disease	Administration of aspirin at most recent outpatient visit Administration of beta-blockers at most recent outpatient visit LDL- C < 130 Prescribing of beta-blockers at discharge (inpatient) Prescribing of aspirin at discharge (inpatient)
Hypertension	BP < 140/90
Chronic obstructive pulmonary disease	Influenza immunization Pneumococcal immunization Percent non-tobacco users
Diabetes mellitus	Visual foot inspection Examination of pedal pulses Foot sensory examination Retinal eye examination Annual Hemoglobin A1c HbA1c < 9.5 BP < 140/90 Lipid profile q2yrs
Major Depressive Disorder	Screening for depression Follow-up for positive screen
Schizophrenia	If on antipsychotic medication, assessed for involuntary movements annually
Tobacco Cessation	Screening for use Counseling x3/yr if tobacco user Percent non-tobacco users

Compliance survey completion rate
The percentage of compliance surveys completed, compared with the number of surveys scheduled at the beginning of the fiscal year. (Education)

Contract disputes electing ADR
The percent of contract dispute matters electing to use Alternate Dispute Resolution (ADR) techniques. ADR techniques refer generally to several formal and informal processes for resolving disputes that do not entail courtroom litigation. (Departmental Management)

Cost per appeals case
A unit decision cost derived by dividing BVA's total obligational authority by the number of decisions. (BVA)

Cost per death award
The average cost of processing a death claim, including appropriate support costs. (Insurance)

Cost per policy maintained
The average cost of maintaining an insurance policy, including all appropriate support costs. (Insurance)

Cumulative number of kiosks installed at national and state veterans cemeteries
The total number of kiosk information centers installed 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 National Cemetery Administration. (Burial)

Customer satisfaction
Percent of veterans who answered "very satisfied" or "somewhat satisfied" when asked about their level of overall satisfaction with vocational rehabilitation and employment services. (VR&E)

Customer satisfaction
Nationally, the percentage of respondents to the education customer satisfaction survey who rated their interactions with VA as "very satisfied" or "somewhat satisfied." (Education)

Decisions containing quality deficiencies
Based on a random sampling of approximately 5 percent of Board decisions, decisions are checked for deficiencies in the following categories: identification of issues, findings of fact, conclusions of law, reasons and bases (or rationale) for preliminary orders, due process, and format. (BVA)

Electronic data transmissions between VBA/VHA
This measure was initiated in September 2000 to track all electronic transmissions between VBA and VHA with the goal of improving the exchange of data related to compensation and pension medical examinations. The tests of measurement methods in FY 2001 found problems with the structure of the measure, so it will be discontinued in FY 2002.

VBA and VHA have initiated other projects to facilitate transmitting electronic data between the two organizations. For example, the Compensation and Pension Records Interchange (CAPRI) application that allows VBA to obtain medical records from VHA was successfully tested in January 2001. In February 2001, VBA and VHA signed a memorandum of understanding to establish a Joint Examination Improvement Office in Nashville, Tennessee, to improve the quality and timeliness of C&P medical examinations. (Medical Care)

Employee job satisfaction
The overall level of job satisfaction, on a five-point scale, expressed by education employees. (Education)

Employee satisfaction
The Insurance Service uses the national *One VA* survey for the purpose of measuring employee satisfaction. The survey, consisting of 100 questions, uses a 5-point scale to measure satisfaction. We include the top three categories as a favorable measure. (Insurance)

Employment timeliness in average days
The average number of days taken from the date the veteran begins Employment Services (job ready) to the date the veteran enters suitable employment. (VR&E)

Fiduciary activities
Nationwide, the percentage of fiduciary initial appointments that require more than 45 days to complete. (C&P)

Foreclosure avoidance through servicing (FATS) ratio
Measures the effectiveness of VA supplemental servicing of defaulted guaranteed loans. The ratio measures the extent to which foreclosures would have been greater had VA not pursued alternatives to foreclosure. (Housing)

Franchise Fund
VA's fund is comprised of six Enterprise Centers that competitively sell common administrative services and products throughout the Federal Government. The Centers' operations are funded solely on a fee-for-service basis. Full cost recovery ensures they are self-sustaining. (Departmental Management)

Headstones and markers that are undamaged and correctly inscribed
This percentage represents the number of headstones and markers that are undamaged and correctly inscribed, divided by the number of headstones and markers ordered. (Burial)

High customer ratings
The percent of insurance customers who rate different aspects of insurance services in the highest two categories, based on a 5-point scale, using data from the insurance customer survey. (Insurance)

Homeless patients with mental illness who receive a follow-up mental health outpatient visit, admission to a Compensated Work Therapy/ Transitional Residence (CWT/TR) or admission to a Psychiatric Residential Rehabilitation Treatment Program (PRRTP) within 30 days of discharge
Operating one of the largest mental health programs in the country, VA provides state-of-the-art diagnosis and treatment to improve the mental and physical functioning of veterans in need of mental health treatment. Care is provided across a broad continuum of inpatient, partial-hospitalization, outpatient, and community facilities. This performance measure tracks the percent of homeless patients with mental health disorders who received follow-up outpatient care related to mental health, admission to a CWT/TR, or admission to a PRRTP within 30 days following discharge from Domiciliary Care for Homeless Veterans (DCHV) or Health Care for Homeless Veterans (HCHV) contract care. (Medical Care)

Indictments, convictions, and administrative sanctions
The results of criminal and administrative investigations conducted in response to allegations or proactive initiatives. (IG)

Individual headstone and marker orders transmitted electronically to contractors
The percent of individual headstone and marker orders that were transmitted to contractors via communication software or Internet e-mail. (Burial)

Inpatients/outpatients rating VA health care service as very good or excellent
This measure reflects the results of VA care and service provided to veterans, based on the Performance Analysis Center of Excellence (PACE) surveys of their experiences during their most recent hospitalization (inpatients) or care received within the previous 2 months (outpatients). In FY 2001, both nationwide and VISN-specific findings for outpatient satisfaction were reported semi-annually. A research team using standard survey methodologies ensures the validity and reliability of the findings. (Medical Care)

Institutional Review Board (IRB) compliance with NCQA accreditation and maintenance, as appropriate, of AAALAC or NRC accreditation or certification
This measure ensures the compliance of research facilities/investigators with regulatory requirements and ensures the safety of research subjects. The IRB is an oversight organization responsible for reviewing and evaluating medical research proposals. (Medical Research)

Low customer ratings
The percent of insurance customers who rate different aspects of insurance services in the lowest two categories, based on a 5-point scale, using data from the insurance customer survey. (Insurance)

Maintain patient access to telephone care 7 days a week, 24 hours a day, in all VISNs
As part of VA's initiative to improve service and access, this performance measure was initiated to identify the number of VISNs that give veterans access to telephone care 7 days a week, 24 hours a day for triage, care, and consultation. The purpose is to provide personalized care when and where it is needed, within certain parameters, and in ways that are creative, innovative, and cost-effective. (Medical Care)

Medical residents' and other trainees' scores on a VHA survey assessing their clinical training experiences
The satisfaction survey for residents and other trainees assists VHA in determining how well VHA is achieving VA's academic mission of providing innovative and high-quality health care training for VA and the Nation. VHA uses the survey results to learn what satisfies residents and other trainees and to target how to improve the clinical training experience. The sources of this data are the responses to a summary question from the Learners' Perceptions Survey. VHA used sound scientific methodologies to develop this survey instrument in order to assure the collection of reliable information. The numerator for this measure is the sum of scores of respondents who indicated they are satisfied with their VA clinical experiences on a scale of 1 to 10. The denominator is the total number of survey respondents. (Medical Education)

Montgomery GI Bill usage rate
The percent of eligible veterans who have ever used their earned benefits. (Education)

Monuments ordered on-line by other federal and state veterans cemeteries using AMAS-R
The percentage represents the number of headstones and markers ordered through NCA's Automated Monument Application System-Redesign (AMAS-R) by other federal (for example, Arlington National Cemetery) and state veterans cemeteries, divided by the total number of headstones and markers ordered by other federal and state veterans cemeteries. (Burial)

National accuracy rate (authorization work)
Nationwide, the percentage of original death pension claims, dependency issues, income issues, income verification matches, income verification reports, burial and plot allowances, claims for

accrued benefits, and special eligibility determinations completed and determined to be technically accurate. The accuracy rate for the Nation is a compilation of the C&P Service's review of the 57 regional offices. (C&P)

National accuracy rate (fiduciary work)
Nationwide, the percentage of field examinations and account audits completed and determined to be technically accurate. The accuracy rate for the Nation is a compilation of the C&P Service's review of the 57 regional offices. (C&P)

National accuracy rate for core rating work
Nationwide, the percentage of original compensation, disability pension, death pension, and DIC claims; reopened compensation and pension claims; and appellate actions completed and determined to be technically accurate. The accuracy rate for the Nation is a compilation of the C&P Service's review of the 57 regional offices. (C&P)

NCQA —National Committee for Quality Assurance
An accrediting body that provides oversight for research programs that include human research. (Medical Research)

Non-rating actions - average days pending
Elapsed time, in days, from date of receipt of a claim (for which work has not been completed) in the regional office to current date. Non-rating actions include the following types of claims: original death pension, dependency issues, income issues, income verification matches, income verification reports, burial and plot allowances, claims for accrued benefits, and special eligibility determinations. (C&P)

NRC — Nuclear Regulatory Commission
A federally sponsored organization responsible for management of radiation hazards, which has oversight in research programs that include radioactive materials. (Medical Research)

Overall satisfaction
This is an index of answers from the annual customer satisfaction survey. The survey assesses the level of satisfaction veterans have with the way their claim is handled by VA and with the service they receive when they contact VA for information. (C&P)

Patients seen within 20 minutes of scheduled appointment at VA health care facilities
Service must be delivered in a timely manner. VA patients with scheduled appointments expect to be seen within a reasonable time of their appointments. This measure reflects the percentage of patients who report being seen in 20 minutes or less. It is derived from the responses to the following question on the annual *National Ambulatory Care Satisfaction Survey*: "How long after the time when your appointment was scheduled to begin did you wait to be seen?" (Medical Care)

Patients who use tobacco products
Smoking remains the single greatest cause of preventable disease in the United States. The smoking program in VHA's Office of Public Health and Environmental Hazards and the National Center for Health Promotion and Disease Prevention is responsible for policy development relating to smoking by patients, employees, and visitors at VA facilities. Activities revolve around developing and disseminating clinical guidelines for smoking cessation and implementing a joint VA-DoD National Smoking Cessation Program. Data obtained through a random sample of the records of patients seen at least once 12-24 months ago and again within the current year (to determine the veteran is an established patient) at one of eight ambulatory care clinics are used to assess the effectiveness of the program. (Medical Care)

Payment accuracy rate
Measures how well decisions reflect payment at the proper rate for the correct period of time. (Education)

Percent change in functional status from admission to discharge from a blind rehabilitation program or unit
The performance index is based on the Historical National Benchmark (HNB) of functional change indicated by the 13 items in the survey instrument. The measurement of functional change is used to determine whether veterans are developing the skills and capabilities that they need to improve the quality of their lives and attain the personal independence and emotional stability that is the goal of the Blind Rehabilitative Service. The index reflects the functional change (in logit units) from pre- to post-rehabilitation that was found in the 2,682 veterans surveyed during the four years of work on the establishment of psychometric properties of the instrument. During this period with data from all blind rehabilitation centers, the average improvement was 1.57 units. This is the denominator, and the numerator is the functional change seen at the blind centers during the reporting period. This computes a percentage of the HNB that is attained. (Medical Care)

Percent increase of EC/EDI usage over 1997 base year
The percent increase in the number of line items ordered through Electronic Data Interchange (EDI) by fiscal year. (Departmental Management)

Percent of full-time employees receiving 40 hours of continuing education or training annually; as part of the 40 hours, all front-line providers will have 20 hours directly related to patient safety
The quality of VHA's service depends on a workforce that understands, believes in, and fulfills the organization's mission and goals. As work processes and organizational needs change, there will be a demand for more multi-skilled individuals who will work in new environments. Rewards will be linked directly to performance measures and organizational goals. Therefore, VHA owes its employees the opportunities to upgrade and/or maintain professional skills and to work in an environment that encourages success. This measure indicates the percent of permanent full-time and part-time VHA employees who meet or exceed the minimum number of hours spent in educational activities or other learning experiences. In FY 2001, employee education emphasized safety training for all front-line providers. (Medical Care)

Percent of insurance disbursements paid accurately
The weighted composite accuracy rate for all disbursements, including death claims, policy loans, and cash surrenders. (Insurance)

Percent of randomly selected admissions from Special Intensive PTSD Programs (SIPPs) that are enrolled in the Outcomes Monitoring program
Patients enrolled in the National PTSD Outcomes Monitoring System are those registered with VHA's Mental Health and Behavioral Sciences Strategic Health Care Group and admitted to the following specialized intensive PTSD programs: Evaluation Brief Treatment PTSD unit, Specialized Inpatient PTSD Program (SIPPS), PTSD Residential program, or a PTSD Day Hospital program. Patients with successful follow-ups are those who have completed a follow-up assessment form, as required for the outcome-monitoring program. (Medical Care)

Percent of spinal cord injury respondents to the Performance Analysis Center of Excellence (PACE) survey who rate their care as very good or excellent

The Spinal Cord Injury and Disorders (SCI&D) program assists veterans with SCI&D to develop the capacities needed to maintain independence, health, and well-being. To accomplish this, the SCI&D program provides rehabilitation, preventive care, sustaining care, and extended care across a continuum. This measure indicates VA's ability to maintain a viable spinal cord injury system providing health care that will receive positive patient evaluations. (Medical Care)

Percent of Veterans Service Standard (VSS) problems reported per patient in the areas of patient education, visit coordination, and pharmacy services

Patient satisfaction with health care services is measured through questions on the National Patient Feedback Survey. The questions involve patient perceptions of patient education, visit coordination, and pharmacy services. Patient education pertains to whether VA healthcare providers give patients understandable answers to their questions and furnish patients with clear explanations of why tests are needed, what the results are, the purpose and side effects of any prescribed medicines, and what to do if problems or symptoms continue or get worse. Visit coordination deals with whether patients are informed of how and when they would find out the results of any test conducted. Pharmacy services pertain to how long patients usually have to wait to get their prescriptions filled, and what patients' overall rating is of VA pharmacy services. (Medical Care)

Percentage of blocked calls

The percentage of call attempts for which callers receive a busy signal because all circuits were in use for the insurance toll-free service number. (Insurance)

Percentage of patients evaluated for the risk factors for Hepatitis C

At the beginning of 2001, responsibility for coordinating the Hepatitis C programs was transferred to the Office of Public Health and Environmental Hazards. This staff's charge was to (1) provide Hepatitis C testing to any veteran who may be at risk; (2) develop an appropriate Hepatitis C risk prevention program; and (3) improve data collection and management, including a proposal to create a new VA Hepatitis C Registry. The registry was to be created to improve how VA tracks the number of patients with Hepatitis C infection, the nature of the care they receive, and the associated workload. (Medical Care)

Presidential Memorial Certificates that are accurately inscribed

A Presidential Memorial Certificate (PMC) conveys to the family of the veteran the gratitude of the Nation for the veteran's service. To convey this gratitude, each certificate must be accurately inscribed. This measure represents the number of PMCs initially sent to the families of deceased veterans that are accurately inscribed, divided by the number of PMCs issued. (Burial)

Prevention Index II
The Prevention Index (PI II) consists of nine medical interventions that measure how well VA follows nationally recognized primary prevention and early detection recommendations for nine diseases or health factors that significantly determine health outcomes. Data contained in the prevention index are estimates of the average percentages of patients receiving appropriate medical interventions for these diseases and health factors. (Medical Care)

Disease/Health Factor	Medical Intervention
Influenza	Influenza vaccination
Pneumococcal pneumonia	Pneumococcal vaccination
Tobacco consumption	Tobacco use screening
Alcohol abuse	Alcohol use screening
Breast cancer	Mammography
Cervical cancer	Cervical cancer screening
Colorectal cancer	Colorectal cancer screening
Prostate cancer	Prostate cancer screening education
Cholesterol levels	Hyperlipidemia screening

Program evaluation
An assessment, through objective measurement and systematic analysis, of the manner and extent to which Federal programs achieve intended outcomes. (Departmental Management)

Property holding time (months)
The average number of months from date of custody of a property to the date of sale of a property acquired due to defaults on VA-guaranteed loans. (Housing)

Proportion of discharges from spinal cord injury (SCI) center bed sections to non-institutional settings
This measure is the percentage of inpatients with SCI who are discharged to non-institutional community living locations from a VA SCI bed section. Excluded from the count are patients with irregular discharges, patients transferred in from institutional care, and patients who have died. Non-institutional community living locations do not include a different hospital, nursing home care unit, state home, domiciliary, or penal institution. (Medical Care)

PTSD - Post Traumatic Stress Disorder
PTSD is an anxiety disorder that can occur following the experience or witnessing of life-threatening events, such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults such as rape. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can be severe enough and last long enough to significantly impair the person's daily life. Common PTSD stressors in veterans include war zone stress (e.g., combat and exposure to mass casualty situations), the crash of a military aircraft, or sexual assault. VA is committed to providing an integrated, comprehensive, and cost-effective continuum of care for veterans with PTSD. (Medical Care)

Rate of delayed prosthetics orders
This measure is important to many veteran service organizations. Enactment of the Veterans Health Care Eligibility Reform Act of 1996, Public Law 104-262, Section 104, eliminated the prohibition on providing prosthetic devices in an ambulatory setting and increased the number of veterans who are eligible for prosthetic devices. It is crucial that the rate of delayed prosthetics orders (that is, orders not placed in five workdays) should not exceed 2 percent of the total workload per month. A 2-percent standard will be maintained despite an expanding workload in FY 2002-2006. The source of the data is the National Prosthetic Delayed Order Report. The data are collected manually on a quarterly basis. The numerator for this target is the total number of delayed prosthetic orders. The denominator is the total number of prosthetic orders received. (Medical Care)

Rating-related actions - average days pending
Elapsed time, in days, from date of receipt of a claim (for which work has not been completed) in the regional office to current date. Rating actions include the following types of claims: original compensation, original disability pension, original DIC, reopened compensation, reopened pension, routine examinations, and reviews due to hospitalization. (C&P)

Rehabilitation rate
The percentage of veterans who acquire and maintain suitable employment and leave the program, compared to the total number leaving the program. For those veterans with disabilities that make employment infeasible, VR&E seeks to assist them to become independent in their daily living. (VR&E)

Remand rate from CAVC to BVA
Percent of decisions entered by the United States Court of Appeals for Veterans Claims (CAVC) that are remanded (returned) to the Board of Veterans' Appeals. (BVA)

Reports issued
Audit, contract review, and health care inspection documents that reflect independent and objective assessments of key operations and programs at VA facilities nationwide. These reports include recommendations for corrective action, cost savings, and/or programmatic improvement of the activities under review. (IG)

Respondents who rate national cemetery appearance as excellent
Using a customer satisfaction survey, NCA measures its success in maintaining cemeteries as national shrines from the customer's perspective. For FY 2001 and subsequent years, NCA 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. The measure for cemetery appearance is the percent of respondents who agree that the overall appearance of the national cemetery is excellent. (Burial)

Respondents who rate the quality of service provided by the national cemeteries as excellent
Using a customer satisfaction survey, NCA measures its success in delivering service with courtesy, compassion, and respect. For FY 2001 and subsequent years, NCA 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. The measure for quality of service is the percent of respondents who agree that the quality of service received from cemetery staff is excellent. (Burial)

Return on investment
The national average on the return on investment (percentage) on properties sold that were acquired due to defaults on a VA-guaranteed loan. It is the amount received for the property (selling price)

divided by the acquisition cost and all subsequent expenditures for improvements, operating, management, and sales expenses. (Housing)

Root Cause Analysis
Patient safety remains of utmost importance to VA. 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 VHA's health care facilities. (Medical Care)

Serious Employment Handicap (SEH) rehabilitation rate
Proportion of all veterans with an SEH who are rehabilitated, compared to all veterans with an SEH who exit a program of services (discontinued or rehabilitated) during the fiscal year. These veterans are also included in the rehabilitation rate. The SEH rehabilitation rate provides additional credit for success in rehabilitating veterans with serious employment handicaps. VR&E Service is targeting veterans with SEH for increased attention and services. (VR&E)

Sharing agreements (Non-DoD and DoD)
Improving coordination of VA and DoD programs and systems is an important purpose of this performance measure. In December 1999, VA and DoD agreed to a Memorandum of Agreement (MOA) to combine their purchasing power to eliminate redundancies. In FY 2001, significant progress was made related to achieving discounts off the lowest VA Federal Supply Schedule (FSS) prices ranging from 0.19 percent to 53.75 percent; converting DoD's Distribution and Purchasing Agreements to FSS for medical/surgical products; and working with 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. (Medical Care)

Speed of entitlement decisions
Average number of days from the time the application is received until the veteran is notified of the entitlement decision. (VR&E)

Statistical quality index
A quality index that reflects the number of correct actions found in Statistical Quality Control reviews, measured as a percentage of total actions reviewed. (Housing)

VA Community-based Outpatient Clinic (CBOC)
A CBOC is a VA-operated, VA-funded, or VA-reimbursed health care facility or site geographically distinct or separate from a parent medical facility. This term encompasses all types of VA outpatient clinics, except hospital-based, independent, and mobile clinics. Satellite and outreach clinics are included as community-based outpatient clinics. (Medical Care)

VA Domiciliary
A VA domiciliary provides comprehensive health and social services in a VA facility for eligible veterans who are ambulatory and do not require the level of care provided in nursing homes. (Medical Care)

VA Hospital
A VA hospital is an institution that is owned, staffed, and operated by VA and whose primary function is to provide inpatient services. Note: Each division of an integrated medical center is counted as a separate hospital. (Medical Care)

VA-managed Federal Coordinating Centers that complete at least one National Disaster Medical System (NDMS) casualty reception exercise every three years

Since disasters are commonplace in today's world, prompt, coordinated response and relief efforts are necessary to reduce morbidity and mortality. As a large integrated health care system with a presence in every state, VA operates a national emergency management program that includes NDMS Federal Coordinating Centers strategically located throughout the country. Emergency preparedness drills and related activities test the effectiveness of existing training programs and capabilities, and keep skills honed for real-life emergency events. This measure provides the percent of VA-managed NDMS Federal Coordinating Centers that complete at least one casualty reception exercise every three years. (Medical Care)

Value of monetary benefits from IG audits

A quantification of funds that could be used more efficiently if management took actions to complete recommendations pertaining to deobligating funds, costs not incurred by implementing recommended improvements, and other savings identified in audit reports. (IG)

Value of monetary benefits from IG contract reviews

The sum of the questioned and unsupported costs, identified in pre-award contract reviews, that the IG recommends be disallowed in negotiations unless additional evidence supporting the costs is provided. (IG)

Value of monetary benefits from IG investigations

Includes court fines, penalties, restitution, civil judgments, and investigative recoveries and savings. (IG)

Veterans served by a burial option within a reasonable distance of their residence

NCA determines the percentage 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. Burial option includes national cemeteries or state veterans cemeteries with space for first interments, whether full-casket or cremain, or both, either in-ground or in columbaria. Reasonable distance means, in most cases, 75 miles; however, for certain sites where historical data exist to demonstrate substantial usage from a greater distance, reasonable distance is defined as that greater distance. 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. (Burial)

Veterans served by a burial option in a national cemetery

The percentage of veterans with reasonable access to a national cemetery with space for first interments, whether full-casket or cremain, or both, either in-ground or in columbaria. Reasonable access means, in most cases, within 75 miles of the veteran's residence. (Burial)

Veterans served by a burial option only in a state veterans cemetery

The percentage of veterans with reasonable access to a state veterans cemetery with space for first interments, whether full-casket or cremain, or both, either in-ground or in columbaria. Reasonable access means, in most cases, within 75 miles of the veteran's residence. (Burial)

Veterans using Vet Centers who report being satisfied with services and saying they would recommend the Vet Center to other veterans

Since 1979, VA has provided counseling services to assist veterans in readjusting to civilian life through a nationwide system of 206 community-

based counseling facilities known as Vet Centers. The Vet Centers were the first VA service program to treat PTSD systematically in returning war veterans. Vet Centers now provide, in a non-hospital community setting, a variety of social services, extensive community outreach and referral activities, psychological assessment, psychological counseling for war-related experiences (including PTSD) and sexual trauma, and family counseling when needed. Initially restricted to Vietnam veterans, current law has extended eligibility for Vet Center services to any veteran who has served in the military in a theater of combat operations or in any area where armed hostility was occurring at the time of the veteran's service. This performance measure tracks the percentage of veterans who respond on the *Vet Center Veteran Satisfaction Survey* that they are satisfied with services and would recommend the Vet Center to other veterans. (Medical Care)

Veterans who obtained employment upon discharge from a Domiciliary Care for Homeless Veterans (DCHV) program or a community-based contract residential care program; Veterans who acquired independent living arrangements at discharge from a Domiciliary Care for Homeless Veterans (DCHV) program or a community-based contract residential care program

VA administers two special programs for homeless veterans: Domiciliary Care for Homeless Veterans (DCHV) and Health Care for Homeless Veterans (HCHV). These programs provide outreach, psychosocial assessments, referrals, residential treatments, and follow-up case management to homeless veterans. The denominator for the homeless/independent living and homeless/employment measures includes all veterans discharged from DCHV programs or HCHV community-based residential treatment programs. The homeless/independent living measure tracks the percentage of these veterans who are discharged directly to independent living in the community. Independent living is defined as residence in one's own apartment, rooms, or house. The homeless/employment measure tracks the percentage of discharged veterans who obtain full-time employment, part-time employment, or therapeutic work opportunities in Veterans Industries at discharge. (Medical Care)

Waiting times for primary care and selected specialty clinic appointments

These performance measures are a major component of VA's initiative to improve service and access. In early 2000, VA implemented software for measuring the average next available clinic appointment time experienced by patients needing a non-urgent 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 measured the actual experience of patients rather than projections based on appointment availability. Further, VHA measures the percent of all patients in primary care and specialty clinics who receive an appointment within 30 days of the desired date. A second, revised version of this software was released January 31, 2001. This version improved the measurement of appointment waiting times for new patients to primary care. (Medical Care)

List of Abbreviations and Acronyms

AAALAC
Association for the Assessment and Accreditation of Laboratory Animal Care

ACSI
American Customer Satisfaction Index

ADR
Alternative Dispute Resolution

AFGE
American Federation of Government Employees

AMAS-R
Automated Monument Application System-Redesign

ARC
Allocation Resources Center

B&O
Beneficiary and Option

BCMA
Bar Code Medication Administration

BDC
Benefits Delivery Center

BOP
Federal Bureau of Prisons

BOSS
Burial Operations Support Systems

BPA
Blanket Purchase Agreement

BRFSS
Behavioral Risk Factor Surveillance System

BVA
Board of Veterans' Appeals

C&P
Compensation and Pension

C&V
Construction and Valuation

CAP
Combined Assessment Program

CAPRI
Compensation and Pension Records Interchange

CARES
Capital Asset Realignment for Enhanced Services

CARF
Rehabilitation Accreditation Commission

CBOC
Community-based Outpatient Clinic

CDC
Centers for Disease Control and Prevention

CDCI II
Chronic Disease Care Index II

CDRH
Center for Devices and Radiological Health

CFO
Chief Financial Officer

CFR
Code of Federal Regulations

CFS
Consolidated Financial Statements

CIO
Chief Information Officer

CMS
Centers for Medicare and Medicaid Services

COLAs
Cost of Living Adjustments

COOP
Continuity of Operations Plan

CoreFLS
Core Financial & Logistics System

COTS
Commercial Off-the-Shelf

CPEP
Compensation and Pension Examination Project

CPRS
Computerized Patient Record System

CWT/TR
Compensated Work Therapy/Transitional Residence

CWT/VI
Compensated Work Therapy/Veterans Industries

DCHV
Domiciliary Care for Homeless Veterans

DEERS
Defense Eligibility and Entitlement Records System

DFAS
Defense Finance and Accounting Service

DIC
Dependency and Indemnity Compensation

DMC
Debt Management Center

DMDC
Defense Manpower Data Center

DMO
Data Management Office

DoD
Department of Defense

DOL
Department of Labor

DOOR
Distribution of Operational Resources

DSS
Decision Support System

EA
Enterprise Architecture

EC/EDI
Electronic Commerce/Electronic Data Interchange

ECAP
Enrollment Certification Automated Processing

EPA
Environmental Protection Agency

EPRP
External Peer Review Program

FAIR Act
Federal Activities Inventory Reform Act

FASAB
Federal Accounting Standards Advisory Board

FASB
Financial Accounting Standards Board

FATS
Foreclosure Avoidance Through Servicing

FDA
Food and Drug Administration

FPDS
Federal Procurement Data System

FECA
Federal Employees' Compensation Act

FERS
Federal Employees' Retirement System

FFMIA
Federal Financial Management Improvement Act

FIFO
First In-First Out

FISCAM
Federal Information System Controls Audit Manual

FMS
Financial Management System

FOIA
Freedom of Information Act

FRP
Federal Response Plan

FSC
Financial Services Center

FSQAS
Financial Systems & Quality Assurance Service

FSS
Federal Supply Schedule

FTE
Full-time Equivalent

FY
Fiscal Year

G2B
Government to Business

G2C
Government to Citizen

G2G
Government to Government

GAAP
Generally Accepted Accounting Principles

GAO
General Accounting Office

GISRA
Government Information Security Reform Act

GMRA
Government Management Reform Act

GPEA
Government Paperwork Elimination Act

GPO
Government Printing Office

GPRA
Government Performance and Results Act

GSA
General Services Administration

HCM
Human Capital Management

HCPCS
Health Care Financing Procedure Code System

HEC
Health Eligibility Center

HEDIS
Health Plan Employer Data Information Set

HHS
Department of Health and Human Services

HIM
Health Information Management

HR LINK$
VA's Integrated Human Resources and Payroll System

HRM
Human Resources Management

IEE
Internal Effectiveness and Efficiency

IFCAP
Integrated Funds Distribution, Control Point Activity, Accounting and Procurement

IG
Inspector General

IL
Information Letter

IOM
Institute of Medicine

IRB
Institutional Review Board

ISMP
Institute for Safe Medication Practices

IT
Information Technology

IVM
Income Verification Match

JCAHO
Joint Commission for the Accreditation of Healthcare Organizations

LDLC
Low Density Lipid Cholesterol

LS&C
Loan Service & Claims

MCCF
Medical Care Collections Fund

MDR
Meta Data Repository

MGIB
Montgomery GI Bill

MMCP
Medicare Managed Care Plans

MOA
Memorandum of Agreement

MOU
Memorandum of Understanding

MPI
Master Patient Index

MVHCB
Military and Veterans Health Coordinating Board

NAGE
National Association of Government Employees

NARS
National Automated Response System

NCA
National Cemetery Administration

NCHS
National Center for Health Statistics

NCPS
National Center for Patient Safety

NCQA
National Committee for Quality Assurance

NDMS
National Disaster Medical System

NHIS
National Health Interview Survey

NHPP
National Health Physics Program

NIH
National Institutes of Health

NOD
Notice of Disagreement

NRC
Nuclear Regulatory Commission

NSLI
National Service Life Insurance

OA&MM
Office of Acquisition and Materiel Management

OCS
Office of Cyber Security

OHRP
Office of Human Research Protections

OIG
Office of Inspector General

OMB
Office of Management and Budget

OPI
Office of Program Integrity

OPM
Office of Personnel Management

OQP
Office of Quality Performance

ORCA
Office of Research Compliance and Assurance

ORD
Office of Research and Development

OSGLI
Office of Service Members' Group Life Insurance

OSHA
Occupational Safety and Health Administration

OWCP
Office of Workers Compensation Program

P&F
Program and Financing

PACE
Performance Analysis Center for Excellence

PACT
Preservation/Amputation Care and Treatment Program

PAID
Personnel Accounting Integrated Data

PCGL
Personal Computer Generated Letter

PI II
Prevention Index II

PIR
Project Initiation Request

PKI
Public Key Infrastructure

PLAN
Property Management Local Area Network

PLOU
Portfolio Loan Oversight Unit

PMC
Presidential Memorial Certificates

PP&E
Property, Plant & Equipment

PRRTP
Psychiatric Residential Rehabilitation Treatment Program

PTF
Patient Treatment File

PTSD
Post Traumatic Stress Disorder

PULSE
Patient User Local Survey Evaluator

PVA
Paralyzed Veterans of America

QA
Quality Assurance

QAS
Quality-Access-Satisfaction

QuIC
Quality Interagency Coordination Taskforce

R&D
Research and Development

RCA
Root Cause Analysis

REPS
Restored Entitlement Program for Survivors

RLC
Regional Loan Centers

RO
Regional Office

RPO
Regional Processing Office

SCGP
State Cemetery Grants Program

SCI
Spinal Cord Injury

SCI&D
Spinal Cord Injury and Disorders

SCI QUERI
Quality Enhancement Research Initiative for Spinal Cord Injury

SDN
Service Delivery Network

S-DVI
Service-Disabled Veterans Insurance

SGLI
Servicemembers' Group Life Insurance

SIPO
Security Infrastructure Protection Office

SIPPs
Special Intensive PTSD Programs

SLMP
Service Loss Mitigation Program

SMC
Strategic Management Council

SQC
Statistical Quality Control

SSA
Social Security Administration

SSN
Social Security Number

STAR
Statistical Technical Accuracy Review

SVES
State Verification and Exchange System

TBI
Traumatic Brain Injury

TIMS
The Imaging Management System

TMC
Travel Management Center

TREASURY
Department of the Treasury (US Treasury)

TRICARE
DoD-Managed Care Support Contract

U.S.C.
United States Code

USGLI
United States Government Life Insurance

VA
Department of Veterans Affairs

VACERT
VA Electronic Education Certification Program

VACOLS
Veterans Appeals Control and Locator System

VAEB
VA Executive Board

VAMC
VA Medical Center

VARO
VA Regional Office

VBA
Veterans Benefits Administration

VCAA
Veterans Claims Assistance Act

VEAP
Veterans Educational Assistance Program

VERA
Veterans Equitable Resource Allocation

VGLI
Veterans' Group Life Insurance

VHA
Veterans Health Administration

VHI
Veterans Health Initiative

VI&I
Veterans' Insurance and Indemnities

VICTARS
Veterans Insurance Claims Tracking and Response System

Vinnie MAC
VA Loan Sales Program

VISN
Veterans' Integrated Service Network

V*ist*A
Veterans Health Information Systems & Technology Architecture

VMLI
Veterans' Mortgage Life Insurance

VR&C
Vocational Rehabilitation and Counseling Service

VR&E
Vocational Rehabilitation and Employment

VRI
Veterans Reopened Insurance

VSLI
Veterans Special Life Insurance

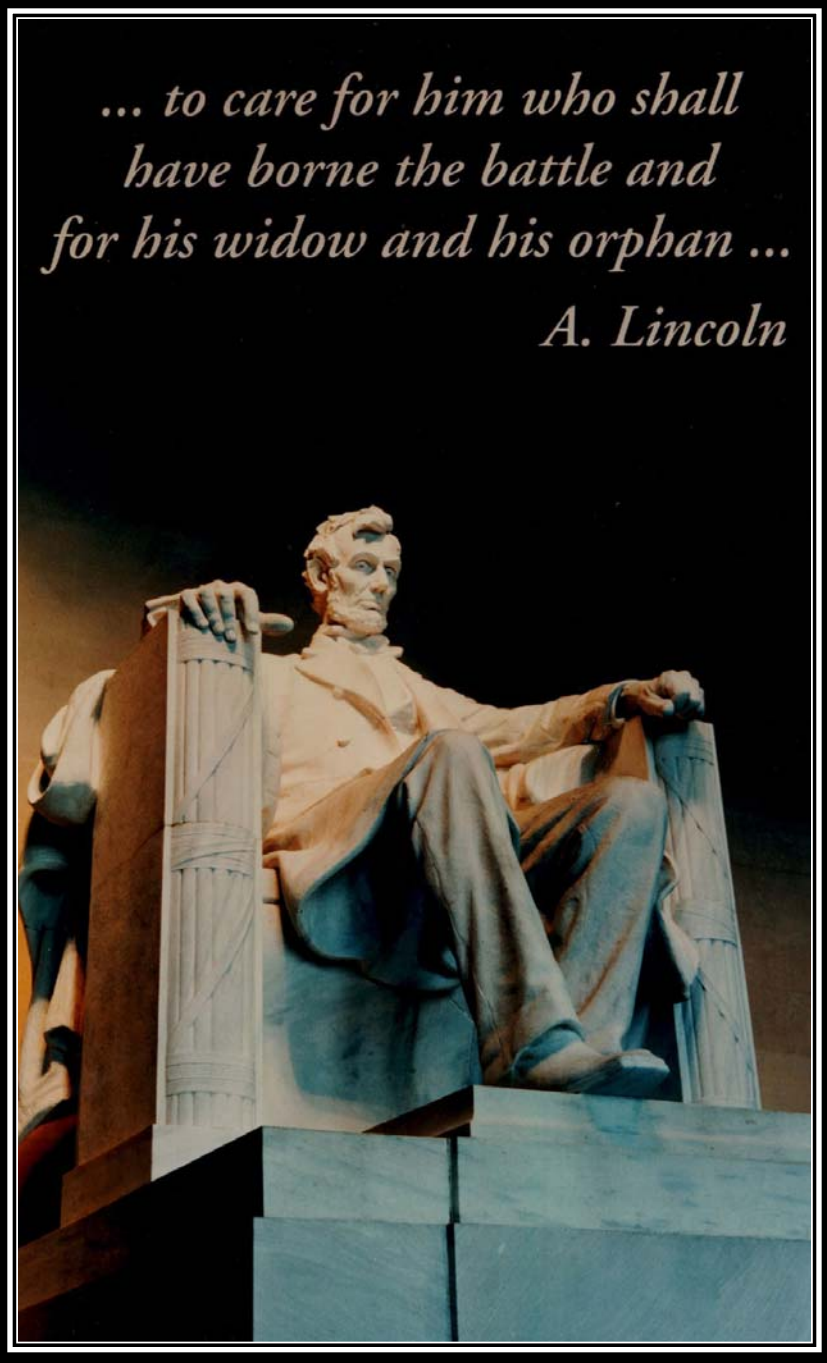
VSR
Veterans Service Representative

VSS
Veterans Service Standard

WAVE
Web Automated Verification of Enrollment

WCP
Workers Compensation Program

WINRS
Waco, Indianapolis, Newark, Roanoke, Seattle VR&E Case Management System



Department of Veterans Affairs
Office of Management
810 Vermont Avenue, NW
Washington, DC 20420

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