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The President of the Senate
The Speaker of the House of Representatives

This report addresses the major performance and management challenges that confront the Department of Veterans Affairs (VA) in carrying out its mission of service to America's veterans and their families. It also addresses corrective actions that VA has taken or initiated on these challenges and further actions that are needed. For many years, we have reported significant management problems at VA. These problems include obsolete infrastructure, poor monitoring of the effects of health service delivery changes on patient outcomes, inadequate data, and ineffective management of non-health-care benefits and management information systems.

VA has made progress in developing a framework for managing and evaluating changes in health care service delivery; however, much more needs to be done. In its restructuring, VA must ensure that it meets its educational and medical missions without compromising efforts to improve efficiency and effectiveness. VA needs to improve the accuracy and reliability of information for measuring the extent to which veterans receive appropriate care, especially veterans with special needs, and have equitable access to care across the country. In managing non-health-care benefits challenges, VA must continue to set results-oriented goals for compensating disabled veterans and develop effective strategies for improving

disability claims processing and vocational rehabilitation. VA must also implement adequate control and accountability mechanisms over its direct loan and loan sales activities as well as institutionalize fundamental changes to its approach to information systems management to ensure that benefits are not disrupted in the year 2000.

This report is part of a special series entitled the Performance and Accountability Series: Major Management Challenges and Program Risks. The series contains separate reports on 20 agencies—one on each of the cabinet departments and on most major independent agencies as well as the U.S. Postal Service. The series also includes a governmentwide report that draws from the agency-specific reports to identify the performance and management challenges requiring attention across the federal government. As a companion volume to this series, GAO is issuing an update to those government operations and programs that its work has identified as "high risk" because of their greater vulnerabilities to waste, fraud, abuse, and mismanagement. High-risk government operations are also identified and discussed in detail in the appropriate performance and accountability series agency reports.

The performance and accountability series was done at the request of the Majority Leader of the House of Representatives, Dick Armey; the Chairman of the House Government Reform Committee, Dan Burton; the Chairman of the House Budget Committee, John Kasich;

the Chairman of the Senate Committee on Governmental Affairs, Fred Thompson; the Chairman of the Senate Budget Committee, Pete Domenici; and Senator Larry Craig. The series was subsequently cosponsored by the Ranking Minority Member of the House Government Reform Committee, Henry A. Waxman; the Ranking Minority Member, Subcommittee on Government Management, Information, and Technology, House Government Reform Committee, Dennis J. Kucinich; Senator Joseph I. Lieberman; and Senator Carl Levin.

Copies of this report series are being sent to the President, the congressional leadership, all other Members of the Congress, the Director of the Office of Management and Budget, the Secretary of Veterans Affairs, and the heads of other major departments and agencies.

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Overview

The Department of Veterans Affairs (VA) is responsible for administering benefits and services that affect the lives of more than 25 million veterans and approximately 44 million members of their families. Through its budget—approximately $43 billion in fiscal year 1999—VA provides an array of health care benefits; non-health-care benefits, such as compensation and pensions; and other supporting programs. Over 200,000 VA employees deliver these services from more than 1,000 facilities. As it administers this diverse group of programs, VA is confronting a number of serious performance and management challenges.

The Challenges

VA Health Care Infrastructure Does Not Meet Current and Future Needs

Many VA facilities are deteriorating, inappropriately configured, or no longer needed because of their age and VA's shift in emphasis from providing specialized inpatient services to providing primary care in an outpatient setting. Despite eliminating about one-half of VA's hospital beds, excess capacity remains.

VA Lacks Adequate Information to Ensure That Veterans Have Access to Needed Health Care Services

VA lacks accurate, reliable, and consistent information for measuring the extent to which (1) veterans are receiving equitable access to care across the country, (2) all veterans enrolled in VA's health care system are receiving the care they need, and (3) VA is maintaining its capacity to care for special populations.

VA Lacks Outcome Measures and Data to Assess Impact of Managed Care Initiatives

VA does not know how its rapid move toward managed care is affecting the health status of veterans because measures of the effects of its service delivery changes on patient outcomes have not been established. Other public and private health care providers have recognized the necessity—and the difficulty—of creating such criteria and instruments.

VA Faces Major Challenges in Managing Non-Health-Care Benefits Programs

In managing non-health-care benefits programs, VA needs to overcome a variety of difficulties. Currently, VA cannot ensure that its veterans' disability compensation benefits are appropriately and equitably distributed because its disability rating schedule does not accurately reflect veterans' economic losses resulting from their disabilities. Also, VA is compensating veterans for diseases that are neither caused nor aggravated by

military service. In addition, claims processing in VA's compensation and pension program continues to be slow, and the vocational rehabilitation program has yielded limited results. Moreover, the data that VA will use to measure compensation and pension program performance are questionable. Furthermore, VA has inadequate control and accountability over the direct loan and loan sales activities within VA's Housing Credit Assistance program.

VA Needs to Manage Its Information Systems More Effectively

VA has made progress in addressing Year 2000 challenges but still has a number of associated issues to address. In addition, VA lacks adequate control and oversight of access to its computer systems and has not yet institutionalized a disciplined process for selecting, controlling, and evaluating information technology investments, as required by the Clinger-Cohen Act.

Progress and Next Steps

As required by the Government Performance and Results Act of 1993, commonly known as the Results Act, VA submitted a strategic plan for fiscal years 1998 to 2003. In this plan, VA developed strategic goals covering all its major programs and included

objectives, strategies, and performance goals to support its strategic goals. VA has made progress in developing a framework for managing and evaluating changes in service delivery. However, there is still much more to do.

In particular, VA must determine whether it will better serve veterans' needs for health care services by repairing, renovating, and maintaining existing buildings or by spending resources directly on patient care. In its restructuring, VA must ensure that it meets its educational and medical missions without compromising efforts to improve efficiency and effectiveness, and it must consider the impact such changes may have on its role in national emergencies. VA must also improve its management information to help it ensure that veterans have equitable access to care across the country, that it maintains its capacity to serve special populations, and that it can meet enrolled veterans' demand for care. Furthermore, VA needs to have clearly understandable, reliable, and consistent information available to its health care managers at all levels to identify and correct negative trends in health outcomes in a timely manner.

In addressing non-health-care benefits challenges, VA must continue to set results-oriented goals, such as whether disabled veterans are being compensated appropriately under the existing disability program. VA must develop effective strategies for resolving its long-term disability claims processing and vocational rehabilitation shortcomings. Also, VA must implement adequate control and accountability over its direct loan and loan sales activities to ensure that the true cost associated with these activities can be measured. Furthermore, VA must implement and institutionalize fundamental changes to its approach to information systems management to ensure that benefits payments and medical care to veterans are not disrupted in the year 2000, unauthorized access to and misuse of VA systems do not occur, and sound information technology investment practices continue.

Major Performance and Management Issues

VA directly touches the lives of millions of veterans and their families every day through its health care and non-health-care benefits programs. VA serves the medical care needs of veterans by providing primary care, specialized care, and related medical and social support services at hundreds of service delivery locations or by purchasing that care from other providers. In addition, VA supports medical education and research and serves as a primary medical backup to other federal agencies during national emergencies. In the last several years, VA has introduced two major initiatives to change the way it manages its approximately $18 billion health care system. In fiscal year 1996, VA decentralized its management structure to form 22 geographically distinct Veterans Integrated Service Networks (VISN) to coordinate the activities of VA's hospitals, outpatient clinics, nursing homes, and other facilities. VA has also been making fundamental changes in the way it delivers health care services by applying managed care practices, such as primary, outpatient, and preventive care, and decreasing its emphasis on providing inpatient care. In addition to providing health care services to veterans, VA provides non-health-care benefits of over $20 billion each year to about 3.3 million veterans, their dependents, and their survivors. The non-health-care

benefits include disability payments, compensation, pensions, and vocational rehabilitation assistance programs that are administered through VA's 58 regional benefits offices.

Over the past several years, our reports and those of VA's Inspector General and others have documented problems with VA's performance in carrying out its complex mission and have identified several management challenges that VA must address. This report highlights some of the serious management challenges that VA must overcome to meet its strategic goals of efficiently and effectively delivering services to veterans and their families. These challenges include an infrastructure that does not meet current and future needs, inadequate information for ensuring that health care services are available to eligible veterans, poor monitoring of the effects of health service delivery changes on patient outcomes, ineffective management of non-health-care benefits programs, disability compensation payments that are inappropriately and inequitably distributed, and ineffective management of information systems.

VA Health Care Infrastructure Does Not Meet Current and Future Needs

Because of their age and recent changes in the way VA delivers health care, many VA facilities are deteriorating, unneeded, or inappropriately configured. As VA shifts its emphasis from providing specialized inpatient services to providing primary care in an outpatient setting, less of VA's existing hospital space is needed. Unneeded vacant space creates a financial drain on VA: maintaining unproductive assets siphons valuable resources away from providing direct medical services. In confronting this challenge, VA needs to make important management decisions about whether and how to maintain, renovate, liquidate, or redirect the use of these buildings and grounds. VA will need to identify services that could be consolidated across its facilities as well as those that could be offered more efficiently by other public and private providers who contract with VA. These decisions must be made in the context of a decreasing population of veterans—one that has a rapidly increasing proportion of members aged 85 and older who will require more intensive services, such as nursing home care. Furthermore, these decisions are likely to affect how VA meets its medical education mission to train physicians and other clinical care providers and will require VA to restructure its affiliation agreements

with medical schools and other institutions. All these decisions will be of critical importance in shaping how VA fulfills its health care role well into the next century.

Many VA Facilities Are Inadequate for Delivering Health Care

Many of VA's facilities—its buildings and grounds—are no longer adequate for efficiently and effectively delivering health care to veterans. Many facilities are poorly configured for the way in which VA delivers health care services today and plans to deliver services in the future. For example, most VA facilities were constructed as hospitals with an array of bed sections, treatment rooms, surgical suites, and other accommodations and equipment for treating an inpatient population. The layout of these facilities is often poorly suited for delivering care to an ambulatory population on an outpatient basis. Although changing care practices and efficiency initiatives, such as emphasizing outpatient care and facility integration, have allowed VA to eliminate approximately half of its 52,000 acute-care hospital beds since 1994, excess capacity remains. Furthermore, the veteran population is declining: VA projects that the number of veterans in the country will drop about 21 percent from 1997 to 2010. We have reported that if past efficiency trends and

demographic projections are realized, VA will need only about 10,000 of its current 26,000 acute-care beds to meet veterans' health care needs in 2010. As a result, VA will likely need to close some facilities.

Meanwhile, VA continues to serve some veterans in aged and deteriorating buildings that will require billions of dollars to renovate or replace in order to meet current industry standards and accommodate changing health care practices. As it considers priorities for renovating or redirecting the use of these buildings, VA should also be planning for the needs of the increasingly older veteran population. As the nation's World War II and Korean War veteran populations age, their health care needs are shifting from acute hospital care to nursing home and other long-term care services. For example, the number of veterans aged 85 and older is projected to increase to about 1.3 million in 2010, a fourfold increase from 1995.

VA's major initiative to integrate various clinical and support operations across some of its facilities recognizes that some facilities cannot meet VA's current and future needs without extensive renovations. For example, we have reported that consolidating services

from four to three locations in the Chicago area could save $6 million to $27 million in future renovation costs. Integrations are also intended to enhance the efficiency and effectiveness of VA's health care delivery system by reducing unnecessary duplication of services. We have reported that the 23 facility integrations involving 48 health care facilities that have been completed or are under way will produce millions of dollars in savings that can be used to enhance veterans' health care. We believe VA needs to identify additional opportunities for integrating facilities. For example, we have reported that if VA closed one of its four hospitals in the Chicago area, it could save $20 million annually and enhance veterans' access to services.

We have also reported, however, that VA's planning and implementation efforts for the integrations it has undertaken have been inadequate. First, in planning integrations VA generally did not conduct comprehensive evaluations thoroughly assessing all potential resources needed to meet the expected workload in a given location over the next 5 to 10 years. As a result of inadequate planning, VA has spent hundreds of millions of dollars over the last decade constructing and renovating inpatient

capacity that is no longer needed. Second, VA has implemented some changes before completing the planning phases and providing detailed integration plans to stakeholders. Third, VA has not used independent planners—that is, planners without vested interests in the geographic area. Consequently, VA has encountered opposition from stakeholders such as veterans, facility personnel, affiliated medical school personnel, and Members of the Congress who represent these groups when it proposed facility integrations. However, VA has recently developed a guidebook for planners to use in developing, implementing, and evaluating potential facility integrations. While this is a step forward, VA needs to apply this framework and evaluate its effectiveness in saving resources for both the short and the long term.

One additional factor that may affect the need for continued use of some VA facilities is the expanded authority to contract for health care services that the Congress provided VA in 1996. Under this authority, VA can contract with public or private providers, who can provide care at lower cost or care that VA does not offer in a particular geographic location. To the extent

that VA uses this authority, it may create additional excess capacity in existing facilities. VA needs to determine whether it will better serve veterans by repairing, renovating, and maintaining existing buildings or by spending resources directly on patient care—for example, by contracting for that care with other providers. In making its decisions and in planning future construction and integrations, VA has the opportunity to dramatically reshape its delivery system to meet the changing medical and long-term-care needs of its veteran population. VA generally agrees that it must take a comprehensive, long-range approach to planning to help ensure that it efficiently and effectively meets the needs of veterans in the future.

Infrastructure Changes Are Complicated by VA's Medical School Affiliations, Research Activities, and Emergency Backup Role

VA's restructuring efforts, particularly integrating administrative and clinical services across two or more medical centers, are complicated by affiliation agreements that VA facilities have with medical schools and agreements with federal agencies regarding VA's role in national emergencies. VA has met its education mission by forging close relationships with medical schools. Since VA's medical education program began in 1946, 130 VA medical centers have

affiliated with 105 medical schools to provide training opportunities for medical students and residents. Today, about 70 percent of all physicians employed by VA hold faculty appointments at these schools. In addition, over 100,000 health professionals from more than 1,000 educational institutions receive clinical experience in VA medical centers each year. VA management decisions about infrastructure affect not only affiliation agreements with medical schools but also VA's responsibility to support the nation's medical needs during national emergencies.

Currently, most VA medical centers are affiliated with a single, nearby medical school, making it easy for students, residents, faculty, and researchers to fulfill their obligations. Transforming VA's health care delivery system from an inpatient to an outpatient focus, increasing reliance on primary care, and integrating services in fewer hospitals are all causing VA and medical schools to rethink their affiliation arrangements. As medical services are eliminated or transferred from one VA facility to another to improve program efficiencies, educational opportunities available in VA facilities will change, which is likely to affect VA medical center affiliation agreements with

medical schools. For example, instead of continuing inpatient surgery and intensive care at both the Montgomery and Tuskegee medical centers, VA removed these services from Tuskegee and consolidated them at Montgomery, which is 35 miles away. In addition, because VA is shifting its emphasis from specialized care to primary care, it has begun to change the mix of training opportunities for medical residents. VA's goal is to offer 48 percent of its medical resident training slots to primary care physicians by the year 2000—an increase of 20 percent from fiscal year 1997. Furthermore, between fiscal years 1996 and 2000, VA plans to reduce the number of medical residents in specialist training by 1,000 (18 percent) by reallocating 750 specialty slots to primary care and eliminating 250 others. Although some medical schools, such as those in the Chicago area, have raised numerous concerns about potential VA integrations, it seems inevitable that more than one medical school will need to share inpatient educational and research opportunities at a single VA facility. VA must work with the medical schools to ensure it meets its educational and medical missions without compromising efforts to improve its efficiency and effectiveness.

Since 1982, VA has served as the primary medical system backup to the Department of Defense (DOD). VA also works with the Federal Emergency Management Agency and the National Disaster Medical System during national emergencies. For example, as DOD's backup, VA has agreed to make beds available in case of war or other military need. The integration of facilities' administrative functions, the consolidation of medical services in fewer VA locations, and VA's reduced reliance on providing specialized care may alter the way VA is able to support DOD and the federal emergency and disaster systems. VA has identified DOD and others as stakeholders that are to be involved in its planning process but has not specified the steps it will take to ensure that its plans for restructuring health care delivery consider the impact such changes may have on its role in national emergencies.

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VA Lacks Adequate Information to Ensure That Veterans Have Access to Needed Health Care Services

Because VA lacks accurate, reliable, and consistent information on how resources are being allocated, it cannot ensure that veterans are receiving equitable access to care across the country. VA has also been unable to ensure that veterans in need of costly specialized treatment and rehabilitative services have access to such care. Finally, VA has not developed information that would enable it to ensure that it meets the increased demand for care generated by its new enrollment process.

VA Does Not Know Whether Veterans Have Equitable Access to Care

VA cannot ensure that veterans who have similar economic status and eligibility priority and who are eligible for medical care have similar access to care regardless of the region of the country in which they live, as required by the Congress. The Congress was concerned that the dramatic shift in the veteran population from the Northeast and Midwest to the South and West had occurred without a corresponding shift in VA health care resources. In fiscal year 1997, therefore, VA introduced a new resource allocation system to begin to correct historical inequities in allocating resources, with the intent of improving the equity of veterans' access to care. Instead of allocating resources directly to medical centers on the

basis of their budget for the previous year, VA now allocates funds to its 22 VISNs. A key factor in these allocations is the number of veterans each VISN has served. VISNs, in turn, allocate resources to the facilities in their geographic area.

We have reported that while the new method has indeed improved the equity of resource distribution among VISNs, VA does not know if it is making progress in providing similar services to similarly situated veterans. VA's strategic plan does not include a goal for achieving equitable access, and VA does not monitor the extent to which equitable access is being achieved among or within VISNs. Instead, VA has focused its efforts on increasing access generally—apparently expecting this to lead to more equitable access sometime in the future. Furthermore, we have reported that VA headquarters neither provides criteria for VISNs to use to equitably allocate resources nor reviews VISNs' allocations for equity. Although VA has made progress in improving the equity of resource allocations nationwide among the networks, it has done little to ensure that when networks allocate funds to their facilities, the promise of the new system is fulfilled. Although VA told us that having national indicators to monitor improvements

in equitable access was contrary to its philosophy of decentralizing authority and accountability, we have reported that VA could use such indicators without being so prescriptive that local authority and accountability were compromised. For example, VA has already used performance measures based on national criteria to hold VISN directors accountable for achieving national goals.

We have also reported that VA's data for measuring changes in access are seriously flawed because different measures are used for the same indicator, users do not clearly understand the measures, and obtaining the same measure over time for comparison purposes can be difficult. As a result, VA does not know whether changes in resource distribution from its new allocation method and other initiatives to improve access (for example, emphasizing primary care in existing medical centers and expanding the number of community-based outpatient clinics throughout the country) are equalizing access nationwide. VA does not know whether additional changes in resource allocation, strategic planning, or management decisionmaking are needed to ensure more equitable access. Without accurate, reliable, and consistent

information on changes in the equity of access, VA does not know whether the number of veterans it has served has increased at the expense of reduced access to services for veterans who have been historically underserved.

VA Cannot Ensure It Has Maintained the Capacity to Serve Special Populations

VA has not been able to adequately address congressional concern that VA maintain its level of certain high-cost specialized services in the face of the many initiatives to become a more efficient provider of care. The Congress required VA to ensure that its capacity for specialized treatment and rehabilitative services for certain conditions was not reduced below October 1996 levels and that veterans with these conditions had reasonable access to care. The Congress identified four disabling conditions requiring specialized care: spinal cord dysfunction, blindness, amputation, and mental illness. VA identified two additional conditions: traumatic brain injury and post-traumatic stress disorder.

We have reported that much more information and analyses are needed to support VA's conclusion that it is maintaining its national capacity to treat special disability groups. For example, VA's data

indicate that from fiscal year 1996 to fiscal year 1997, the number of veterans served increased by 6,000 (or 2 percent), but spending for specialized disability programs decreased by $52 million (or 2 percent). VA attributes the decreased spending to reducing unnecessarily duplicative services and replacing more expensive hospital inpatient treatment with outpatient care. Such aggregate data and assertions may, however, mask potential adverse effects on specific programs and locations. For example, VA data also show that expenditures were reduced for veterans with serious mental illness and post-traumatic stress disorder. In addition, VA data show that about 3,000 fewer substance abuse patients with serious mental illness were served, and $112 million less was spent.

Consistent with the Results Act, VA plans to develop outcome measures to track, among other things, whether the care provided to disabled veterans is effective as a result of VA's shift from inpatient to outpatient care. While this is a step in the right direction, we and two of VA's advisory committees have questioned the accuracy of VA's data for these populations. We have reported difficulties arising from changing definitions for data that make it difficult to establish

baselines for comparison purposes; inaccurate reporting at the local level; and irreconcilable differences among medical center, VISN, and national data. For example, we reported that in its 1997 and 1998 reports to the Congress, VA used different 1996 baseline expenditure capacity data for each of the six special disability programs. VA needs to develop more comprehensive, uniform, accurate, and reliable information on these programs.

VA May Not Be Able to Meet Enrolled Veterans' Demand for Care

VA has not developed information to help ensure that it meets the increased demand for care generated by its new process for enrolling veterans in its health care system. As a result, VA's success in enrolling veterans may jeopardize the availability of care for some veterans. As part of its 1996 eligibility reform legislation, the Congress required VA to develop a priority-based enrollment system to allow VA to better manage access while operating within its budgetary limits. VA has determined that in fiscal year 1999 it will serve each veteran who enrolls and is assigned a primary health care provider regardless of the veteran's priority category. VA projects that by the end of fiscal year 1999, it will have enrolled about 4.4 million veterans. If each of these veterans received

medical services from VA in fiscal year 1999, the percentage of veterans receiving VA care would increase about 47 percent compared with the percentage of those served annually in recent years.

Because enrolled veterans are eligible for all needed hospital and medical care from VA regardless of their priority category, care for higher-priority veterans may be jeopardized as medical centers provide care to all enrollees, including high-income veterans without service-connected conditions. VA does not know how many enrollees will use its services and what services they will need to use. Several challenges result. VA may not have sufficient systemwide funds to serve its enrollees. For example, officials at one medical center told us that they will need at least an additional $5 million in fiscal year 1999 to serve newly enrolled veterans who already numbered 8,000 early in the fiscal year. In addition, VA's allocation process may not be able to distribute funds adequately to ensure that access to care is equitable if VISNs grow at different rates—that is, if the number of veterans VISNs must serve begins to vary widely. Furthermore, veterans' waiting times to get an appointment scheduled or be seen after arriving for an appointment may increase greatly. Finally,

VA's local and systemwide capacity to serve special populations, such as those with spinal cord injuries or amputations, may be reduced because of the sheer number of veterans seeking other services and the cost of providing those services. For example, veterans who do not have pharmacy benefits available from Medicare or private insurers may enroll in VA's system to obtain these benefits, potentially reducing resources available for low-income veterans or those with service-connected conditions. Without knowing the number of enrollees who will use services or the types and amounts of services to be used, VA may be risking the availability of services to veterans with service-connected disabilities and those with low incomes.

VA's authority to retain collections from third-party insurers for care provided to veterans for conditions that are not service-connected could help maintain VA's financial viability. For each of the last 6 fiscal years, VA's financial collections averaged about $544 million, with $560.1 million collected in fiscal year 1998. Increased collections resulting from increased enrollment of privately insured veterans could provide funds to help meet infrastructure and direct care needs. VA has

recently initiated efforts to improve its collections, such as automating the bill collection process. We have reported, however, that VA may have difficulty in achieving its goals for collecting third-party payments for two reasons. First, the number of veterans participating in private managed care organizations is increasing, and such organizations typically do not pay for care delivered outside their plans. In addition, the shift away from costly inpatient services to less costly outpatient care could reduce private insurance recoveries and increase recovery costs. To effectively manage its resources, VA needs to closely monitor and evaluate the impact of its decision to open enrollment to veterans in all priority categories.

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VA Lacks Outcome Measures and Data to Assess Impact of Managed Care Initiatives

VA has made little progress in developing, implementing, and evaluating results-oriented outcome measures to assess the health status of veterans. Instead, VA's efforts to determine how well it delivers health care have relied primarily on process-oriented performance measures. VA needs to ensure that its rapid change toward a managed care system is not adversely affecting the appropriateness of health services provided to veterans.

Responsibility for monitoring quality assurance shifted several times in the last few years among headquarters and VISN offices, and VA's Inspector General and veterans' service organizations raised concerns that VA had weakened its quality assurance efforts with some of these shifts. In response, in fiscal year 1998, VA realigned the Office of Performance and Quality to report directly to the Under Secretary for Health. The realignment has the potential to improve VA's quality assurance efforts because this office is situated to more readily identify emerging challenges across the health care system, implement and oversee local and national corrective actions when needed, and help create the single standard of care required by accrediting agencies.

Providing centralized oversight is an important step, but until recently, VA has made little progress in developing, implementing, and evaluating results-oriented outcome measures to assess the health status of veterans. Instead, VA's efforts to determine how well it delivers health care have relied primarily on process-oriented performance measures. For example, VA has been tracking the number of beds in use, the number of patients served, and the number of patients receiving certain diagnostic tests. Although these measures can provide useful information on progress toward meeting managed care goals, they provide little information on the specific impact of changes on the health status of veterans.

Moreover, although VA has designed one performance measure to assess the functioning of seriously mentally ill patients and another to assess the functioning of patients with a primary diagnosis of substance abuse, VA has generally not performed the program evaluations necessary to determine whether these are the most appropriate or sensitive measures for assessing responses to treatment and changes in health outcomes. The need for such measures is critical, given the multitude

of changes in delivering care that VA has introduced over the last few years. Indeed, the need is exacerbated by the flexibility VISNs and medical centers have in choosing how they deliver care in VA's decentralized management structure. VA recognizes that it needs to ensure that the changes made to improve its efficiency and effectiveness do not unintentionally compromise the health status of veterans. VA is not alone in its need to design, implement, and evaluate health outcome measures. Other public and private providers have recognized the necessity—and the difficulty—of creating such criteria and instruments.

VA's challenges in assessing outcomes are further complicated by poor data. We and others have reported numerous concerns with VA's outcome data. These concerns, which are similar to those with VA's access data, include inconsistent, incompatible, and inaccurate databases; changes in data definitions over time; and lack of timely and useful reporting of information to medical center, VISN, and national program managers. For example, in evaluating VA's fiscal year 1999 performance plan, we reported that VA identified data sources and collection methods for many of its performance measures but provided little information

about how these data would be verified or validated. Given VA's history of data weaknesses, such an omission is potentially quite damaging. Prudent management requires that managers of local programs, VISNs, and national programs have ready access to clearly understandable, reliable, and consistent information in order to identify and correct negative trends in health outcomes in a timely manner.

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VA Faces Major Challenges in Managing Non-Health-Care Benefits Programs

We have reported that VA's current disability rating schedule does not reflect the economic loss experienced by veterans today and may not be equitably distributing disability compensation funds. We have also reported that VA is compensating veterans for diseases that are neither caused nor aggravated by military service, calling into question the fairness of VA's treatment of veterans who were disabled because of their

service. In addition, slow claims processing in the compensation and pension program and lack of program results in the vocational rehabilitation program have been long-standing challenges for VA. Moreover, concerns have been raised recently about the accuracy and reliability of the data VA will use to measure compensation and pension program performance. Furthermore, there is concern about VA's accountability over the direct loan and loan sales activities within VA's Housing Credit Assistance program.

VA Cannot Ensure That Veterans' Disability Compensation Benefits Are Appropriately and Equitably Distributed

VA's largest non-health-care benefits program is disability compensation. Under this program, VA compensates veterans for disabilities incurred or aggravated during their military service. Since fiscal year 1996, cash benefits to veterans and their survivors have steadily increased by about $1 billion annually. In fiscal year 1998, VA received over $17 billion in appropriations to provide benefits to 2.3 million veterans, and VA requested an additional $1.2 billion for fiscal year 1999. VA's disability program is required by law to compensate veterans for the average loss in earning capacity in civilian occupations that results from injuries or conditions incurred or aggravated during

military service. The disability ratings in VA's current schedule are primarily based on physicians' and lawyers' judgments made in 1945 about the effect service-connected conditions had on the average individual's ability to perform jobs requiring manual or physical labor. Although the ratings in the schedule have not changed substantially since 1945, dramatic changes have occurred in the labor market and in society. Advances in the management of disabilities, like medication to control mental illness and computer-aided prosthetic devices that return some functioning to the physically impaired, have helped reduce the severity of the functional loss caused by some mental and physical disabilities. Moreover, electronic communications and assistive technologies, such as synthetic voice systems, standing wheelchairs, and modified automobiles and vans, have given people with certain types of disabilities more independence and potential to work.

In the late 1960s, VA conducted a study of the 1945 version of the schedule to determine whether the schedule constituted an adequate basis for compensating veterans with service-connected conditions. The study concluded that at least some disability ratings in the schedule did not accurately

reflect the average impairment in earning capacity among disabled veterans and needed to be adjusted. Specifically, VA found that of the schedule's approximately 700 diagnostic codes, 330 overestimated veterans' average loss in earnings as a result of their conditions, and about 75 underestimated the average loss among veterans. Despite the results of this study, however, VA has done little to ensure that the schedule's assessments of the economic loss associated with service-connected conditions are accurate. Instead, VA's efforts to maintain the schedule have concentrated on improving the appropriateness, clarity, and accuracy of the descriptions of the conditions. Basing disability ratings at least in part on actual earnings losses rather than solely on physicians' and lawyers' judgments of loss in functional capacity as determined using a rating scale that is over 50 years old would help to ensure that veterans are compensated commensurately with their economic losses and that compensation funds are distributed equitably. Successful implementation of a revised rating schedule to reflect actual earnings losses would likely require congressional action.

In addition to compensating disabled veterans on the basis of a rating schedule

that does not accurately reflect economic losses, according to a 1996 Congressional Budget Office report, VA was paying about 230,000 veterans about $1.1 billion in disability compensation payments annually for diseases or injuries neither caused nor aggravated by military service. VA regulations provide that a disease or injury resulting in disability is considered service-connected if it was incurred during a veteran's military tour of duty or, if incurred before the veteran entered service, was aggravated by service. No causal connection is required between the circumstances of the disability and official military duty. Thus, veterans can receive compensation for diseases related to heredity or life-style, such as heart disease and diabetes, rather than military service. Our 1993 study of five countries showed that most of those countries do not compensate veterans under such circumstances; rather, they require that a disability be closely related to the performance of a military duty for a veteran to qualify for disability benefits. Eliminating disability compensation to those veterans whose disabilities were not clearly caused by their military service could control entitlement spending without penalizing veterans disabled because of their service, but such a change would likely require congressional action.

VA Continues to Face Challenges in Processing Claims and Rehabilitating Disabled Veterans

In 1997, the National Academy of Public Administration reported that the timeliness and quality of adjudication decisions and slow appellate decisions continued to be a major challenge in VA's compensation and pension program. VA reported in fiscal year 1997 that it took an average of 133 days to complete the processing of a veteran's original disability compensation claim. While this is substantially faster than the average of 213 days required in fiscal year 1994, VA's goal is to reduce the average to 53 days in fiscal year 2002. Furthermore, veterans who appeal VA's initial decision may have to wait 2 years or more for a final decision. In addition, VA's vocational rehabilitation program continues to place few disabled veterans in jobs. Our 1996 review of records of about 74,000 applicants for vocational rehabilitation between October 1991 and September 1995, who were classified by VA as eligible for assistance, showed that only 8 percent had completed the vocational rehabilitation process by finding a suitable job and holding it for at least 60 days.

Moreover, VA's Under Secretary for Benefits has raised concerns about the accuracy of VA's existing management reporting systems that will be used for measuring compensation and pension program

performance. In September 1998, VA's Office of Inspector General (OIG) reported on its audit of three key compensation and pension claims processing performance measures. The OIG found that the performance measures lacked integrity because the compensation and pension program's automated information system was vulnerable both to reporting errors and to manipulation of data by regional offices to show better performance than was actually achieved.

VA is implementing a number of initiatives to address its compensation and pension claims processing and vocational rehabilitation performance weaknesses, including establishing performance measures for processing times and unit costs, initiating quality assurance efforts, and reassessing its business process reengineering. VA is in the process of developing results-oriented goals for its compensation, pension, and vocational rehabilitation and counseling programs. Also, VA has developed a results-oriented objective to increase the number of vocational rehabilitation participants who get and keep suitable employment. VA also has plans to review and revise its operations to focus the vocational rehabilitation

program less on training and more on helping veterans get jobs. For example, program applications, brochures, and other forms of written communication will be revised to ensure that they clearly communicate the program's focus on employment.

VA has also begun to address the need to ensure that it has accurate and reliable data for planning and management purposes. It is taking action in response to the OIG's September 1998 report on compensation and pension workload data concerns by (1) collecting and analyzing historical data to identify suspect transactions in the compensation and pension information system and (2) conducting on-site inspections of transaction processing at VA regional benefits offices.

While VA has taken steps toward improving its strategic planning, performance measures, and accountability to improve its non-health-care programs, it has much more to do. VA faces significant challenges in setting clear strategies for achieving the goals it has established and in measuring program performance. For example, VA considers its business process reengineering efforts to be essential to the success of key

performance goals, such as reducing the number of days it takes to process a veteran's disability compensation claim. VA is in the process of reexamining the business process reengineering implementation; at this point, however, it is unclear exactly how VA expects reengineered processes to improve claims processing timeliness. VA is also currently identifying and developing key data it needs to measure its progress in achieving specific goals. At the same time, VA is working to make its data more accurate and reliable with its existing management reporting systems. Until these issues are resolved, veterans and other beneficiaries of VA's non-health-care benefits programs will continue to suffer from slow claims processing and poor customer service.

VA Does Not Have Adequate Control and Accountability Over Its Direct Loan and Loan Sales Activities

VA's Annual Accountability Report, Fiscal Year 1997 described several deficiencies that contributed to VA's receiving a qualified opinion. Among the areas of concern was the level of control and accountability over the direct loan and loan sale activities within VA's Housing Credit Assistance program. Specifically, the auditors were unable to conclude that the $3 billion loans receivable account balance was accurate because of inadequate controls and incomplete records.

In addition, the auditors identified a number of errors, including inaccurate recording of loan sales transactions and improper accounting for loan guarantees.

When VA transferred the servicing of its direct loan portfolio to a contractor in fiscal year 1997, it did not adequately plan the transfer. VA converted only those loans that were fully documented on its legacy system to the contractor's system. Furthermore, once VA shut down its legacy system, it no longer had a centralized automated system to record those loans that were in process. Without such a system, VA transferred responsibility for tracking and recording loans in process to the regional offices. As a result of the contractor's having incomplete records, significant delays occurred in recording new loans in the contractor's accounting records, processing borrowers' loan payments, and paying property taxes and insurance from escrow accounts.

In addition, VA did not appropriately account for or report its loan sale activities. Proceeds from the loan sales were not accurately recorded in the accounting records, and the liability of the loan guarantees was not estimated and reported in accordance with federal accounting standards. Because VA did

not account for its loan sales activities as required under federal accounting standards, the true cost associated with this activity could not be measured.

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VA Needs to Manage Its Information Systems More Effectively

VA faces significant information systems challenges. It does not know the full extent of its health-care-related Year 2000 challenges; it lacks adequate control and oversight of access to its computer systems; and it has not yet institutionalized a disciplined process for selecting, controlling, and evaluating information technology investments, as required by the Clinger-Cohen Act. Failure to adequately address these issues could result in disruptions in benefits payments and medical care to veterans, unauthorized access to and misuse of VA systems, and poor information technology investment practices.

VA could face widespread computer system failures at the turn of the century if its systems cannot adequately distinguish the year 2000 from the year 1900. Thus, veterans who are due to receive benefits and medical care could appear ineligible. VA recognizes the urgency of addressing this issue and has made progress, but challenges remain. For example, VA does not know the full extent of its Year 2000 challenges regarding its health care services. Furthermore, VA has not completed development of its Year 2000 business continuity and contingency plans. Failure to adequately address these issues

could result in disruptions in benefits payments and medical care to millions of veterans and their dependents.

Significant challenges also exist in VA's control and oversight of access to computer systems. For example, VA has not established effective controls to prevent individuals, both internal and external, from gaining unauthorized access to VA systems. VA's access control weaknesses are compounded by ineffective procedures for monitoring and overseeing systems designed to call attention to unusual or suspicious access activities. In addition, VA is not providing adequate physical security for its computer facilities, assigning duties in such a way as to segregate incompatible functions, controlling changes to powerful operating system software, or updating and testing disaster recovery plans to prepare its computer operations to maintain or regain critical functions in emergency situations. VA also does not have a comprehensive computer security planning and management program. If these control weaknesses are not corrected, VA operations, such as financial management, health care delivery, benefits payments, life insurance services, and home mortgage loan guarantees—and the assets

associated with these operations—are at risk of misuse and disruption.

Finally, VA has not yet institutionalized a disciplined process for selecting, controlling, and evaluating information technology investments. Information technology accounted for approximately $1 billion of VA's fiscal year 1999 budget request of $43 billion. At the time of the budget request, VA decisionmakers did not have current and complete information, such as cost, benefit, schedule, risk, and performance data at the project level, which is essential to making sound investment decisions. In addition, VA's process for controlling and evaluating its investment portfolio has deficiencies in in-process and postimplementation reviews. As a result, decisionmakers do not have the information needed to (1) detect and avoid difficulties early and (2) improve VA's investment process. Consequently, VA does not know whether it is making the right investments, how to control these investments effectively, or whether these investments have provided mission-related benefits in excess of their costs.

Over the past several years, we have made numerous recommendations to help VA address information systems management

issues. VA has concurred with most of these recommendations and has taken actions to implement many of them. Such actions include making fundamental changes to its methodology and approach to information systems management. For example, the Veterans Benefits Administration changed its Year 2000 strategy from developing new systems to converting existing ones. In another major change, VA separated the Chief Information Officer function from the Chief Financial Officer function and established a new Assistant Secretary position to serve as Chief Information Officer reporting directly to the Secretary on all information resources issues. This newly established position should help VA ensure prompt and efficient handling of information resources management issues.

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Related GAO Products

VA Health Care Infrastructure

VA Health Care: VA's Plan for the Integration of Medical Services in Central Alabama (GAO/HEHS-98-245R, Sept. 23, 1998).

Veterans' Health Care: Challenges Facing VA's Evolving Role in Serving Veterans (GAO/T-HEHS-98-194, June 17, 1998).

VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

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Veterans' Access to Needed Health Care Services

VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed (GAO/HEHS-98-226, Aug. 28, 1998).

VA Health Care: VA's Efforts to Maintain Services for Veterans With Special Disabilities (GAO/T-HEHS-98-220, July 23, 1998).

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Impact of VA Managed Care Initiatives

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VA Information Technology: Improvements Needed to Implement Legislative Reforms (GAO/AIMD-98-154, July 7, 1998).

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