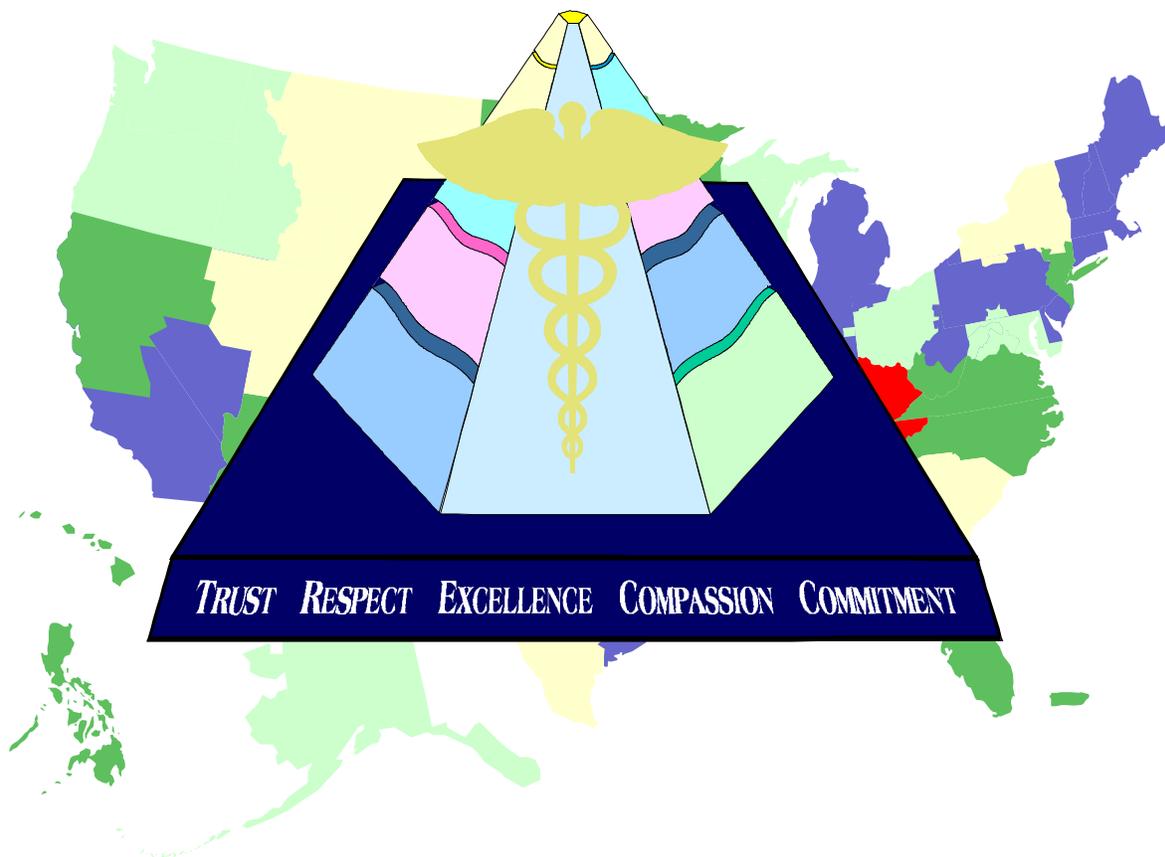


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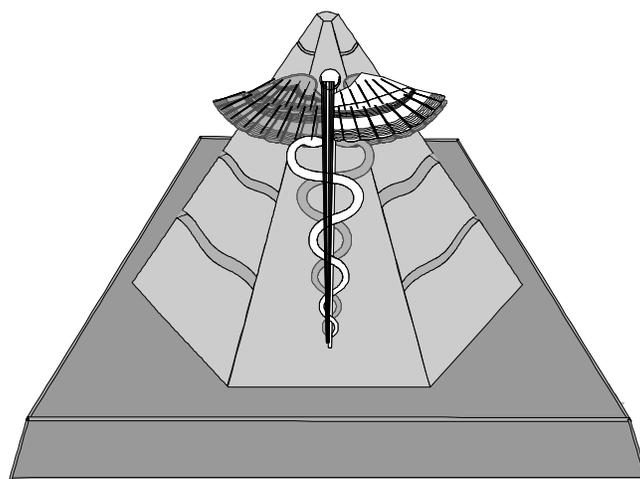
JOURNEY OF CHANGE II

ANNUAL REPORT AND STRATEGIC FORECAST



JULY 1998

Department of Veterans Affairs • Veterans Health Administration



JOURNEY OF CHANGE II

**ANNUAL REPORT AND
STRATEGIC FORECAST**

JULY 1998



FOREWORD

The past year has seen further substantial progress in VHA's "journey of change", and this report represents the culmination of our second full strategic planning cycle, covering the years 1998-2003. We have achieved many milestones during this time.

Last year we established the five critical domains of value – i.e., Technical Quality, Customer Satisfaction, Improved Patient Functional Status, Access, and Cost/Price – along with strategic themes and performance goals for Network Directors to use as corporate strategic themes that guide our efforts and strategy. Our programs have been organized around these themes and our annual accomplishments noted throughout this report.

Journey of Change II highlights the achievement of significant milestones in our journey into the future. Among our accomplishments over this past year include:

- Development and implementation of a comprehensive quality management framework (discussed extensively in Chapter 1) that encompasses programs in clinical guidelines, performance management and quality assessment, including:
 - a patient safety initiative;
 - practice guidelines for diabetes, heart disease, hypertension, smoking, and major depression;
 - chronic disease and prevention indices; and,
 - physician credentialing;
- VISNs that are fully operational with strong programs, management structures and performance measures that promote cost effectiveness. VISNs have also enhanced their ties to their communities through strong academic affiliations and sharing agreements;
- Significant achievements towards the year 2002 strategic targets (these are discussed throughout the report);
- Initiation of programs to identify both external and internal performance benchmarks and establishment of a process to recognize and disseminate innovations and internal best practices throughout the system; and,
- Continued refinement of the VHA strategic planning process and provision of systemwide sharing of information on network strategic plans for strategic management and best practices.

Other areas of accomplishment include the implementation and validation of the Veterans Equitable Resource Allocation (VERA) system for budgeting and the launching of major initiatives in information management, including (1) improving technology infrastructure, (2) developing the electronic patient record, (3) implementing the Decision Support System (DSS) and (4) developing an interface with the Veterans Benefits Administration to provide "One VA" service. VHA also is working closely with the Congress toward legislation that would authorize a pilot program to test Medicare subvention.

We have fully implemented basic elements of our strategic management system and are beginning the critical process of fully establishing them within VHA as the cornerstones of the "new VHA." We also have begun the process of formally incorporating program evaluation into all levels of our strategic management framework.



There are some significant changes to the format and content of *Journey of Change II (Journey II)*. The most significant change is the increased linkage to the VA Strategic Plan. *Journey II* has been designed to be an annual report, with an overview of the past year, both in terms of accomplishments and lessons learned. It also serves as a succinct précis of the strategic targets for the coming year. These targets directly reflect the goals and objectives VHA has established as part of the VA Strategic Plan as mandated in the Government Performance and Results Act (GPRA).

Journey II begins with an overview of the strategic direction for VHA and an examination of both 1997 accomplishments and 1998 strategic targets in light of the VHA mission and strategy. Network tactical achievements, both actual and expected, will be summarized with innovations and/or internal best practices highlighted.

We expect 1998 to be another year characterized by substantial restructuring of our delivery system. The implementation and use of a new enrollment system to manage healthcare delivery and the additional workload from possible Medicare enrollees will require even greater adaptation. Controlling healthcare inflation and improving quality, customer satisfaction, accessibility and innovation remain the forefront of our tactical and strategic thinking. We will continue to strengthen and fortify the “new VHA” through a deepening focus on quality, strategic management, and institutionalization of best practices - through both external comparison and internal innovation. These strategic issues will be the targeted elements for 1998.

Our success in restructuring VHA has positioned VA healthcare to effectively compete in the marketplace and to achieve comparable or better performance when benchmarked against private sector best practices. The efforts proposed for 1998 - 1999 should allow us to achieve a level of quality that will be widely recognized as setting the national standard of excellence for the healthcare industry.

(Signed July 1998)

Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

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INTRODUCTION

VHA is an organization in major transition. There have been fundamental changes in how we are organized and how we relate to each other; in how we deliver service and provide care; in how we think about and judge ourselves; and in how we are funded and will support ourselves in the future. No other healthcare system in the country can match the nature, extent and rapidity of change that has occurred in VHA.

*Kenneth W. Kizer, M.D., M.P.H.
December 1997*

1997 saw the undeniable emergence of the “new VHA” amid the continued transformation of healthcare in America. The competition continues and has intensified among healthcare providers. Events such as mergers, changes in healthcare financing, provision of new services, new collaborative arrangements and new technologies, all impact the evolving marketplace. However, the insistent demands for cost containment and greater accountability that have been the driving force of change in the marketplace have softened to some degree. The focus of competition has shifted sharply to leadership in healthcare quality.

VHA has worked hard this year to accomplish the transformation envisioned in *Vision for Change* and outlined in *Prescription for Change*. The “new VHA” is emerging as a truly coordinated continuum of care grounded in both ambulatory and primary care to achieve performance outcomes in terms of cost, access, customer satisfaction and improved patient care: a more efficient and patient-centered healthcare system.

The implementation process included reengineering VHA’s operational structure, diversifying its funding base, streamlining processes, implementing “best practices,” improving information management, reforming eligibility rules, expanding contracting authority, and changing the culture of VA healthcare. The success of these new initiatives has positioned VA to effectively compete in the evolving marketplace. Throughout this rapid reorganization, VHA has made quality the guiding principle of its ongoing implementation and internalization efforts.

During 1998, both external and internal forces are expected to shape VHA healthcare. These forces and VHA’s response to them provide an unprecedented opportunity to consolidate the gains from the reorganization and to assume a national leadership position.

MARKING THE EMERGENCE OF THE “NEW VHA”

When VHA embarked upon the process of implementing the *Vision for Change*, key strategic objectives and targets were established. These included:

- Reengineering healthcare delivery programs to focus on primary care including the shift to increasing utilization of ambulatory services
- Moving to a population-based, community-oriented, enrollment-based system that facilitates access to services and programs
- Instituting managed care principles and cost efficiencies

Introduction

To ensure that these objectives were fully achieved, performance measures and strategic targets were developed to support restructuring efforts. Key strategic targets for 2002, known as “10 for 2002,” were established. These include:

Table 1
“10 FOR 2002” STRATEGIC TARGETS

TARGET 1	Decrease the systemwide average cost (expenditure) per patient by 30 percent
TARGET 2	Increase the number of users of the veterans healthcare system by 20 percent
TARGET 3	Increase the percent of the operating budget obtained from non-appropriated sources to 10 percent of the total
TARGET 4	Exceed by 10 percent the proportion of patients of other large healthcare providers who achieve maximal functional potential
TARGET 5	Increase to 90 percent the proportion of patients reporting VA healthcare as very good or excellent
TARGET 6	Increase to 90 percent the proportion of patients who rate the quality of VHA healthcare as equivalent to or better than what they would receive from others
TARGET 7	Increase to 99 percent the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of the VA
TARGET 8	When asked, 95% of physician house staff and other trainees would rate their VA educational experience as good or superior to their other academic training
TARGET 9	Increase to two percent, or 40 hours per year, the amount of an employee’s paid time that is spent in continuing education to promote and support quality improvement or customer service
TARGET 10	Increase to 100 percent the number of employees who, when queried, are able to appropriately describe how their work helps meet the mission of the “new VHA”

To continue the transformation to the “new VHA” and to achieve these targets, VHA is adopting a four-point quality parameter:

- The patient as partner
- Five star service
- Easy access
- Consistent and predictable quality

Substantial progress has been reported in the achievement of these quality measures during the past year. 1997 accomplishments have allowed VHA to quickly move forward towards target goals.

THE ROAD FORWARD: HEALTHCARE CHALLENGES FOR THE END OF THE CENTURY

The years leading up to the new millennium offer both unparalleled challenges and unprecedented opportunities for VHA. Our mandate for this period must be to provide healthcare value through:

- Enhancing quality
- Increasing access
- Continuing to improve service satisfaction
- Optimizing patient functionality
- Focusing on managing care

Our accomplishments during the last two years have enabled us to provide cost effective and efficient services to special populations. Our experiences with chronic health problems and managing under budgetary constraints have given us several advantages in that competition. Many of the issues we have already struggled with are now on the forefront of the private sector agenda.

For example, the President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry was established last year to develop recommendations for improving quality in healthcare. While underscoring that American healthcare is of very high quality, the Commission identified several major industry problems with healthcare quality nationally: wide variation in healthcare services delivery, under and overuse of services, and an unacceptably high level of errors.

To maximize the achievement of the highest quality, the Commission is recommending several national initiatives including reducing the underlying causes of illness, expanding research on new treatments, assuring the appropriate use of healthcare services, reducing healthcare errors, increasing customer participation, and addressing under and oversupply of services. The focal point of the Commission's recommendations for achieving these initiatives is a focus on the measurement and national standardization of reporting on quality.

VHA has been addressing each of these areas for some time:

- VA has strong programs in prevention and early detection
- VHA has refocused all aspects of its research programs to concentrate on the major illnesses affecting veterans. These programs will also be beneficial to the general population as a whole
- VHA's quality program is substantial including implementation of clinical guidelines and performance indices, external reviews, internal monitoring, physician credentialing and customer feedback
- Specific programs have been in place for some time to encourage customer participation and to review service utilization
- VHA has placed major emphasis on patient safety and reducing errors in health delivery

Through the achievement of the 1998 strategic targets, VHA is in position to set the standard for quality improvement. A program for moving forward with this initiative – Strategic Framework for Quality Management – is highlighted in the *Journey II*.

QUALITY AND CORE VALUES

VHA will continue the implementation of the “new VHA” as outlined in *Vision for Change* and *Prescription for Change*. We will work to formally consolidate and institutionalize the new ways of doing business. Expansion and standardization of quality assessment and measurement programs will be the guiding strategy for this consolidation process. Quality enhancement efforts will center on:

- Personnel
- Clinical care activities
- Performance indicators
- Internal review and improvement
- External review and oversight
- Technology Management
- Patient Reported Outcomes
- Education
- Research
- Change Management

Goals for each aspect of the quality improvement program will be clearly articulated in *Journey II*. Strategic targets for quality management will be part of all VHA programs. It is expected that achievement in these areas will form the basic standards of quality that can support national quality management efforts for the private sector.

As a foundation for these quality improvement efforts, VHA has also developed a broad platform of core values. These values, defined through a process of synthesizing individual program and facility values and wide discussion of this synthesis with members of the VHA community and stakeholders, represent our best consensus of the core values held by a majority of VHA staff.

Table 2
VHA CORE VALUES

TRUST	Means having a high degree of confidence in the honesty, integrity, reliability and sincere good intent of those with whom we work, the services that we provide, and the system that we are a part of. Trust is the basis for the caregiver-patient relationship and is fundamental to all that we do in healthcare.
RESPECT	Means honoring and holding in high regard the dignity and worth of our patients and their families, our co-workers, and the system we are a part of. It means relating to each other and providing services in a manner that demonstrates an understanding of and a sensitivity and concern for each person’s individuality and importance.
EXCELLENCE	Means being exceptionally good and of the highest quality. It means being the most competent and the finest in everything we do. It also means continually improving what we do.
COMPASSION	Means demonstrating empathy and caring in all that we say and do. It means sharing in the emotions and feelings of our co-workers, our patients and their families, and all others with whom we are involved.
COMMITMENT	Means dedication and a promise to work hard to do all that we can to provide service to our co-workers and our patients that is in accordance with the highest principles and ethics governing the conduct of the healthcare professions and public service. It is a pledge to assume personal responsibility for our individual and collective actions.

These Core Values - **TRUST, RESPECT, EXCELLENCE, COMPASSION AND COMMITMENT** - will guide all national planning and program management and will be reflected in our entire organizational behavior. Combined with our Domains of Value, they will constitute true north on our compass to direct our further Journey of Change. First and foremost, these values will be reflected in our approach to quality improvement.

Two additional elements will underpin our strategic targets: implementation of best practices and strategic management. These additional foci will be evident in the formal implementation of program evaluation and monitoring systems and in the continued -- external and internal-- definition and implementation of best practices and innovations. Innovation and program enhancement will be widely encouraged and assessment and utilization of lessons learned will be rewarded.

JOURNEY OF CHANGE II

The purpose of *Journey of Change II, (Journey II)* is threefold:

- Highlight 1997 accomplishments
- Reaffirm the strategic direction articulated in *Vision for Change* and *Prescription for Change*
- Review 1998 - 2003 strategic targets

Operating strategies for reaching or exceeding those targets are highlighted and expectations for performance are set. The relationship of both prior accomplishments and expected achievements to the VA Strategic Plan and the concept of “One VA” is also outlined.

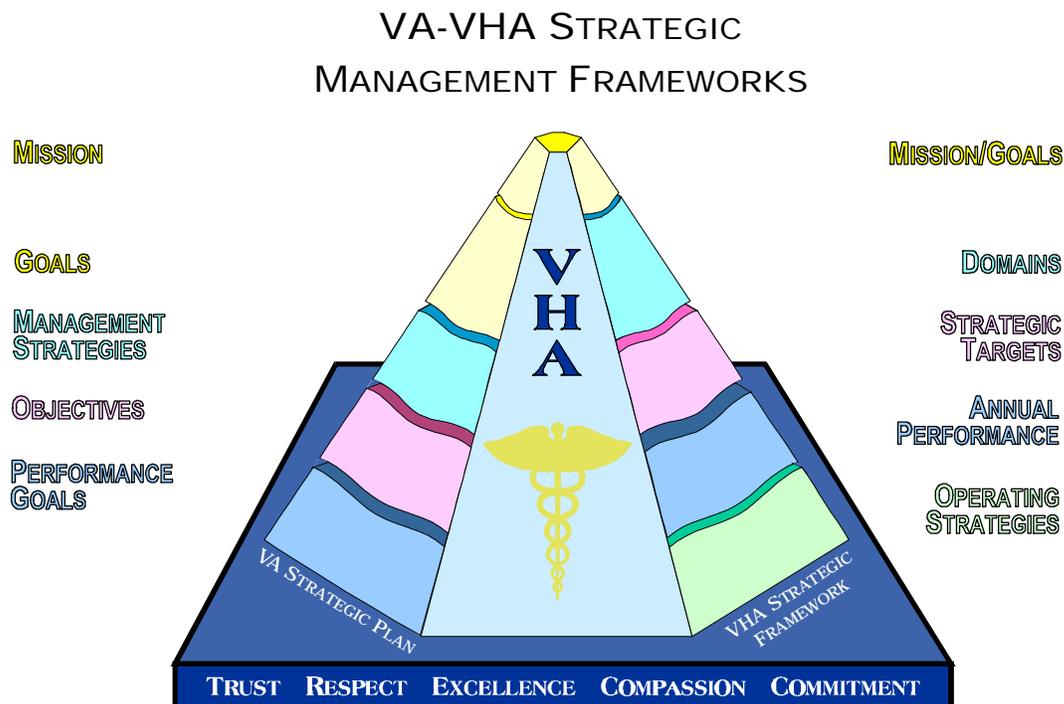


Figure 1

Introduction

Figure 1 presents an overview of the relationship between the VA and VHA Strategic Plans. Based on a foundation of Trust, Respect, Excellence, Compassion and Commitment (the VHA values), VHA programs integrate seamlessly with the agency mission, goals, objectives and performance goals as articulated in VA's Strategic Plan.

The VHA plan components: Mission/Goals, Domains/Values, Strategic Targets and Annual Performance Measures all relate to the VA strategic plan elements and begin to provide the detail of how VA will achieve its strategic direction in healthcare delivery.

When combined with the strategic plan elements from the Veterans Benefits Administration and the National Cemetery System, the blueprint for "One VA" is clearly evident. The operating strategies included as part of *Journey II* provide a clear framework for how the VHA strategic targets will be achieved.

Journey II summarizes 1997 accomplishments and sets the strategic direction for 1998 - 2003. This direction will focus on all aspects of quality: continuous internal and external quality reviews; implementation of clinical guidelines and performance indices for chronic care, prevention and early detection; education; research; personnel training; and change management.

In addition, strategic targets also focus on enhancing and expanding information systems both at the clinical and at the infrastructure level, integrating with the Veterans Benefits Administration to serve veterans as "One VA," and increasing access and enrollment of all eligible veterans. The "new VHA" will set the standard for national healthcare quality and provide cutting edge healthcare services, research and education to optimize the health status of the nation's veterans.

Taken together, all of the VHA strategic goals are addressed and the 1997 accomplishments and the expected 1998-2003 strategic issues in each area are presented. Each chapter will provide:

- An overview of the chapter defining the topics to be discussed in each section and highlighting both the themes of the chapter and specific ties with the VA Strategic Plan
- Major sections for each sub-topic or content area that:
 - Introduce the sub-topic
 - Summarize 1997 accomplishments for that area by domain (quality, service/satisfaction, access, functional status and cost/price) and highlight best practices for the area
 - Forecast 1998-2003 activities and expected accomplishments also by domain
- A chapter conclusion

Integration of best practices and innovations will be highlighted with specific symbols and set off in boxes. Quality assessment and management emphasis will be integrated throughout each chapter.

The following symbols are used throughout the chapters to highlight quality dimensions, performance goals and indicators, and best practices/innovations:



VHA STRATEGIC FRAMEWORK FOR QUALITY MANAGEMENT

The quality management program emphasizes 10 Dimensions that directly support systematic and comprehensive renewal and improvement of VHA's healthcare delivery system. This symbol designates VHA activities that directly support accomplishment of a specific dimension.

**BEST
PRACTICES
OR
INNOVATIONS**



BEST PRACTICES OR INNOVATIONS

This symbol designates innovative efforts for accomplishing a substantial improvement in any VHA program, process, or other activity integral to delivering the highest quality healthcare to veterans.



VHA PERFORMANCE GOALS

These performance goals appear in the VHA Strategic Plan, the VA Annual Performance Plan, and the Network Performance Agreement. They are output/outcome measures established to assess progress toward intended program goals. This symbol designates VHA activities that directly support accomplishment of a specific performance goal.



VA OUTCOME INDICATORS

Outcome indicators (or also known as Performance Indicators) function similarly to VHA performance goals. They appear in the VHA Strategic Plan and the VA Annual Performance Plan, but not the Network Performance Agreement. This symbol designates VHA activities that directly support accomplishment of a specific performance indicator



REPORT BY THE PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN HEALTHCARE

The Commission, which released "A Consumer Bill of Rights and Responsibilities" in November 1997, released its final report in April 1998. The report contained 56 recommendations on how best to promote and ensure consumer protection and healthcare quality. This symbol designates VHA activities that directly support accomplishment of one or more of the 56 recommendations

GLOSSARY

In addition to these symbols, a Glossary of Acronyms used in *Journey II* is provided at the end to assist the reader.

CHAPTER 1: STRATEGIC MANAGEMENT FRAMEWORK

As VA moves toward the future, the quality component of value is the centerpiece of its transformation.

*Kenneth W. Kizer, M.D., M.P.H.
December, 1997*

This chapter presents the 1998 VHA Strategic Framework. This framework will be presented in three sections:

- “One VA”: The Department of Veterans Affairs Strategic Plan
- The 1998 VHA Strategic Management Framework
- VHA Strategic Management Basics

The purpose of this chapter is to introduce the VA Strategic Plan and “One VA,” present the 1998 VHA management structure, explain differences from the 1997 structure, and introduce the VHA management basics supporting the VHA Strategic Management Framework.

Building on the Strategic Management Framework designed to implement *Vision for Change* and *Prescription for Change*, the 1998 strategic management framework presented in this section carries through the direction set in *Journey of Change I (Journey I)*, integrates refinements that are derived from progress in achieving the “new VHA,” and demonstrates continued evolution to better reflect VHA goals and strategies.

The two major refinements to the strategic framework presented in *Journey I* are: (1) more specific linkages to the VA Strategic Plan, and (2) focus on specific 1998-2003 target initiatives. The major strategic target initiatives are:

- Full consolidation of VHA programs
- A deepening focus on quality
- Full implementation and consolidation of strategic management programs
- Continued institutionalization of best practices

The VHA strategic management framework presented in *Journey I* has also been reframed to specifically highlight these focus areas:

- Enhancement and systemwide standardization of quality
- Establishing internal and external benchmarks
- Refining and expanding strategic planning and management processes

These strategic refinements are all grounded upon the basic operational structure and underlying principles of the Strategic Management Framework presented in *Journey I* that remain unchanged.

“ONE VA”: THE DEPARTMENT OF VETERANS AFFAIRS STRATEGIC PLAN

The Department of Veterans Affairs Strategic Plan, FY 1998-2003, is grounded in the notion of “One VA.” A major goal for VA is to organize the strategic planning and programs of its component parts (VHA, Veterans Benefits Administration, and National Cemetery System) to function as a unified organization. At the outset of the Strategic Plan, VA offers a concise and clear statement of that goal:

Our vision is to become a more customer-focused organization, functioning as “One VA” and delivering seamless service to veterans and their dependents.

As part of creating this source of seamless service, the VA Strategic Plan is focused on integrating state-of-the-art planning techniques into a process that will build a strong and resilient strategic base for the future. The key components of that planning process include developing:

- Measures of program efficiency (unit cost)
- Measures of program outcomes
- Information systems that ensure that management data are available for each measure
- Benchmark levels of performance
- Mechanisms to link performance measurement to the budget
- Mechanisms to link organizational goals and performance with individual employee goals and performance

Other areas of focus for VA strategic planning include the use of reengineering/restructuring and consolidation options, promotion of total quality improvement practices and advances in technology to enhance current VA programs. All of these elements are also goals of the VHA planning process and strategic management framework.

The four overall goals in the VA Strategic Plan that directly apply to VHA programs are:

- VA programs meet their legislated intent and are prepared to meet future needs;
- The overall healthcare of veterans is improved;
- VA medical research programs meet the needs of the veteran population and contribute to the nation’s knowledge about disease and disability; and,
- VA’s healthcare education and training programs help assure an adequate supply of clinical care providers for veterans and the nation.

Each of these goals has objectives and performance goals articulated for it and identified external factors that may affect its achievement.

VA has identified a specific strategy for providing healthcare value and customer satisfaction to veterans:

To provide the integration of performance measurement, strategic planning and financial goals and targets to achieve a patient-oriented, ambulatory care-based, results-driven, organized system of coordinated healthcare delivery focused on continuous quality improvement.

Specific elements of that strategy include (1) providing more services to greater numbers of veterans, and (2) maximizing the veterans healthcare potential through an emphasis on quality. These goals are also at the heart of VHA strategic planning. They form the basis of recommendations in *Vision for Change* and *Prescription for Change* and are the focus of the “10 for 2002” strategic targets. The specific VA Strategic Plan objectives for achieving these targets are summarized below.

Goal One: Improving Healthcare Delivery:

- Increase the number of unique users (individuals using VHA healthcare services) by 20 percent
- Exceed the proportion of patients of other healthcare providers who achieve maximum functional potential by 10 percent by the year 2002
- Provide medical backup to DoD in the event of a national security emergency, provide medical and other support during Federal disaster response, and provide for contingencies within VA to ensure continued service delivery for eligible veterans

Goal Two: Improving Medical Research:

- Increase to 99 percent VA medical research projects that are demonstrably related to the healthcare of veterans or to other Department missions

Goal Three: Improving Medical Education:

- Realign academic training programs and update the curriculum with a greater emphasis on primary care to better meet the needs of VHA, its patients, students, and academic partners

These goals and objectives have been at the heart of the VHA effort to develop the “new VHA” that began in 1995. The accomplishments and proposed initiatives in *Journey I* reflected this direction and the highlights of accomplishments and expected achievements presented in *Journey II* refine and continue that strategic direction. “One VA” and the “new VHA” are based on common goals and an integrated approach for achieving them.

In addition to specific healthcare goals, the VA Strategic Plan has identified two other strategic areas that directly affect VHA programs and services: (1) Special Emphasis Programs, and (2) Management Strategies.

Special emphasis programs are clinical and administrative programs that:

- Address illnesses specific to the service-connected veteran population
- Are areas of special VA expertise
- Are unique or legislatively mandated programs that address the psychosocial needs of certain veterans

These programs include: Agent Orange, AIDS, Blind Rehabilitation, Ex-Prisoner of War, Geriatrics and Long-Term Care, Homelessness, Ionizing Radiation, Minority Veterans, Persian Gulf, Post-traumatic Stress Disorder, Preservation/Amputation Care and Treatment, Prosthetics and Rehabilitation Medicine, Readjustment Counseling, Seriously Mentally Ill, Spina Bifida, Spinal Cord Injury and Disorders, Addictive Disorders, Traumatic Brain Injury, and Women Veterans. Many of these programs focus on injuries and illnesses specifically due to military service. VA has a special commitment to those veterans who bear life-long burdens resulting directly from military service trauma or injury. Both VA and VHA are working to ensure that “One VA” works particularly seamlessly for these populations. Chapter Four reviews VHA accomplishments and forecast of activities in this area of the VA Strategic Plan.

Chapter 1: Strategic Management Framework

With regard to Management Strategies, the VA Strategic Plan has identified three management strategies for achieving its articulated program goals:

- Providing “One VA” World-Class Customer Service
- Creating and Maintaining a High-Performing Work Force to Serve Veterans
- Providing Maximum Return on Taxpayer Investment

Six general goals have been articulated for “One VA” World Class customer service:

- Ease of Access
- Customer Satisfaction
- Courtesy
- Do It Right the First Time
- Prompt Delivery of Service and Benefits
- Effective Outreach

Each of these goals has been incorporated as a basic tenet of the “new VHA.” Many of these principles were articulated in the *Vision for Change* in 1995, and VHA heartily embraces the challenge to refine and enhance these goals as a part of the “One VA” concept of seamless service delivery.

VHA’s commitment to an empowered, accountable and efficient workforce also relates directly to the VA Strategic Plan. The “new VHA” has been firmly rooted in the belief of the importance of a creative and resourceful work force. Programs to reward performance, assure accountability and tie both elements to strategy are at the center of reengineering and redesign of programs within VHA and at the heart of VA’s strategic direction. Workforce credentialing, education and support are some of the ten points in our quality management program.

THE 1998 VHA STRATEGIC MANAGEMENT FRAMEWORK

The 1998 Strategic Management Framework is still based on increasing levels of specificity, from broad corporate mission goals to explicit objectives and tactical actions as presented in the pyramid in *Journey I* (See Appendix B). The emphasis on the flow from goals and objectives to strategies and actions remains constant, and, as illustrated in Figure 1-1 (VA-VHA Strategic Management Frameworks), is also the organizational structure for the VA Strategic Plan.

Mission/Goals:

The five VHA corporate mission goals identified in *Prescription for Change* remain in place:

1. Excellence in Healthcare Value
2. Excellence in Service as Defined by Customers
3. Excellence in Education and Research
4. Exceptional Accountability
5. An Employer of Choice

The goals also include meeting the needs of the VA special populations and maintaining emergency preparedness to support DoD and other national emergencies.

These goals are consistent with and build on the corporate goals included in the VA Strategic Plan. Excellence, Value and Accountability are hallmarks of the VA strategic vision and are included in the VA Strategic Plan healthcare strategy statement. The five VHA mission/goals begin to flesh out how the VA Strategic Plan goals and “One VA” will be achieved.

VA-VHA STRATEGIC MANAGEMENT FRAMEWORKS

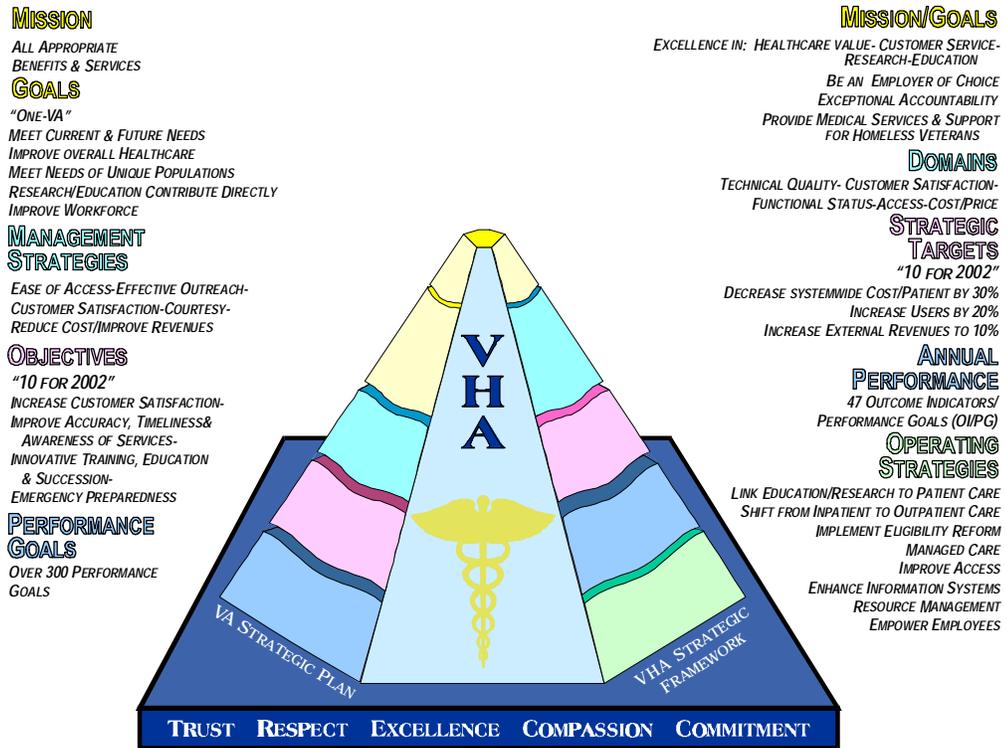


Figure 1-1

Domains of Value:

These five critical domains – technical quality, service satisfaction, access, functional status, and cost/price – remain the driving force behind all VHA operations. They are in keeping with VA management strategies and remain the clear focus of VHA strategic planning.

They mirror the central tenets of “One VA” – access, customer satisfaction, and effective outreach and service delivery. Building upon the success of last year’s efforts, and in response to shifts in the healthcare marketplace, VHA has also shifted by increasing the focus on quality enhancement and quality management.

Strategic Targets:

VHA strategic targets provide the specific content for VA Strategic Plan objectives in healthcare. The strategic targets articulated for *Journey I*, “Ten for 2002,” remain the focus for *Journey II*. Each of the “10 for 2002” targets has been included as an objective under a VA Strategic Plan goal. VHA strategic targets respond both to healthcare delivery goals in the VA Strategic Plan and to administrative goals. The specific nature and explicit, behaviorally measurable terms of these targets work well as a guiding focus for understanding how “One VA” will be achieved.

Annual Performance Measures:

The VA Strategic Plan describes over 300 performance goals for the agency. The 47 VHA Annual Performance Measures first articulated in *Prescription for Change* in 1996 remain an essential component of VHA's strategic management system and are part of the VA Strategic Plan. They have been modified to reflect the increased emphasis on quality, strategic planning and best practices. They also provide the underpinnings for understanding how the performance goals articulated in the VA Strategic Plan will be achieved.

Operating Strategies:

While derived from the overall goals and foci of the VA Strategic Plan, VHA operating strategies do not have direct parallels in that Plan. Instead they represent the specific steps that VHA will take to achieve both its plan and the VA Strategic Plan. The 1998 network operating strategies reflect the shift in strategic direction for VHA with increased emphasis on quality, best practices and program evaluation.

VHA STRATEGIC MANAGEMENT BASICS

Figure 1-2, VHA Strategic Management Basics, depicts the relationship of the strategic underpinnings of VHA to the VA Strategic Plan and its presentation in *Journey II*. The Domains of Value, the VHA Value Statement, VHA programs, and Quality Framework are the basic elements of the Veterans Health Administration. This section summarizes these underpinnings and explains how they have been refined for 1998.

VHA Core Values and Domains of Value:

Underlying everything that VHA does and is are the Core Values that define how VHA will conduct its business – Trust, Respect, Excellence, Compassion and Commitment. In conjunction with the Domains of Value, these VHA values constitute the VHA compass to the future. They will guide all national planning and program management, and be reflected in every aspect of daily operations.

VHA STRATEGIC MANAGEMENT BASICS

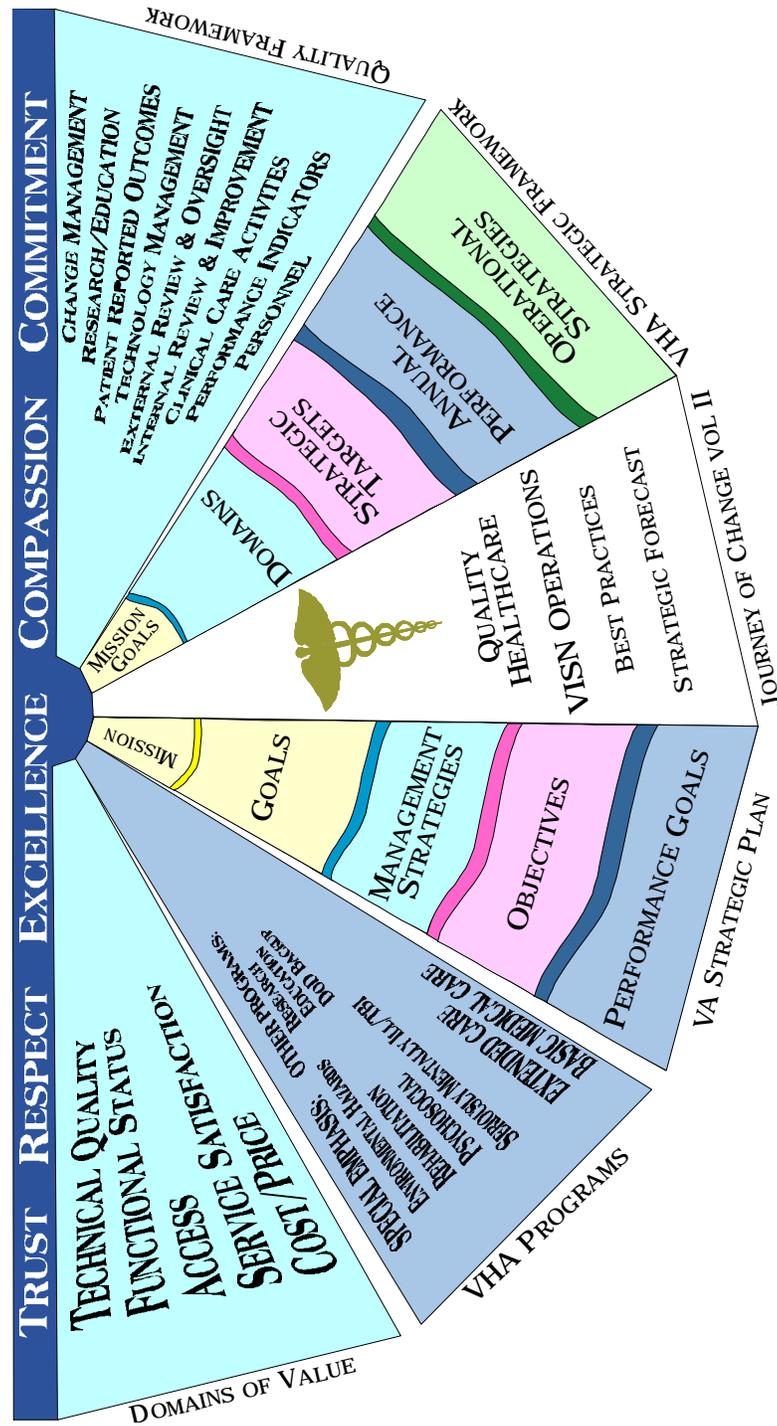


Figure 1-2

Expansion and Standardization of Quality Management:

Figure 1-3, VHA’s Strategic Framework for Quality Management, summarizes the 10 elements of VHA’s quality program. Quality Care is based on two critical factors:

1. VHA Core Values, and
2. The 10 Quality Management Elements

The Institute of Medicine (IOM) defines quality as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The goal of the VHA strategic management program is to become the national standard for achieving optimal health outcomes.



**VHA'S STRATEGIC FRAMEWORK
FOR QUALITY MANAGEMENT**

Figure 1-3

Key components of managing quality are:

- Standards: setting standards for quality
- Assessment: systematically assessing programs against these standards
- Refinement or Enhancement: Refining or enhancing of programs as necessary based on the results of that assessment

At the heart of VHA's quality management program is the definition of and organization of programs around 10 elements that together will provide a structured and stable platform for application of the quality assessment and improvement components:

Personnel:

Attract and retain the best work force possible by the effective use of credentialing, privileging/scope of practice, mentoring, workplace environment, academic affiliations and performance-based interviewing.

Clinical Care Activities:

Employ clinical care activities such as primary care, telephone-linked care, community-based care/home care, care/case management, practice guidelines/clinical pathways, shared decision making, palliative care, practice profiling and contract specifications to increase the likelihood of achieving desired health outcomes.

Performance Indicators:

Measure and monitor progress in achieving desired health outcomes. This includes the use of a Prevention Index, a Chronic Care Index, a Palliative Care Index, surgical morbidity and mortality rates, medical cohort survival rates, the Long Term Care Index, analysis of functional outcomes, mental health performance indicators, and a review of case registries.

Internal Review and Improvement:

Engage all levels of the organization in both routine and event-triggered cycles of improvement. This includes clinical pathology conferences, morbidity and mortality conferences, ad hoc review teams, Bioethics Committee reviews, the Patient Safety Review Registry, causation analyses, tort claims analyses, the Patient Safety Oversight Committee, the Office of the Medical Inspector, the National Surgical Quality Improvement Program, Quality Management Officer reviews, Baldrige assessments, benchmarking, employee feedback, Process Action Teams, and Quality Councils.

External Oversight and Review:

Achieve an impartial and independent review of care through use of a Quality Management Advisory Panel, quality related advisory committees, accreditation and certification programs, contracted external peer review, use of the Office of the Inspector General, and communication with veterans service organizations, academic affiliates, Congress and the media.

Technology Management:

Optimize the use of technology to achieve desired outcomes. Decision support aids, electronic medical records capabilities programs, physician order/entry programs, medical record direct patient input technology, and a technology recommendations panel will all be a part of this component.

Patient-Reported Outcomes:

Optimize patient and patient family involvement in the design and delivery of healthcare services. This element will involve the use of focus groups, surveys, improved complaint handling, patient advocates and service evaluation/action teams.

Chapter 1: Strategic Management Framework

Education:

Prepare the current and future healthcare workforce to deliver quality healthcare and to actively participate in care improvement through health professional training, workforce development programs, and quality management fellowships.

Research:

Generate new knowledge that facilitates improved health outcomes. Health services studies, clinical care studies, biomedical studies, technology assessment, and quality related research advisory committees will all address this component.

Change Management:

Implement active management of change strategies to achieve strategic goals. This effort includes a Quality Management Integration Council, Executive Performance Agreements, resource allocation strategies, standardization of language, integrated collaborative planning, and awards and recognition.

The implementation of these 10 quality assessment and management initiatives constitutes a complete quality management system. The goal in 1998 will be to expand and refine these 10 elements into a quality management program that will set the national standard for quality.

Chapter 2: Healthcare Delivery

As one of our key strategic objectives, VHA is committed to the enhancement and systemwide standardization of quality. We are committed to improving healthcare quality in VA treatment facilities, and in the healthcare industry overall. Indeed, I believe VHA should set the healthcare industry's standard for quality.

Kenneth W. Kizer, M.D., M.P.H.
“Journey of Change” Leadership Conference
Baltimore, MD December 1997

VHA is rebuilding its healthcare delivery system with the express purpose of ensuring that VA care is second to none. Shifting from inpatient to outpatient care, implementing managed care, and improving access are all important to this end, but delivering quality healthcare is the fundamental key to success! This chapter covers VHA's accomplishments and expectations for (1) the strategic framework VHA designed for quality management, (2) VHA implementation of nationally approved guidelines and quality performance indicators, (3) programs for primary and palliative care, and (4) VHA performance in accreditation reviews by oversight organizations. It highlights the accomplishments of VHA in 1997 and forecasts 1998-2003 in these four areas with regard to efforts and initiatives by VHA and individual VISNs to ensure that veterans receive the highest quality healthcare available.

VHA STRATEGIC FRAMEWORK FOR QUALITY MANAGEMENT

The basic purpose of all healthcare activity is to renew, preserve, or promote patients' health in order to enhance their quality of life. But delivering healthcare is a complicated undertaking, and although it can be monitored, evaluated, and managed using a multiplicity of tools, no one approach best addresses the intricate relationships among the many parts. Maintaining and improving the consistency and predictability of high quality care has been a central focus of VHA's reengineering effort. Our quality management program has been strengthened by realigning the Office of Performance and Quality to report directly to the Under Secretary for Health, by setting goals that clearly define future expectations, by refining monitoring capabilities, by appointing oversight/advisory groups, and by establishing awards for exceptional accomplishments. This last activity directly supports the VA Strategic Plan objective to recognize and reward individual and group achievement consistent with VA's restructured performance management system.

A principal objective of VHA has been to focus efforts at the VISN level to foster more coordinated local quality care, promote initiative and maximize the use of resources. Based upon our structure of 22 VISNs and the national headquarters, VHA's strategic framework for quality management was designed to examine the parts individually and as a whole, while attempting to account for their complex interdependence. This framework, built on VHA's core values of trust, respect, excellence, commitment, and compassion — fundamental ingredients in quality, comprises 10 dimensions as listed in Table 2-1 (with related strategies and examples of tactics):

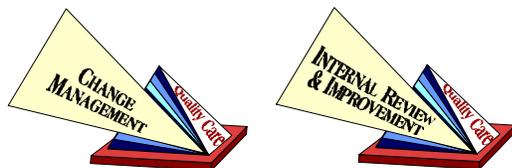
**Table 2-1
STRATEGIC FRAMEWORK FOR QUALITY MANAGEMENT**

DIMENSION	STRATEGY	TACTIC
I 	To attract and retain the best people possible.	<ul style="list-style-type: none"> • Credentialing (board certification, licensure) • Workplace environment • Mentoring
II 	To employ clinical care activities that increase the likelihood of achieving desired health outcomes.	<ul style="list-style-type: none"> • Primary care • Care/case management • Palliative care
III 	To measure and monitor progress in achieving desired health outcomes.	<ul style="list-style-type: none"> • Prevention Index • Chronic Disease Index • Medical cohort survival rates
IV 	To engage all levels of the organization in both routine and event-triggered cycles of improvement.	<ul style="list-style-type: none"> • Clinical pathology conferences • Patient Safety Events Registry • Baldrige assessments
V 	To enlist impartial and independent review of care.	<ul style="list-style-type: none"> • Quality Mgmt. Advisory Panel • Accreditation & certification • External peer review (contracted)
VI 	To optimize use of technology to achieve desired health outcomes.	<ul style="list-style-type: none"> • Decision support aides • Electronic medical record • Physician order entry
VII 	To optimize patient and patient family involvement in the design and delivery of healthcare services.	<ul style="list-style-type: none"> • Focus groups • Surveys • Patient advocates

<p>VIII</p> 	<p>To prepare the current and future healthcare work force to deliver high quality healthcare and to actively participate in improving care.</p>	<ul style="list-style-type: none"> • Health professions training (academic environment) • Workforce development • Quality management fellowships
<p>IX</p> 	<p>To generate new knowledge that facilitates improved health outcomes.</p>	<ul style="list-style-type: none"> • Health services studies • Clinical care studies • Biomedical studies
<p>X</p> 	<p>To actively manage change to achieve strategic goals.</p>	<ul style="list-style-type: none"> • Eligibility reform implementation • Executive performance agreements • Resource allocation strategy

Many tactics, including those noted above, are embedded in VHA’s daily efforts to maintain what is good about the existing system while focusing on areas that require improvement.

1997 Accomplishments:



FY 1997 saw a number of concrete steps to enhance the strategic framework for quality management. During that year, VHA:

- Appointed a Quality Management Advisory Panel (QMAP) to assess the clarity, coherence, and comprehensiveness of VHA’s quality management framework; review and advise VHA about specific quality management programs; and provide input regarding quality of care and quality management issues. (Members are clinicians from non-VA medical schools/institutes.)
- Established the Patient Safety Improvement Awards Program to systematically identify safety risks and develop improved processes or procedures to minimize risks. 
- Appointed the Quality Management Integration Council (QMIC) to monitor, evaluate and oversee the coordination and coherence of VHA quality and patient safety improvement activities; to provide direction to these activities; and to facilitate the systemwide deployment of best practices and promising innovations in quality management. (QMIC members are VHA clinicians/staff.) 
- Established the Quality Achievement Recognition Grant to reward VISNs that achieve truly outstanding performance by engaging the entire workforce in a results-oriented improvement process that leads to exceptional outcomes and demonstrates exemplary processes for assessment, learning and improvement. 

Chapter 2: Healthcare Delivery

- Each VISN appointed a Quality Management Officer who is clinically active, but for whom a majority of work time is dedicated to VISN quality management activities, including patient safety improvement activities.

Plans for 1998-2003:

VHA plans to continue emphasis on technical quality by:

- Presenting the first safety improvement award for developing practices to identify/reduce risk;
- Establishing a well-organized process for the recently appointed QMIC and the QMAP to become operational rapidly and successfully and fully integrated with other quality management activities;
- Identifying best practices in healthcare quality management for application to VHA operations;
- Fully implementing the strategies incorporated in the Strategic Framework for Quality Management; and,
- Continuing to survey customers to determine their perceptions of VA healthcare quality.

NATIONAL GUIDELINES AND QUALITY PERFORMANCE MEASURES AS RELATED TO VHA

An organization must know how it is currently performing in order to determine what it is doing well and where it can improve. By comparing: 1) VHA to others via nationally accepted guidelines, 2) VHA to VHA across the timeline of different fiscal years, or 3) VHA to VHA across the VISNs, VHA can identify successes as well as areas for improvement.



This section provides information on all three types of comparisons for hospital inpatient and outpatient activities, and suggests that our emphasis on measurable quality improvement is yielding good results.

The accomplishments and expectations in this area are closely tied to meeting several VA/VHA goals and objectives, including the “10 for 2002” goal for *exceeding by 10% the proportion of patients of other large healthcare providers who achieve maximum functional potential*. This work also supports the VA Strategic Plan objectives to improve the level of accuracy for all work, to correct errors in the shortest possible time as appropriate for each business line, and to incorporate organizational goals and objectives into individual or team performance plans.

1997 Accomplishments:

Chronic Disease Index:



VHA made remarkable progress in implementing 14 nationally recognized clinical interventions applicable to five high volume diagnoses (ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus, and obesity). Adherence to these interventions was improved to levels of 93% to 72% in FY 1997 compared to a range of 54% to 33% in FY 1996. Charts 2-1 and 2-2 reflect this performance while Table 2-2 describes the 14 interventions themselves.

Chart 2-1

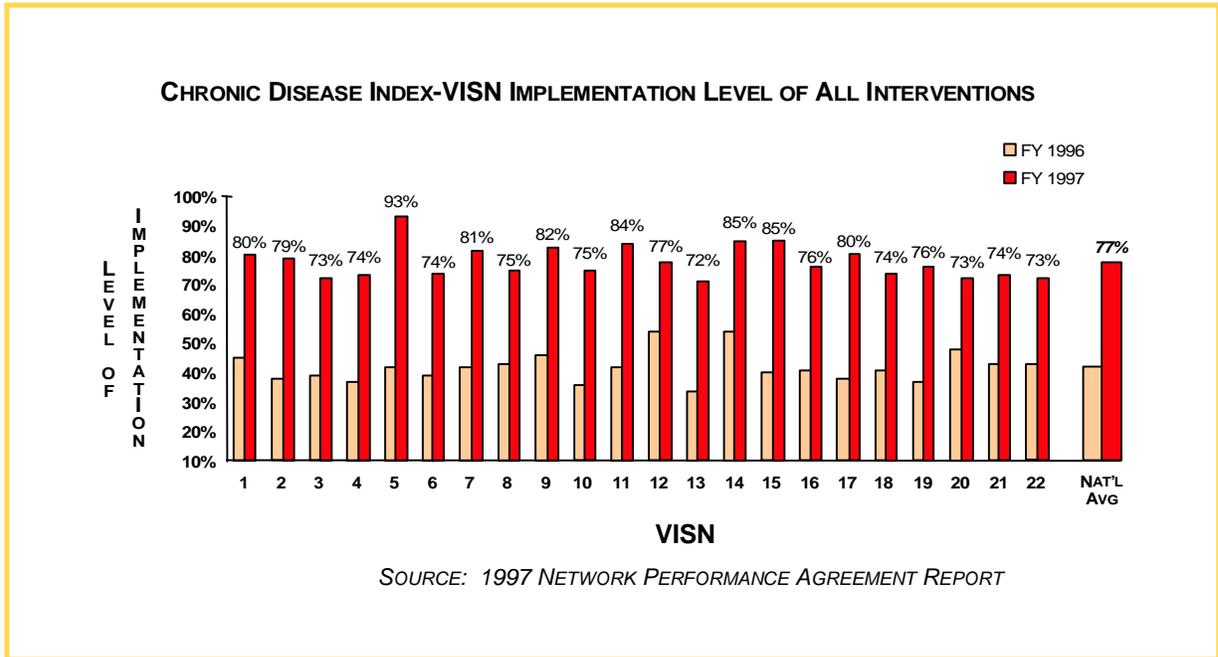
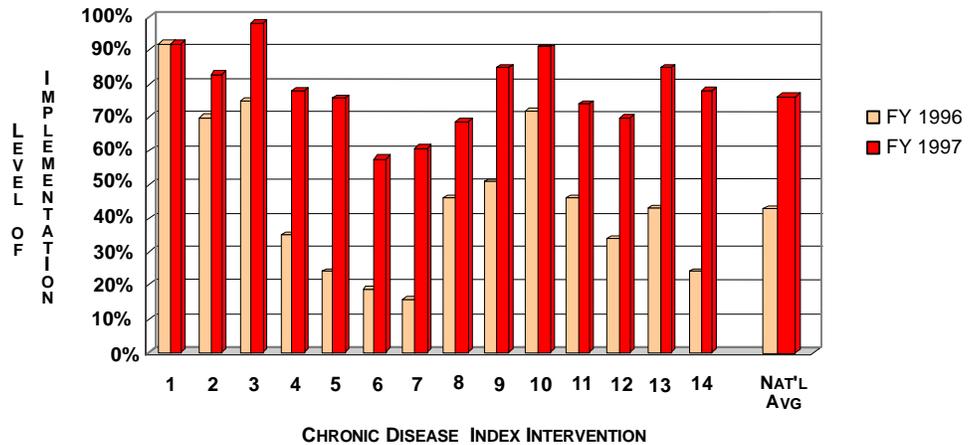


Chart 2-2

Chart 2-2 “Chronic Disease Index – Nationwide Implementation Level of Each Intervention” indicates that implementation has improved for each intervention, with the highest level at 98% and the lowest at 58% in FY 1997 compared to a high of 91% and a low of 16% in FY 1996.

CHRONIC DISEASE INDEX - NATIONWIDE IMPLEMENTATION LEVEL OF EACH INTERVENTION



SOURCE - 1997 NETWORK PERFORMANCE AGREEMENT REPORT

See Appendix C for the 1998 3rd Quarter Network Performance Report for progress on this index.

**Table 2-2
CHRONIC DISEASE INDEX INTERVENTIONS**

DIAGNOSIS	#	CLINICAL INTERVENTION
ISCHEMIC HEART DISEASE	1	Administration of aspirin.
	2	Administration of beta blockers.
	3	Documentation of plan to manage cholesterol in the chart of outpatient record.
HYPER- TENSION	4	Documentation of counseling about nutrition/weight control during past two years.
	5	Documentation of counseling about exercise during past two years.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	6	COPD patients on inhaled drugs, first receiving an inhaler in the past 3 years with documentation that they were instructed and observed using inhaler properly.
	7	COPD patients using an inhaler, admitted to the hospital in past 3 years with COPD diagnosis, whose use of inhaler was subsequently observed and corrected if necessary.
DIABETES MELLITUS	8	Diabetics with documentation of past year fundoscopic examination of the retina.
	9	Diabetics with documentation of past year hemoglobin A1c determination.
	10	Diabetics other than bilateral amputees with past year documentation of visual inspection of the feet.
	11	Diabetics other than bilateral amputees with past year documentation of examination of pedal pulses.
OBESITY	12	Diabetics other than bilateral amputees with past year documentation of foot sensory examination.
	13	Overweight persons with documentation of nutrition counseling during past 2 years.
	14	Overweight persons with documentation of exercise counseling during past 2 years.

**BEST
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Implementation of Clinical Care Guidelines Accelerated

To accelerate the use of clinical practice guidelines (CPG), VAMC Tampa created a system that allows physicians at the point of patient care, using their personal computers, to implement the guidelines quickly and easily via the hospital Intranet. The CPG for chronic obstructive pulmonary disease (COPD) are presented on World Wide Web pages in hypertext-linked algorithms and—for even greater speed—in mouse clickable frames. For the direct ordering of action steps, both Web presentations are connected to direct physician order entry (POE) in the Decentralized Hospital Computing System (DHCP). Using the frames, the physician can electronically place 5 or more orders (for referral to smoking clinic, etc.) in less than 30 seconds. The resident physicians (who rotate each month) implemented the CPG in more than 80% of the first 60 COPD patients consecutively admitted to the Medical Service following project onset. The residents complied with enthusiasm and excellent adherence to the CPG’s recommendations. This degree of full implementation of a complex CPG has been possible due to 1) customization of the computer-human interface according to the clinical needs and the explicit sustained physician user feedback to system designers, and 2) the observed process improvement and medical benefits produced following computerized implementation of the CPG.

Implementation of Clinical Practice Guidelines by the Use of World Wide Web Pages Connected to Physician Order Entry
by Nicholas A. Coblio, Andrea L. Davis, Richard A. Silver, Michael T. McCormick, Mary Ann Romeo, Lynn J. Martinez, and Willard S. Harris; James A. Haley Veterans’ Hospital, Tampa, FL
 “Journey of Change” Leadership Conference, Baltimore, MD December 1997.

Prevention Index:



Charts 2-3 and 2-4 demonstrate the success with which VHA has implemented nine interventions such as immunizations, cancer screening, tobacco consumption screening, and alcohol consumption screening that are nationally recognized for the primary prevention and early detection of diseases with major social consequences. (Table 2-3, following the charts, defines the nine interventions.) All VISNs have made significant progress in implementing the interventions, with the highest implementation level at 83% and the lowest at 51% in FY 1997 compared to a high of 41% and a low of 23% in FY 1996. (See Chart 2-3.)

Chart 2-3

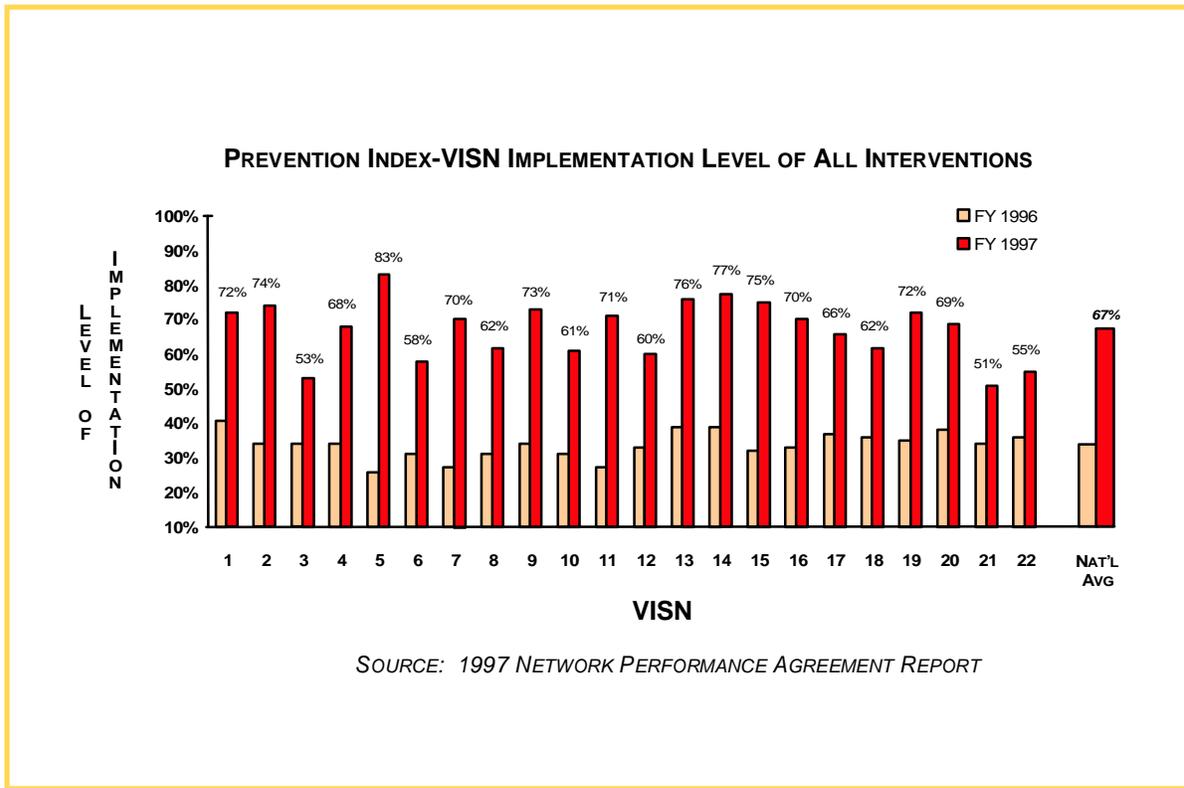
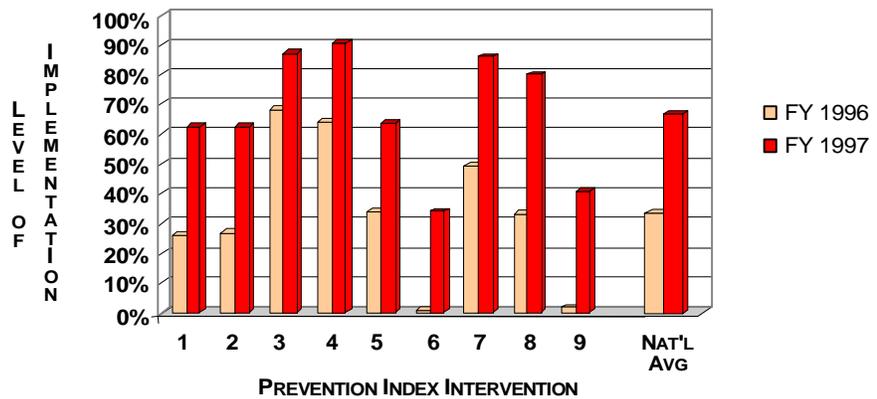


Chart 2-4

Chart 2-4
“Prevention Index
Nationwide
Implementation
Level of Each
Intervention”
 indicates that implementation has improved for each guideline, with the highest level at 90% and the lowest at 33% in FY 1997

PREVENTION INDEX - NATIONWIDE IMPLEMENTATION LEVEL OF EACH INTERVENTION



See Appendix C for the 1998 3rd Quarter Network Performance Report for progress on this index.

**Table 2-3
PREVENTION INDEX INTERVENTIONS**

CATEGORY	#	INTERVENTION
IMMUNIZATIONS	1	Person age 65 or older or at high risk of pneumococcal disease with documentation of ever receiving pneumococcal vaccine.
	2	Person age 65 or older or at high risk of pneumococcal disease with documentation of ever receiving influenza vaccine in past year.
CANCER SCREENING	3	Females age 50-69 with documentation of mammography in past two years.
	4	Females age 65 and younger who have not had a hysterectomy with documentation of receiving a Pap smear in the past three years.
	5	Persons age 50 or older with documentation of fecal occult blood screening in the past year or sigmoidoscopy in the past 10 years.
	6	Males age 50 and older with documentation in the chart of past year discussion of risks and benefits of prostate cancer screening.
TOBACCO CONSUMPTION	7	Persons whose charts document screening for tobacco use in the past year.
	8	Current smokers whose charts document advice to stop smoking in the past year.
ALCOHOL CONSUMPTION	9	Persons whose charts document screening for alcohol using a standardized instrument.

While there is no one universally accepted method for measuring quality, there are numerous widely accepted benchmarks that are considered indicators of good quality healthcare. In addition to the use of prevention and chronic disease management interventions, VA monitors indicators such as survival rates for selected conditions and surgical mortality rates nationally. VISNs implemented several other guidelines/monitors locally.

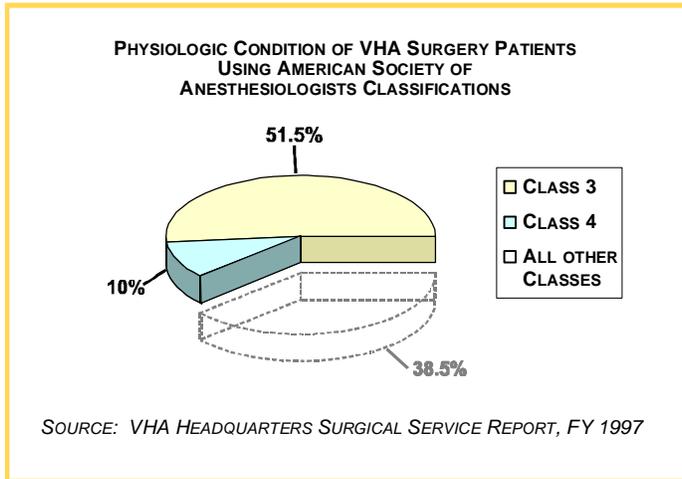
Survival Rates for Selected Conditions:

VHA has been tracking the one-year survival rates for nine high volume conditions—conditions that affect some of our most vulnerable patients. From the baseline year of 1992 to 1997, the survival rates have increased for:

- congestive heart failure – a 9% increase to 83.5%
- chronic obstructive pulmonary disease – a 4% increase to 88%
- pneumonia – a 7% increase to 89%
- chronic renal failure – an over 9% increase to 81.4%

The rates have remained stable for diabetes mellitus (95%), angina pectoris (97%), major depressive disorder (98%), bipolar disorder (99%), and schizophrenia (98%).

Chart 2-5



Surgical Mortality Rates:

The mortality rates of VHA patients treated in FY 1997 within 15 surgical specialties decreased or remained stable in 12 of those specialties while increasing only slightly in the other three. While this improvement is important in and of itself, it is especially significant in the context of VHA. In 1997, 62% of surgical cases involved persons over age 60, and the vast majority (61.5%) of VHA patients are categorized as Class 3 and 4 under the American Society of Anesthesiologist (ASA) classification system – very ill to extremely ill. Chart 2-5 “Physiological Condition of VHA Surgery Patients Using ASA Classifications” indicates the proportion of VHA surgical patients treated in FY 1997 within each of the five classes. Even with this “sicker than usual” population, mortality rates decreased or remained stable in 12 of the 15 surgical specialties tracked in VHA.

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Operating Room Crisis Program Created

The VAMC Palo Alto established the Crisis Simulation Center to train anesthesiologists in how to most efficiently handle crisis situations in the operating room. The Centers staff can, from an adjacent control room, create multiple combinations of patient reactions to treatment using an anatomically correct life-like mannequin. This mode of training has proven highly effective for VA staff. Additionally, with the Enhanced Sharing Authority recently approved by Congress, VA “sells” this service to several other local organizations that seek training. The revenue generated from this educational pursuit is directly targeted at enhancing programs for veterans. The Crisis Simulation Center also has tremendous medical research value. Fatigue and stress studies are two of the numerous subjects in which the Center plays a significant role in improving the operating room environment for physicians and patients. The Center has been highlighted on television on several occasions, and most recently received the 1997 Government Technology Leadership Award from the Government Technology Institute. The Center helps VHA reach the goal of providing the safest and most efficient healthcare services to veterans every time a physician trains in the simulated operating room.

The Simulation Center for Crisis Management

by Eric Raffin and David Gaba, VA Palo Alto Health Care System, Palo Alto, CA
“Journey of Change” Leadership Conference, Baltimore, MD December 1997.

Other Guidelines/Monitors:

While taking the action necessary to meet the requirements of the Chronic Disease Index and the Prevention Index, VISNs implemented numerous other clinical practice guidelines developed by VHA or other national organizations, such as the Agency for Health Care Policy and Research. Table 2-4 indicates which VISNs implemented guidelines; 21 VISNs implemented at least 12 new guidelines, all VISNs implemented 2 that targeted special emphasis populations, and 10 VISNs implemented the 12 guidelines based on covering the VISN’s 20 common disease entities.

Table 2-4

VISN IMPLEMENTATION OF ADDITIONAL GUIDELINES			
VISN	TWELVE		
	NETWORK-WIDE GUIDELINES	TWO SPECIAL EMPHASIS	COMMON DISEASE ENTITIES
1	✓	✓	✓
2	✓	✓	
3	✓	✓	
4	✓	✓	
5	✓	✓	✓
6		✓	
7	✓	✓	✓
8	✓	✓	✓
9	✓	✓	✓
10	✓	✓	✓
11	✓	✓	
12	✓	✓	
13	✓	✓	✓
14	✓	✓	
15	✓	✓	
16	✓	✓	
17	✓	✓	
18	✓	✓	✓
19	✓	✓	✓
20	✓	✓	
21	✓	✓	✓
22	✓	✓	

SOURCE: 1997 NETWORK PERFORMANCE AGREEMENT REPORT

BEST PRACTICES OR INNOVATIONS



VA Adopts Safety Reporting System

The Department of Veterans Affairs (VA) is designing a healthcare error reduction system based on the Aviation Safety Reporting System (ASRS) for use across the entire VA healthcare system. The VA error-reporting program will address all VA and contractor hospitals, nursing homes, primary care providers, home health programs, and domiciliary care facilities.

Quality First: Better Health Care for All Americans, Final Report to the President of the United States. Ch. 10: Reducing Errors and Increasing Safety in Health Care

by The President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, April 1998

Plans for 1998-2003:



Several national goals have been established to ensure that veterans receive healthcare of exceptional quality. The following (Charts 2-6 through 2-9) are from the 1998 VHA Performance Plan.

Chart 2-6

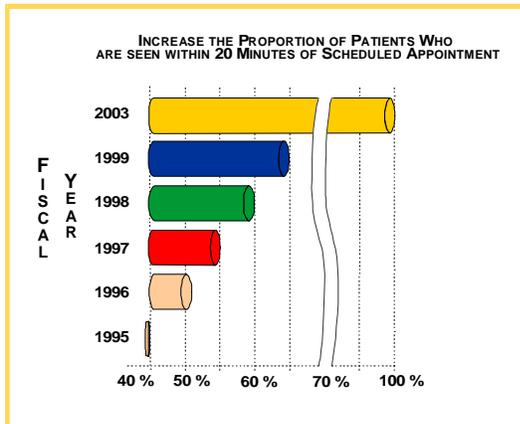


Chart 2-7

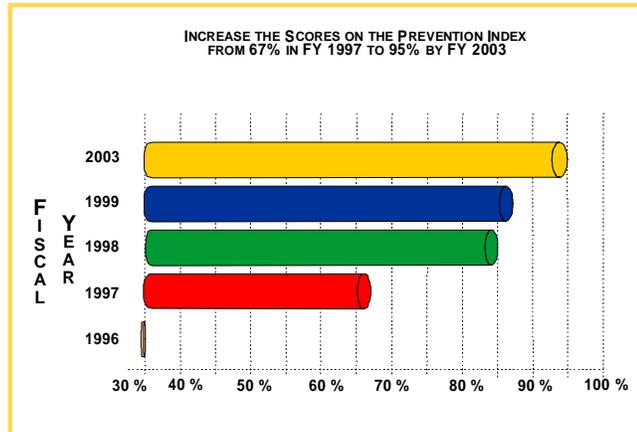


Chart 2-8

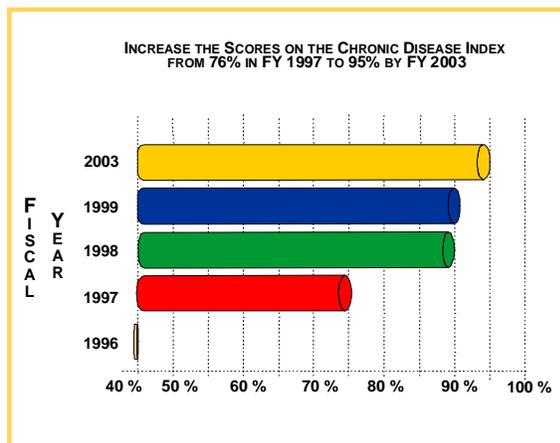
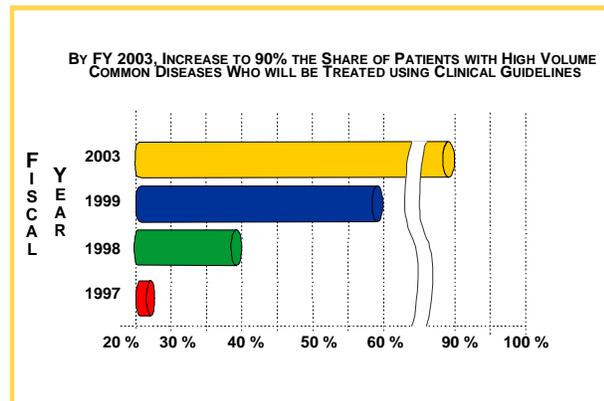


Chart 2-9



SOURCE: VHA PERFORMANCE PLAN, 1998

The Networks are planning to achieve these goals through a variety of activities, including:

Technical Quality

- Establishing VISN joint medicine-psychiatry training program for addiction medicine (Network 6)
- Identifying and implementing 19 additional clinical practice guidelines by the end of 2000 (Network 12)
- Installing automated system to remind clinicians to follow the network adopted health promotion and disease prevention guidelines and report results to the VHA National Center (Network 14)



Service Satisfaction

- Establishing performance based evaluations and ratings for all employees (Network 19)

Access

- Increasing the number of surgical and invasive diagnostic procedures performed in an outpatient setting (Network 11)

Functional Status

- Developing standard policy for utilization of cardiac stress testing practices (Network 4)
- Implementing Global Assessment of Functioning (GAF) tool with all general mental health, chronically mentally ill and post trauma stress disorder programs in FY 1998-2000 (Network 16)

Cost/Price

- Forming an interdisciplinary surgical advisory group at the network level to improve efficiency and quality outcomes (Network 9)

Primary and Palliative Care:

Primary and palliative care; the first aimed at preventing disease or diagnosing it as early as possible to prevent/manage ill health, and the second aimed at end-of-life care for terminally ill patients; are the two extreme ends of the healthcare spectrum. This section covers these two programs, both of which are intimately associated with fulfillment of the “10 for 2002” goals and the VA Strategic Plan objective targeted on maximizing the functional potential of all VA patients. The following information indicates that VHA performance improved during FY 1997 in both of these aspects of healthcare.

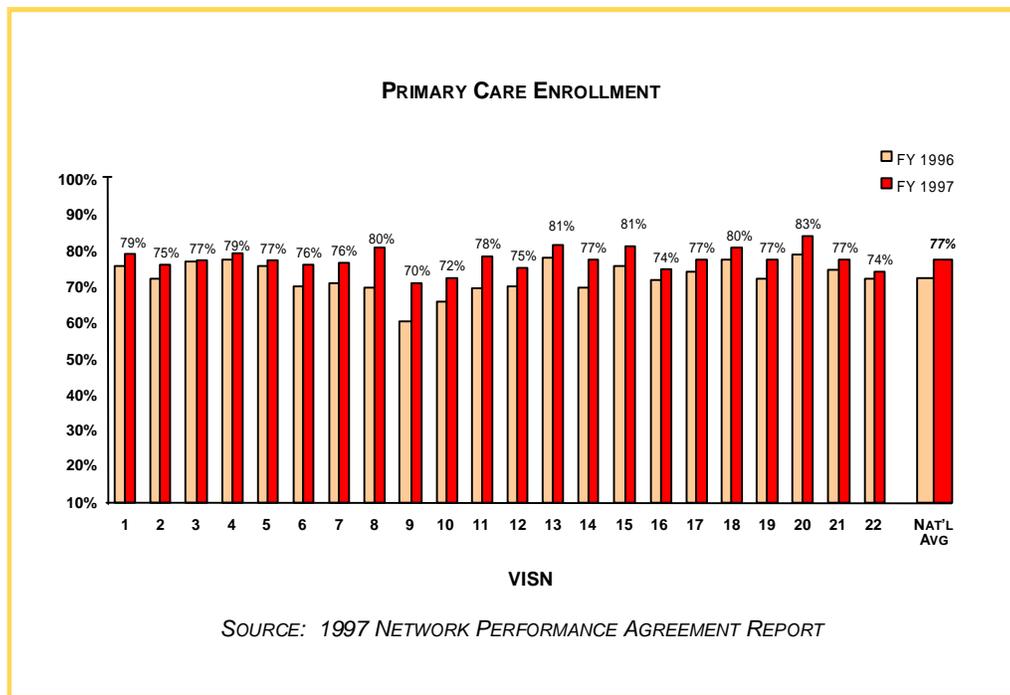
1997 Accomplishments:

Primary Care:



Having the care of each patient coordinated by one individual or a specific group of individuals is an essential element of providing quality care, as it improves both continuity and consistency of care. In VHA, patients are asked whether they know that one person or team is in charge of their care. Chart 2-10, “Primary Care Enrollment,” shows the survey results (patients who answered yes when asked if they knew that one person or team was in charge of their care).

Chart 2-10



See Appendix C for the 1998 3rd Quarter Network Performance Report for progress on this measure.

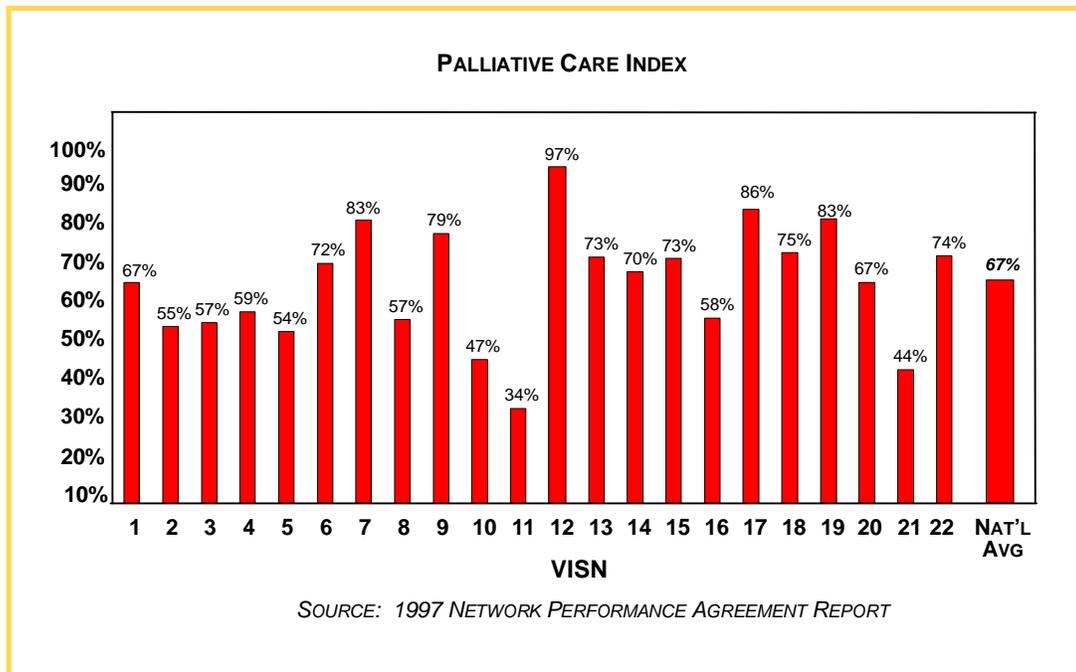
Palliative Care:



An area of healthcare that is receiving increased attention in the private as well as the public sector is end-of-life planning for terminally ill patients. VHA’s work is outstanding in this area, aimed at minimizing physical and psychological suffering and optimizing quality of life for these patients. VHA was presented with an award for exceptional work in improving care of those approaching the end of life – the first of its kind – from Americans for Better Care of the Dying.

To further improve care in this area, VHA developed the Palliative Care Index to track VISN efforts in end-of-life planning for all appropriate patients. The end-of-life planning is incorporated in activities to comprehensively manage the physical, psychological, social, spiritual and existential needs of patients with incurable, progressive illnesses. For appropriate patients with cancer, AIDS, chronic renal failure, chronic heart failure, or chronic obstructive pulmonary disease, Chart 2-11 “Palliative Care Index” indicates the proportion who have documentation of an individualized plan for comprehensive, coordinated end-of-life care services.

Chart 2-11



Plans for 1998-2003:



Technical Quality

- Credentialing providers and tracking quality of care in alternative care settings (Network 1)
- Developing specialized primary care quality monitors (Network 7)

Service Satisfaction

- Publish and implement the “new VHA” directive “VA Care Management” requiring primary care teams to provide care management at the appropriate level for all patients to ensure patient centered, easily accessible, coordinated, continuous, high quality healthcare.
- Publish and implement the “new VHA” directive “Patient and Family Participation in Shared Healthcare Decision-Making” requiring networks to conduct clinical training and to implement one new initiative that supports improvement in patient/provider partnerships. The training and initiative must enhance patient knowledge of disease entities, self-management skills, and the risks/benefits of treatment options enabling informed decision-making in conjunction with the provider.
- Increase to 80% the proportion of patients who know there is one provider or team in charge of their care (to 96% in FY 2003).
- Increase to 80% the proportion of appropriate patients who have an individualized palliative care plan (to 100% in FY 2003).
- Ensuring that a single care manager is assigned to monitor and guide patient care across all settings, including the home (Network 3)
- Initiating disease management as an extension of case management (Network 2)
- Identifying effective patient education strategies for implementation of clinical guidelines and other patient education initiatives (Network 10)



REVIEWS BY ACCREDITING ORGANIZATIONS

Another major indicator of quality care is approval by a formal body with accreditation or licensing jurisdiction, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Rehabilitation Accreditation Commission (CARF).



VHA facilities have been reviewed and accredited by JCAHO for many years, and we are now actively pursuing CARF accreditation for rehabilitation programs. Although all patients benefit by having VHA facilities and programs meet the standards set by these organizations, care of the special emphasis populations (e.g., spinal cord injury and disorders, amputations, traumatic brain injury criteria) is especially affected by meeting CARF requirements. These efforts support the VA Strategic Plan objective to maximize the functional potential of special populations of veterans, assess their needs, improve the quality of their care, and ensure that access to VA programs and benefits is equitable.

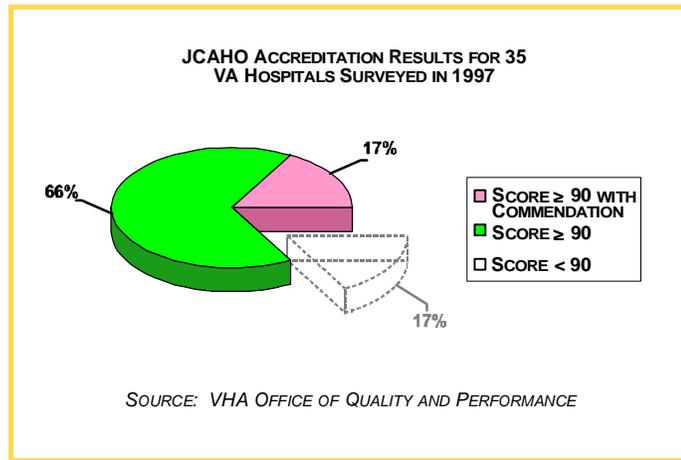
1997 Accomplishments:



Joint Commission on Accreditation of Healthcare Organizations:

Chart 2-12

As Chart 2-12 displays, of the 35 VHA hospitals surveyed by JCAHO in 1997, 6 received accreditation with commendation, 26 received scores of 90 or higher, and 6 received scores below 90%. The average VA score was 92. This compares favorably with the average non-VA score of 92. The VA facilities receiving commendation (i.e.; no “Type I” recommendations) were VA Connecticut Health Care System (HCS); Providence, RI; VA Western New York HCS; New York, NY; VA Central Texas HCS; and VA Northern California HCS.



Rehabilitation Accreditation Commission:

VHA began a systemwide, long-term joint venture with the CARF to promote continuous quality improvement in rehabilitation services, through the mechanism of national accreditation as offered by CARF. This joint venture includes mutual efforts to enhance the use of outcome measurement and management in affirming efficient and effective delivery of rehabilitation services. CARF provides an international, independent, peer review system of accreditation that is widely recognized by several federal agencies, forty state governments, several major insurers, and all of the leading professional groups in rehabilitation, as well as by consumer and advocacy organizations throughout the field. VHA established the CARF Accreditation Steering Committee to develop a process and guidance for pursuing accreditation for rehabilitation programs within the three main accreditation categories of medical rehabilitation, employment and community support services, and behavioral health.

Plans for 1998-2003:

Technical Quality

- Promoting VHA's systemwide use of our newly published guidebooks on safety, health, industrial hygiene, environmental compliance, and JCAHO compliance. To address the challenge of constantly-developed new regulations and limited safety and health staff, VHA produced a seven volume, cross-referenced set of guidebooks compiling policies, procedures, and best practices for each of the major areas of regulation as well as JCAHO compliance. Field practitioners, who have implemented these policies and procedures, wrote the samples. All of the policies selected for use in the guidebooks are peer reviewed for accuracy, consistency with national policies, and compliance with underlying laws and/or regulations. The policies and procedures, including sample charts and tables, are available on floppy discs in Microsoft Word and Excel for ease of use at each VAMC.
- Publishing and implementing a "CARF Annual Business Plan" that guides the accreditation process for VHA rehabilitation programs. The plan will outline activities to obtain, by the conclusion of the year 2000, three-year accreditation status for the following rehabilitation programs, approximately:
 - 65 comprehensive inpatient medical rehabilitation programs (acute/subacute)
 - 200 programs of employment/vocational rehabilitation therapy
 - 80 psychosocial residential rehabilitation programs
 - 100 community support rehabilitation programs
 - 30 partial hospitalization programs
 - 40 domiciliary residential treatment programs
 - 4 lead traumatic brain injury centers
 - 20 spinal cord injury centers

CONCLUSION

Systematic vigilance defines VHA's efforts to provide the highest quality healthcare. We have made momentous headway in becoming an organization that routinely and methodically evaluates all aspects of our operations to identify strengths and weaknesses, one that recognizes exemplary work as well as service delivery problems and that disperses best practices or solutions rapidly across the national system. Beginning with the Strategic Framework for Quality Management, quality considerations are built into all components of care delivery. Following the old saying that "what gets measured, gets done," VHA implemented and is tracking compliance with clinical interventions for prevention of disease and management of chronic disease, enrollment in primary care, and implementation of end-of-life planning. VHA's excellent results on JCAHO reviews and our new involvement with CARF confirm our capabilities and intent to meet or exceed the same standards set for the non-VA sector.

FY 1997 accomplishments in all these areas show outstanding performance, which, when combined with the goals for 1998 and beyond, indicate that our focus on quality is unwavering. VHA is dedicated to maintaining and improving the consistency and predictability of high quality care, ensuring that veterans receive the best healthcare America has to offer.

CHAPTER 3: CUSTOMER SERVICE AND PATIENT SATISFACTION

But what patients care about is not necessarily what health professionals think they care about...hospital patients who have participated in focus groups or interviews make little mention of the “hotel” amenities...nor do clinic and office patients attach as much importance to the politeness of office staff as doctors think they do...The real business of healthcare is about much more than mergers and acquisitions, financing mechanisms, or structural reforms that have occupied center stage on the public agenda for much of the past decade. It is about preventing ill health, caring for people who are sick, meeting the needs of people who must live their lives with disabilities or chronic disease, and making people in communities healthier.

*Excerpts from Eye on Patients Report
A Report from the American Hospital
Association and the Picker Institute*

The Department of Veterans Affairs’ very reason for existence is to provide services and benefits that improve the quality of life for veterans. As a major part of this effort, the role of VHA is to focus on improving the health of the served veteran population by providing high quality primary care, specialty care, extended care and related social support services through an integrated healthcare delivery system. In doing so, VHA is working diligently to achieve the VA Strategic Plan general goal of providing “One-VA” world class customer service – service comparable to the best service provided by public and private sector organizations. The purpose of this chapter is to:

- Review the Customer Service Standards used throughout VHA
- Describe how customer satisfaction is measured by VHA
- Present the 1997 accomplishments and future goals for specific patient-reported outcomes
- Discuss training and incentives provided for the work force to deliver world class customer service

The *Prescription for Change*, 1996, stated that effective communication is the cornerstone of the physician-patient relationship and is the single most important factor determining patient satisfaction. Beyond the primary physician/patient relationship, VHA believes that every VA employee should exemplify a “Patients First” approach to the delivery of services (*Vision for Change*, 1995).

CUSTOMER SERVICE STANDARDS

In 1995, VHA put into place a comprehensive set of Customer Service Standards that was widely distributed throughout VHA and posted in every VHA field facility. These customer service standards were developed by listening to our patients who said they expect the highest quality care and services available. They told us that the following ten items were the most important to them. We have turned those items into standards that they can expect us to meet.



Table 3-1

CUSTOMER SERVICE STANDARDS	
1. STAFF COURTESY	We will treat you with courtesy and dignity. You can expect to be treated as the 1 st class citizen that you are.
2. TIMELINESS	We will provide you with timely access to healthcare. You told us that you expect to have your urgent needs met when they come up and your non-urgent needs taken care of in a reasonable period of time. We have established timeliness standards and will strive to achieve them.
3. ONE PROVIDER	One healthcare team will be in charge of your care. Because healthcare often involves many different providers, it is important that one provider or team have overall responsibility. You can expect to know whom to contact when you need help or have a problem.
4. DECISIONS	We will involve you in decisions about your care. Your preferences will be met whenever possible and medically appropriate. We will listen to your concerns and discuss them with you.
5. PHYSICAL COMFORT	We will strive to meet your physical comfort needs. This includes help with things like pain management, eating, bathing, or getting to the bathroom while in the hospital. It also includes maintaining privacy during examinations and tests when an inpatient or outpatient. We will ensure proper facilities for veterans with special needs.
6. EMOTIONAL NEEDS	We will provide support to meet your emotional needs. We will encourage you to share any anxieties and fears you may have about your condition or treatment. You can expect our staff to be sensitive to your feelings and help you deal with your healthcare experience.
7. COORDINATION OF CARE	We will take responsibility for coordination of your care. Healthcare can be very complicated, and many patients may need to see more than one healthcare professional. We will ensure that your providers talk to each other and give you clear plans for your care. If you need a specialist, you can expect us to make all necessary arrangements to ensure that one is provided for you.
8. PATIENT EDUCATION	We will strive to provide information and education about your healthcare that you understand. You can expect us to try to answer your questions in a way you understand.
9. FAMILY INVOLVEMENT	We will provide opportunities to involve your family in your care when appropriate. Whether your family is involved, however, should generally be your choice.
10. TRANSITION	We will provide smooth transition between your inpatient and outpatient care. You can expect to understand what medicines you are to take, what danger signals to look out for, and what activity level you can have after discharge. You can expect to know whom to contact if you need help or advice right away, and when your first follow-up appointment is scheduled.

SOURCE: VA CUSTOMER SERVICE STANDARDS, VA FORM 10-0360

Setting customer service standards is a commendable accomplishment. However, we must measure the results in order to determine how satisfied our patients are and identify where we need to improve. Improving the quality of care is a process, not a single survey event.

HOW CUSTOMER SATISFACTION IS MEASURED

VHA relies heavily on periodic feedback from customers as to the level of their satisfaction with service. Such feedback is obtained through surveys, focus groups, complaint handling, patient advocates, and Service Evaluation and Action Teams (SEAT). In 1993, VHA established the National Customer Feedback Center (NCFC), which completely transformed the 1972 version of the patient satisfaction survey questionnaire. In order to do this, VHA developed a partnership with the Picker-Commonwealth Foundation of Boston, Massachusetts.

The Picker Institute, formerly the Picker-Commonwealth Program for Patient-Centered Care, has been a leader in assessing non-VA patient experiences with healthcare since 1987. More than 200,000 patients and healthcare consumers in more than 400 healthcare institutions have been interviewed using Picker patient satisfaction surveys. The Picker Institute has surveyed patients receiving healthcare in a variety of settings, including health plans, health systems, hospitals, clinics, physician practices and business/purchasing coalitions.

The Picker patient satisfaction surveys target the dimensions of care that patients are most concerned about: access to care, respect for patients' values, coordination of care, information and education, involvement of family and friends, physical comfort, emotional support, and transition and continuity of care. Their survey questionnaires are the product of highly trained statisticians backed by research in statistical design.

VHA, in collaboration with the Picker Institute, adapted patient survey questionnaires to our healthcare delivery system. VHA's surveys, adapted from the Picker Institute surveys, have proven over time to have a high level of validity and reliability. The NCFC now distributes surveys to patients who have received care in a variety of settings, e.g. inpatient, outpatient, mental health, home-based hospital care, and certain special emphasis programs. VHA continues to use non-VA benchmarks drawn from the database compiled by the Picker Institute. The Picker Institute provides VHA benchmarks that represent similar academic and non-affiliated healthcare institutions across the country. These non-VA benchmarks are noted throughout this report.

ACCOMPLISHMENTS AND GOALS FOR SPECIFIC PATIENT REPORTED OUTCOMES



This section discusses 1997 accomplishments and goals for the following patient reported outcomes:

- Customer Service (Average Percentage of Problems per patient) using the example of the Outpatient Survey for 1997
- Customer Service Standards Scores using the example of the Outpatient Survey for 1997
- The percent of customers rating VA healthcare as very good or excellent (both inpatient and outpatient service are measured separately) (a "10 for 2002" strategic target)
- The percent of patients who rate the quality of VHA healthcare as equivalent to or better than what they would receive from any other healthcare provider (a "10 for 2002" strategic target)

Customer Service (Average Percentage of Problems):

This measure, included in the Satisfaction domain of value, is based on the ambulatory care patient satisfaction survey. It also supports the general goal of customer satisfaction – service will meet or exceed customer expectations, included in the VA Strategic Plan.

1997 Accomplishments:

The results of the 1997 Ambulatory Care Customer Survey are shown below. A Customer Service Standard (CSS) score is the percentage of unfavorable answers received on the questions related to that Customer Service Standard. CSS scores are computed by first assigning a score of zero (0) to each question answered in a favorable manner and a score of (1) to each unfavorable answer. The questions related to each CSS are then averaged together to obtain a score for that CSS for each patient. Individual CSS scores are averaged together to obtain VAMC-level or Network-level CSS scores.

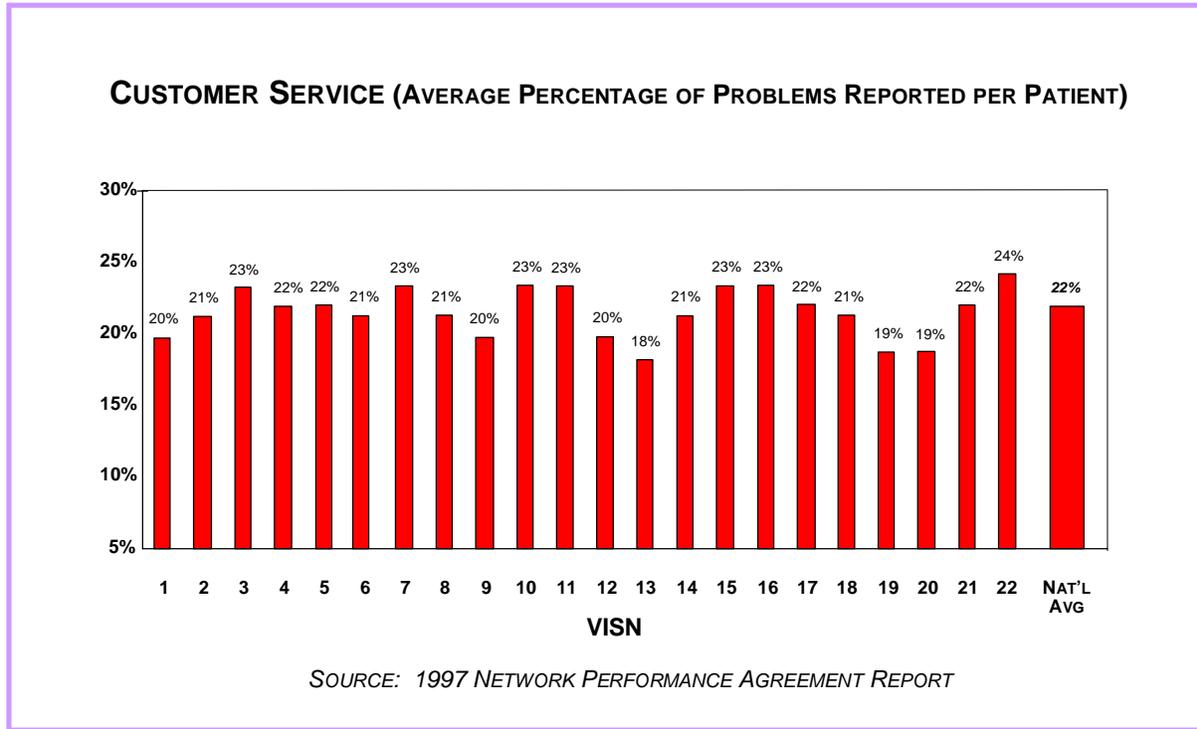
302 ambulatory care sites affiliated with 149 medical centers were included in the sampling. Scores were not reported when the number of respondents was less than 30 but were combined with those from the parent clinic when generating facility-level scores. In 1997, 38 of the 302 ambulatory care sites sampled did not meet the minimum sample size requirement of 30. To be eligible for the survey, a veteran had to meet two criteria (1) an outpatient visit to the general medical clinic, primary care clinic, or women's clinic between 6/2/97 and 8/2/97 and also a visit to an outpatient specialty clinic within the six months prior to the index primary care visit.

A total of 43,034 veterans were selected to participate in the 1997 survey nationwide. Of the 43,034 in the initial sample, 5.7% (2,457) could not be contacted. Of the remaining 40,267, 71% (28,703) returned surveys, which is considered an excellent response rate.

The Picker Institute has provided VHA with satisfaction data obtained using comparable methods from 13,363 individuals who received outpatient care in 1996 at 65 non-government facilities located in nine states across the country. The non-VHA benchmark scores provided in this report are the national averages for this sample of 13,363 after weighting. The non-VA benchmark is 15% or one problem reported per six questions answered. This external benchmark data is risk-adjusted for age, sex, and health status, i.e., the benchmark problem rates are the rates that non-VA patients would report if they had the same age, sex, and health status as the VA patients surveyed.

In VHA, the percentage of problems reported per patient dropped from 25% to 22% overall.

Chart 3-1



Plans for 1998-2003:

Service Satisfaction

- Providing the results of the 1997 survey to the networks to give them base information to use to improve customer service education for employees
- Providing feedback to the networks on a quarterly basis during the 1998 survey period
- Conducting a mid-year Customer Service Satisfaction Survey (Bedford, MA, Health Services Research and Development organization) and providing the results in the Office of Performance and Quality's mid-year performance report.

See Appendix C for the 1998 3rd Quarter Network Performance Report for progress on this measure.

Customer Service Standards (CSS) Scores:

The CSS Survey assesses the following parameters described earlier in this chapter: (1) Access, (2) Education, (3) Preferences, (4) Emotional Support, (5) Coordination (Visit), and (6) Courtesy. VHA compares the results of their own survey to a non-VA benchmark from the database of the Picker Institute. The VHA 1998 Performance Plan adds the Overall Coordination of Care measure, with goals to reduce problems reported.

1997 Accomplishments:

The 1997 Customer Service Standards Scores (from the 1997 Ambulatory Care Survey) for each parameter are listed below along with the Picker (non-VA) benchmark. The lower the score, the higher the patient satisfaction level. The closer the score is to the benchmark, the better the job the VA is doing.

Table 3-2

COMPARISON OF 1997 VA CUSTOMER SURVEY RESULTS WITH NON-VA BENCHMARK		
CUSTOMER SERVICE STANDARD	PICKER (NON-VA) BENCHMARK	VA
ACCESS	.15	.15
EDUCATION	.16	.33
PREFERENCES	.14	.25
EMOTIONAL SUPPORT	.13	.22
COORDINATION (VISIT)	.11	.19
COURTESY	.05	.09
AVERAGE	.12	.21

SOURCE: 1997 NETWORK PERFORMANCE AGREEMENT REPORT

See Appendix C for the 1998 3rd Quarter Network Performance Report for progress on this measure.

Plans for 1998-2003:



The VHA 1998 Performance Plan includes the measure “Improve (Reduce) VISN score on the overall coordination of care customer service standard.” Improvement is defined as a reduction in the number of problems reported and this reduction is in the form of a percentage in the table below.

Table 3-3

REDUCE VISN SCORE ON THE OVERALL COORDINATION OF CARE CUSTOMER SERVICE STANDARD			
1997	1998	1999	2003
35%	33%	31%	23%

SOURCE: VHA PERFORMANCE PLAN, 1998

BEST
PRACTICES
OR
INNOVATIONS



**Providing Excellent Customer Service Is the Key
to Becoming the Healthcare Provider of Choice.**

The VA is determined to change from a healthcare system centered around staff and bureaucracy to one centered around patients. The Quality Service Improvement project is an innovation initiated to foster a complete change in the culture, which delivers services to patients, employees and the community – our “Veteran Guests.” In 1995, both internal and external reviews found the VA network below the national average in courtesy.

After selecting customer service as our organizational issue, the Service Improvement project was begun in 1996. Specific behavioral dimensions were identified for the topic of Courtesy/Communication. Project teams included Great Expectations, Recognition, Greeters, Tip Board, Adopt an Area, Public Relations and Perceptions (which measures customer perceptions primarily using face-to-face focus groups and surveys). After the first year, as measured by complaints and customer feedback, improvement was seen in six key areas. In 1997, the project teams include Timeliness, Patient/Provider Interaction, and Perceptions.

The commitment to excellent customer service is ongoing. In addition to improvement in customer service standards, team strategies have also focused the institution on action-oriented problem solving. New Project teams for 1998 are being formed. We are determined to be the healthcare provider of choice for veterans in this community!

**Excellent Customer Service: Becoming the
Veterans’ Healthcare Provider of Choice**
*By William Feeley and Harry Ray, VA Health-care
Network Upstate New York, Buffalo, NY*
“Journey of Change” Leadership Conference,
Baltimore, MD. December 1997

Rating VA Healthcare as Very Good or Excellent:

The third patient satisfaction measure discussed in this chapter is the “10 for 2002” strategic target to increase to 90 percent the proportion of patients reporting VA healthcare as very good or excellent. These inpatient and outpatient satisfaction measures support the VA Strategic Plan to meet the objective to increase customer satisfaction to the highest possible level. They are also included in the VHA 1998 Performance Plan, as shown in Tables 3-4 and 3-5.

Chapter 3: Customer Service and Patient Satisfaction

1997 Accomplishments:

The actual levels of achievement for inpatient and outpatient ratings of VHA care as very good or excellent are 65% and 63%, respectively, as shown in the tables below.

Plans for 1998-2003:



VHA has set aggressive goals for 1998 through 2003. Intensive efforts will need to be made in a number of areas, including customer service training, cultural change, and patient-provider relationships, to achieve these goals.

Table 3-4

BY 2002, INCREASE TO 90% THE PROPORTION OF PATIENTS REPORTING VA HEALTHCARE AS VERY GOOD OR EXCELLENT - INPATIENT					
1996	1997	1998	1999		2003
65%	65%	75%	79%		95%

SOURCE: VHA PERFORMANCE PLAN, 1998

Table 3-5

BY 2002, INCREASE TO 90% THE PROPORTION OF PATIENTS REPORTING VA HEALTHCARE AS VERY GOOD OR EXCELLENT - OUTPATIENT					
1996	1997	1998	1999		2003
61%	63%	75%	79%		95%

SOURCE: VHA PERFORMANCE PLAN, 1998

Rating VA Healthcare Quality Equal To or Better Than Other Providers:

The last patient satisfaction measure discussed in this chapter is the “10 for 2002” strategic target to increase to 90 percent the proportion of patients who rate the quality of VHA healthcare as equivalent to or better than what they would receive from others. This satisfaction measure is included in the VA Strategic Plan to help meet the objective to increase customer satisfaction to the highest possible level. It is also included in the VHA 1998 Performance Plan, as shown below.

1997 Accomplishments:

The actual level of “equal or better” ratings rose to 78.4% in 1997, up slightly from a 1996 level of 77.9%.

Plans for 1998-2003:



Patients define excellence according to the degree to which services received match their expectations (Principle 17, *Prescription for Change, 1996*). Extensive efforts are being made to improve quality and consistency across the system. These efforts were more fully described in Chapter 2. The Framework for Quality Management described in that chapter demonstrated our commitment to quality healthcare for veterans.

Table 3-6

INCREASE TO 90 % THE PROPORTION OF PATIENTS WHO RATE THE QUALITY OF VHA HEALTHCARE AS EQUIVALENT TO OR BETTER THAN WHAT THEY WOULD RECEIVE FROM OTHERS				
1996	1997	1998	1999	2003
77.9%	78.4%	85%	87%	90%

SOURCE: VHA PERFORMANCE PLAN, 1998

ACCOMPLISHMENTS AND PLANS AT THE NETWORK LEVEL

All networks are committed to providing excellent customer service. It is the foundation of retaining current customers and expanding the number of customers by 20%, a “10 for 2002” strategic target. Customers must be satisfied with the service provided by VHA. Customer expectations must be ascertained, performance standards established, and continual feedback obtained.

1997 Accomplishments:

The networks have recognized significant success with regard to the indicators of patient satisfaction: timeliness (discussed in Chapter 2), ease of access (discussed in Chapter 5), and meeting patients concerns (discussed in Chapter 2). Activities reported by the networks include:

- Conducted customer surveys at the medical centers under the guidance of the Customer Service Council (Network 2)
- Revised employee performance standards to include a strong focus on customer service (Network 4)
- Developed a customer service plan with actions, responsible individuals, time frames, estimated costs, and performance measures (Network 8)
- Established a Service Evaluation and Action Team (SEAT) for Gulf War veterans to rapidly resolve and monitor trends on customer satisfaction (Network 8)
- Conducted customer (patient) satisfaction surveys in all facilities (Network 11)
- Instituted special awards for customer service in six medical centers (Network 11)
- Began implementing VA’s “Customer Service: An Integrated Approach” at all sites (Network 12)
- Established process action teams to address issues identified from the national VA consumer survey (Network 12)
- Addressed actions to meet customer service standards (e.g. customer service training, renovations of urgent care areas, provider identification cards, etc.) (Network 13)
- Pilot tested and then implemented network-wide patient satisfaction monitoring systems (Network 16)
- Included customer service standards in all employees’ performance standards (Network 16)
- Established Customer Service Boards at many facilities (Network 16)

Plans for 1998-2003:

Networks' plans to improve customer service include:

- Supplementing the national customer survey feedback by utilizing focus groups and local surveys for customer perceptions (Network 1)
- Visiting each facility with a peer/consultation team to offer new insights for improvements in customer satisfaction (Network 2)
- Implementing formal patient/family/clinician shared decision-making in one clinical area by each Health Services Council subcommittee (Network 4)
- Giving customer service awards at each site in the network and one quarterly network goal award to the individual or group making significant contributions in support of network goals (Network 5)
- Organizing a VISN customer service best practices task force to identify the essential elements for VISN-wide customer service (Network 5)
- Appointing a network-wide Quality Management coordinator to provide oversight of customer service (Network 6)
- Hiring a Network Coordinator to continue the development of the Network Customer Service/Customer Satisfaction Program and the Enhanced Volunteer Assistance Program (Network 7)
- Implementing a customer service program based on proven principles as in the Malcolm Baldrige Performance Improvement Criteria and the nine critical success factors of customer service identified by the employee education system (Network 10)
- Conducting patient satisfaction surveys more frequently than annually (Network 13)
- Continuing an extensive program of customer feedback, events, forums, town halls, employee communications, process re-engineering, quality improvement, and veteran outreach by all facility directors (Network 14)
- Ensuring that customer service standards and corresponding network and facility performances are widely shared with customers, stakeholders, and employees (Network 16)
- Conducting family member focus groups to develop understanding of the needs and concerns of dependents (Network 17)
- Improving volunteer services and training and establishing a youth volunteer program (Network 18)
- Developing a uniform guest (patient) service package for implementation by all facilities (Network 18)
- Supporting and promoting at each network facility the development of a "customer intelligence system" (selected quantitative and qualitative data) which is designed to communicate the organizational expectations, needs, satisfiers and dissatisfiers of patients on a consistent, regular basis (Network 18)
- Developing a standardized, comprehensive feedback mechanism and management system to provide customer information on a regular, consistent basis that will allow comparison between facilities on a quarterly basis allowing timely/immediate responses for improvement (Network 18)
- Improving communication to customers by distributing network newsletter and direct mailing when appropriate (Network 21)
- Developing and administering network and local customer surveys to complement national efforts and provide more timely and frequent feedback (Network 21)

LEARNING INITIATIVES AND INCENTIVES PROVIDED FOR THE WORKFORCE TO DELIVER WORLD CLASS CUSTOMER SERVICE



Education and training is a vital piece of the multi-faceted re-engineering effort that has been started in the VHA healthcare delivery system. The 1995 *Vision for Change* recognized that change of this magnitude does not come quickly or easily. Key to managing change while maintaining quality care, excellent customer service, and high levels of patient satisfaction, is employee education and training. For that reason, VHA established a “10 for 2002” strategic target to increase to 2 percent, or 40 hours per year, the amount of an employee’s paid time that is spent in continuing education to promote and support quality improvement or customer service. This meshes with the VA Strategic Plan’s general goal to create and maintain a high performing work force to serve veterans today and tomorrow and that Plan includes our strategic target.

A systemwide incentive to provide world class customer service is the Under Secretary for Health’s Award for Customer Service.

1997 Accomplishments:

A major accomplishment of the re-engineering effort was the establishment of the Office of Employee Education (OEE). OEE’s primary responsibility was changed to provide leadership to enhance and broaden systemwide support of an all employee learning culture within VHA. The mission of the Employee Education System (EES) was identified as follows: To partner with clients to provide customer-focused educational and performance services which are accessible, timely, cost-effective and driven by organizational objectives and strategic initiatives. In moving toward achieving its vision, which is to be an innovative leader in a “One VA” approach to all employee learning and high performance workforce development, the EES endeavored to expand its role from serving primarily as a provider of education to providing leadership in partnering with its customers to meet the educational needs of all employees through collaborative efforts.

Collaborative, systemwide activities already completed that relate directly or indirectly to improving quality and customer service (e.g. timeliness, ease of access, meeting patient’s concerns) include:

Technical Quality

- Received approval to begin a demonstration project with the American Council of Continuing Medical Education (ACCME) to accredit physician educational activities, which focuses on a performance/outcome driven approach to accreditation. This pilot is the first in the ACCME and VHA history.
- Developed and implemented a computerized training initiative using CD-ROM technology focusing on Compensation and Pension examination training for physicians. This educational tool provides just-in-time training at the physician’s work site.
- Continued primary care educational activities including: provision of Primary Care Education and Consultation Team (PCECT) visits to VA facilities, development and nationwide distribution of a Primary Care video and CD-ROM learning packages, and nationwide development and distribution of Primary Care education modules.
- Developed Learning Maps which are work-site based learning initiatives designed to promote employee understanding of: Becoming One VA, Our Journey for Change, the Process of Delivering Care, the Economics of Providing Care, and the Changing Healthcare Environment.
- Continued Total Quality Improvement courses focusing on customer service.
- Developed and implemented a computerized record keeping system designed to track education and training at the local level.



Chapter 3: Customer Service and Patient Satisfaction

The networks completed additional customer-service oriented activities including:

Service Satisfaction

- Designed and implemented a National Customer Service Education Toolbox (Network 2)
- The VA Black Hills Healthcare System educated staff on customer service standards and established facility-specific monitors (Network 13)
- Provided customer service training to most VISN employees (Network 16)
- Implemented customer service training within each market area (Network 21)

Plans for 1998-2003:

Future EES efforts will emphasize implementing educational initiatives focusing on, among other things, improved quality and customer service both internal and external services.

Technical Quality

- Continuing to work collaboratively with Bayer Institute of Healthcare Communications to provide clinician/patient communications training
- Continuing to work with the ACCME to achieve accreditation for Continuing Medical Education credits for a diverse group of non-didactic activities.

Service Satisfaction

- Implementing learning initiatives focusing on improved customer service. One initiative should focus on shared decision-making.
- Improving customer service with timeliness of service of educational providers. Implementing a prototype system for customer service to be used by various levels of educational providers



The networks will continue educational activities that directly or indirectly contribute to quality and customer service. Each network will provide employees continuing education for activities with Total Quality Improvement (TQI) principles such as process improvement, customer service, data driven decision-making, empowerment, and team-driven change. Examples of activities that meet the intent of the strategic target are:

- Baldrige training
- Bayer related training for both clinicians and front-line staff
- Participation in the development of national guidelines
- Participation in focused reviews for risk management
- Mortality and morbidity conferences focusing on system issues rather than individuals
- JCAHO training on performance improvement
- Participation in process improvement teams
- Shared-decision making training (i.e., provider-patient communication)

More specific examples that were identified in the network plans include:

Service Satisfaction

- Implementing Kaset Training, a behavior-based customer service skill development program (a total of 1,000 staff will receive this nationally recognized training) (Network 2)
- Engaging an external consultant to present a train-the-trainer program on customer service (Network 5)
- Conducting focus group moderator training to increase number of moderators (Network 17)

Customer Service Award:



The Under Secretary for Health established a new award as an incentive and to recognize superior customer service given to our veterans. This new award program was established to support the customer service values as defined in the *Prescription for Change*. That definition is “...the mission of the veterans healthcare system is to serve the needs of America’s veterans.... To accomplish this mission, VHA needs to be a comprehensive, integrated healthcare system that provides excellence...in service as defined by is customers....”

This annual award program recognizes individuals and activities that have delivered superior customer service in response to customer expectations. Awards are considered for the following categories: individual, team (two or more individuals), facility, VISN, and VHA Headquarters. To emphasize the importance of personal initiative, two awards will be granted in the individual and team categories.

The criteria for bestowing the award are:

1. Demonstrated improvement in ratings in overall customer feedback surveys. Improvements in the category include:
 - Customer service ratings greater than or equal to two standard deviations above the national average; and/or
 - Customer service ratings greater than or equal to those in comparative community data
2. Achieved improvements in Timeliness or Access. Examples of improvements in this criteria could include, but are not limited to:
 - Exceeded national timeliness goals
 - Improve timeliness from scheduled appointment until seen by provider
 - Shorter pharmacy waiting times
 - Changes in admission/discharge procedures thus eliminating patients’ delays
 - Better access to care (distance or time traveled)
 - Improved access to care team
3. Achieved improvement in or implemented systems and/or Processes that led to improvement in customer service. Such achievement is evident by excellence in one or more of the customer service standards or other relevant empirical customer data. Examples of improvements in systems/processes could include but are not limited to:
 - Rewards and recognition focused toward customer service
 - Customer service requirements incorporated in position descriptions and/or performance requirements
 - Customers’ needs and expectations included in strategic planning and goals
 - Employees included in the process of identifying and solving customer service problems
 - Leadership initiated decisions/actions focused on improving customer service
4. Other tangible benefits and results of improved customer service. Examples of benefits could include, but are not limited to:
 - Teamwork
 - Cross functional and/or facility and/or community collaboration
 - Improve cost-effectiveness
 - Cost savings

Chapter 3: Customer Service and Patient Satisfaction

1997 Accomplishments:

The award was established and the first round of nominations were solicited from throughout the organization. The nominations were reviewed and the first round of awards were made.

Plans for 1998-2003:

Continue this successful incentive and recognition program.

CONCLUSION

Customer Service and Patient Satisfaction are keystones to successful healthcare delivery for the veterans healthcare system. One of the five Mission Goals initially identified in *Prescription for Change – Provide Excellence in Service as Defined by Customers*, continues to receive a significant amount of resources throughout VHA.

Customer Service Standards provide the guideposts for employees to deliver world class customer service. VHA measures the success of its efforts through surveys, focus groups, complaint handling, patient advocates, and Service Evaluation and Action Teams. Our survey questionnaire is adapted from a world class survey instrument with proven reliability and validity. We have and will continue to compare ourselves to non-VA benchmarks provided by the Picker Institute to demonstrate the high level of quality in our system.

VHA measures and monitors patient reported outcomes such as Customer Service Standards Scores, the percentage of customers rating VA healthcare as very good or excellent (a “10 for 2002” strategic target), and the percent of patients who rate the quality of VHA healthcare as equivalent to or better than what they would receive from any other healthcare provider (another “10 for 2002” strategic target). Weaknesses are identified and corrective actions are taken to improve the level of customer service and patient satisfaction.

To further emphasize the importance of customer service and patient satisfaction, VHA established a goal to increase to 2 percent, or 40 hours per year, the amount of an employee’s paid time that is spent in continuing education to promote and support quality improvement or customer service (a “10 for 2002” strategic target). In addition, the Under Secretary for Health has reinforced the importance of customer service by creating an award that will be given annually.

Improving the quality of care, patient satisfaction, and customer service is a process, not a single survey event. VHA is working continuously and diligently to meet our patients’ expectations in every way.

CHAPTER 4: SPECIAL EMPHASIS PROGRAMS

VHA is especially focused on delivering quality healthcare to VA’s special populations within our Special Emphasis Programs (SEPs). Typically, SEPs are clinical services that address illnesses specific to the service-connected veteran population, constitute areas of special VA expertise, or are unique programs that address the psycho-social needs of certain identified veterans. This chapter presents the 1997 accomplishments and 1998-2003 strategic forecast for the VHA designated 12 SEPs, as well as one additional program (Traumatic Brain Injury) designated a Special Disability Program (SDP), with a focus on improvements in quality, access, and patient functional status. Current accomplishments and future plans for SEPs support VA’s strategic objective to ensure that access to VA programs is equitable and link directly to the “10 for 2002” goals to:

- Exceed by 10% the proportion of patients of other large healthcare providers who achieve maximal functional potential.
- Increase to 90% the proportion of patients reporting VA healthcare as very good or excellent.
- Increase to 90% the proportion of patients who rate the quality of VHA healthcare as equivalent to or better than what they would receive from others.



In an effort to assure the highest quality in these program areas, VHA utilizes independent external quality advisory committees for external review, oversight and participation in the SEPs. These committees include: the Committee on Care of Severely Chronically Mentally Ill Veterans, the Geriatrics and Gerontology Advisory Committee, the Persian Gulf Expert Scientific Committee, and the Advisory Committee for Prosthetics and Special Disabilities Programs.

The *Vision for Change, 1995*, established 12 special programs that need unique support from management both in headquarters and the field. Generally, these services have been ones that are unlikely to be adequately served by a market-driven system and ones for which VHA has developed unique expertise and resources. Congress has generally recognized these programs by targeting funding or taking other specific actions to emphasize their importance. Often, special funding is identified, special tracking mechanisms are put in place, and special training programs are developed in order to institutionalize the management and delivery of the program services to veterans over a period of years. Additional programs may be designated as “special program” status as the need arises. *Prescription for Change, 1996*, specified that action would be taken to explore ways of improving access, quality, and cost-effectiveness (“10 for 2002” strategic targets) of the special programs. Therefore, the development of policies and performance measures has already been well underway in the prior years (1996-1997). The programs designated as Special Emphasis Programs are as follows:

Table 4-1
VHA SPECIAL EMPHASIS PROGRAMS

ADDICTIVE DISORDERS	PRESERVATION/AMPUTATION CARE
BLIND REHABILITATION	PROSTHETICS AND REHABILITATIVE MEDICINE
GERIATRICS AND LONG-TERM CARE	READJUSTMENT COUNSELING
GULF WAR VETERANS	SERIOUSLY MENTALLY ILL
HOMELESSNESS	SPINAL CORD INJURY & DISORDERS
POST TRAUMATIC STRESS DISORDER	WOMEN VETERANS

Source: *Prescription for Change, 1996*

Chapter 4: Special Emphasis Programs

Overlapping the SEP group are the Special Disability Programs (SDPs), which address six disabling conditions in the veteran population. Congress designated these disabling conditions in the Eligibility Reform legislation, Public Law 104-262, Section 104, which was enacted in the fall of 1996. VA is required to provide for the specialized treatment and rehabilitative needs of these disabled veterans within distinct programs or facilities of the Department that are dedicated to their specialized needs. These disabling conditions are identified in the legislation as follows: spinal cord injury and disorders, blindness, traumatic brain injury, loss of limb, serious mental illness, and post traumatic stress disorder. In response to this legislation, it was necessary for a Special Disability Programs Work Group to establish definitions for (1) the population of each group, (2) the current capacity measure for each program, and (3) access measures. Based on these definitions, a common understanding will be used across all the VISNs to plan and execute quality and performance measures for these programs. An annual report (April 1 of 1997, 1998, and 1999) must be submitted to Congress by the Secretary reporting on compliance with the requirements of the law including data by facility and by network. The 1998 report will include available data to demonstrate compliance as well as the results of the consultation with the Federal Advisory Committee on Prosthetics and Special Disabilities Programs (ACPS-DP) and the Committee on Care of Severely Chronically Mentally Ill Veterans (CCSCMI), as required by the law.

ADDICTIVE DISORDERS

The Addictive Disorders program provides services that improve identification, management and treatment of addictive disorders. The program provides early intervention, stabilization (including detoxification), and rehabilitative services, continuing care and monitoring services, staff education, and research.

1997 Accomplishments:



The Addiction Severity Index (ASI) was selected and implemented as the performance measure to monitor patients in this program. 60% (national average) of addictive disorders patients seen in September underwent the standardized ASI clinical assessment. The private sector benchmark is 50%. The results at the network level are shown in Chart 4-1. (Technical Quality)

VHA has also played a leadership role in the development and utilization of new medications for the treatment of opiate dependence.

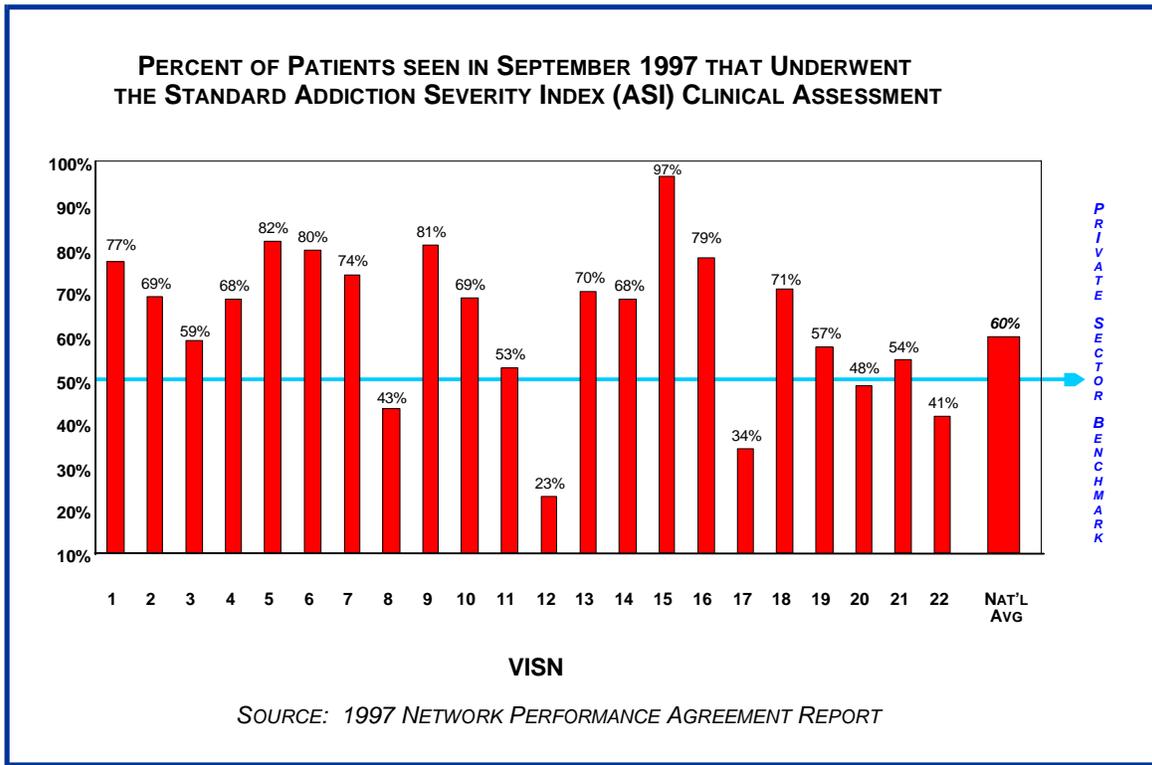
Technical Quality:

- Established Center of Excellence in addictive disorders (Network 4)
- Completed a business plan for implementing efficiencies in addictive disorders services (Network 12)
- Implemented ASI network-wide as an assessment tool (Network 17)

Access:

- All but eliminated waiting times for detox and stabilization (Network 20)

Chart 4-1



Plans for 1998-2003:



The use of the ASI diagnostic testing will be fully implemented this year. Patients with a primary addictive disorders diagnosis will be tested using the ASI instrument. The initial goal for treatment is that at least 50 percent of the patients will show improvement in their composite score during the course of the year.

Technical Quality:

- Assuring ASI rating done on 90% of patients with active addictive disorders diagnosis (Network 3)
- Developing tools for primary care providers so more veterans are identified and referred for addictive disorders treatment (Network 8)
- Pilot testing addictive disorders criteria (Network 20)
- Administering short version of ASI to all patients with primary or secondary diagnosis of addictive disorders (Network 21)

Access:

- Providing addictive disorders treatment for SCD veterans through the VAMC Augusta mental health service line (Network 7)
- Addressing provision of addictive disorders services to special populations, e.g., geriatric, minority and women veterans (Network 8)

BLIND REHABILITATION

The Blind Rehabilitation Service is dedicated to improving the quality of life for blinded veterans by assisting them to develop the skills and capabilities needed to attain personal independence and emotional stability. The Service accomplishes this goal through identification of visually impaired veterans, provision of comprehensive inpatient and outpatient rehabilitation services, education of blinded veterans and their families, and on-going research.

1997 Accomplishments:

Nationally, the focus of this program is to increase the number of eligible veterans who receive blind rehabilitation services appropriate to their needs through rehabilitation care in blind rehabilitation centers, at outpatient locations or in the home, as required by veterans' rehabilitation service needs.



Technical Quality:

- Began the process for CARF accreditation for the National Blind Rehabilitation Program
- Developed National Blind Rehabilitation Training Performance measures

Access:

- 1,634 veterans participated in the residential Blind Rehabilitation Center inpatient program in FY 1997. This represents an increase of 250 over FY 1996
- The new Blind Rehabilitation Outpatient Specialist positions, established in FY 1995, worked with over 800 blinded veteran patients
- Conducted outreach efforts to reach blind veterans and support groups were established for blind veterans in State Veteran Homes (Network 21)



Service/Satisfaction:

- Developed and implemented a National Blind Rehabilitation Patient Satisfaction Survey instrument

Plans for 1998-2003:

Technical Quality:

- Leading the development of new Blind Rehabilitation Program Standards in conjunction with the National Advisory Committee established by The Rehabilitation Accreditation Commission (CARF) Board of Trustees. These new standards are scheduled for field review starting mid-1998



Service/Satisfaction:

- Conducting the new National Blind Rehabilitation Patient Satisfaction Survey
- The 1998 performance goal is 90% or greater of patients are fully or highly satisfied with their care

Locally, selected Network plans include the following planned actions:

Access:

- Enhancing access of low-vision services to blind veterans (Network 6)
- Evaluating need for Blind Rehabilitation Service (Network 10)
- Improving access for blind veterans by increasing outpatient services, reducing inpatient length of stays, and ensuring that the education curriculum meets patient needs (Network 12)
- Pursuing development of Blind Rehab Outreach Programs at Denver and Salt Lake City (Network 19)

Cost/Price:

- Conducting a make/buy analysis for provision of Blind Rehab services within network (Network 16)

GERIATRICS AND LONG-TERM CARE

The Geriatrics and Long-Term Care program provides health and related support services for aged and other veterans requiring long-term care. The needs of these veterans are assessed and a setting most conducive to meeting these needs while maintaining functional independence is determined. Services are offered through a number of programs including: Home-Based Primary Care; Geriatric Research, Education and Clinical Centers (GRECCs); Geriatric Evaluation and Management Units (GEMs); State Home Construction and Per Diem Grants; VA and community nursing home care; Domiciliary Care; Adult Day Healthcare; Hospice; Respite Care; Homemaker/Home Health Aide; Alzheimer's and dementia initiatives; Community Residential Care, and Assisted Living.

1997 Accomplishments:

The Department has initiated a comprehensive re-evaluation of its long-term care and geriatric services. This re-evaluation will examine VA's traditional long-term and geriatric care in its facilities in light of changes in public and private sector services. Recommendations by this Federally chartered advisory committee will be incorporated into the performance goals for this program during FY 1998.

The Geriatric and Extended Care Strategic Healthcare Group (GECSHG) in headquarters has initiated a major new initiative to enhance the delivery of care to veterans at the end of life. The Robert Wood Johnson Foundation recently awarded VA grant funds to develop educational initiatives to enhance physician training for end-of-life care.

A joint venture between VA and the University HealthSystem Consortium resulted in a new practice guideline, *Dementia Identification and Assessment: Guidelines for Primary Care Practitioners*. The guideline is accompanied by an instructional videotape and a pocket-size laminated card containing the algorithm for the identification and differential diagnosis of dementia.

VHA participated in a national demonstration project examining the application of managed care concepts to the continuum of care needed by dementia patients and their families. GECSHG is on the National Leadership Committee and Network 2 is VHA's designated demonstration site. Co-sponsored by the Alzheimer's Association and the National Chronic Care Consortium, the project is expected to continue through 2000.

Chapter 4: Special Emphasis Programs

The network focus on this program during 1997 is noted in the following examples from the network plans:

Technical Quality:

- Established Center of Excellence in long term care (Network 4)

Access:

- Implemented consolidated admissions/eligibility criteria for Long Term care patients (Network 5)
- Established an extended care service line with a strategic plan and received a grant to determine the placement needs of the frail rural elderly (Network 7)
- Defined a full continuum of services available for extended care/geriatric patients, including home healthcare (Network 8)



Plans for 1998-2003:

Nationally, VHA will solicit proposals from the networks to establish three new Geriatric Research, Education, and Clinical Centers (GRECC). The solicitation will be offered to the eight VISNs that currently do not have a GRECC. The solicitation of proposals for competitive review and selection is expected to begin in FY 1998, and depending on the availability of funds, funding support for the new GRECCs will begin in FY 1999. (Technical Quality)

VHA will continue to participate in the Chronic Care Networks for Alzheimer's Disease national demonstration project on managed care for dementia patients and their families. Pending outside funding being available, the project will run from January 1998 through December 2000.

Wider marketing and dissemination of the new CD-ROM, Alzheimer's Caregiving Strategies, is in the early stages. Developed through a collaborative effort by the Minneapolis GRECC, the GECSHG, and the University of Minnesota, the interactive program provides basic information on Alzheimer's disease; guidelines with examples for assessing the functional capacity, or stage, of dementia; and specific strategies for day-to-day dementia care appropriate at each stage.

With funding from the Alzheimer's Association, VA (Bedford GRECC) began a one-year demonstration project on dementia end of life care. The anticipated product is health care policy recommendations intended to improve home- and community-based end of life care for persons with advanced dementia.



VHA plans to increase the percentage of patients being cared for in a clinically appropriate community setting by 25% over the FY 1997 baseline. (Technical Quality)

Selected Network plans include the following:

Technical Quality:

- Implementing Geriatrics and Long Term Care Service Line (Network 6)
- Completing VISN-wide implementation of long term care minimum data set for measuring extended care outcomes (Network 8)



Functional Status:

- Developing or modifying existing tools to forecast needs for next 3 to 5 years in geriatrics and long-term care (Network 13)

Access:

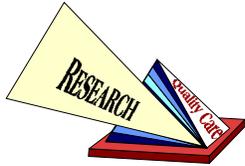
- Establishing network-wide long-term care admission and discharge criteria and screening processes (Network 5)



GULF WAR VETERANS

The Gulf War Veterans program provided strategic direction for the clinical, research, education and outreach programs for these veterans and ensures that available benefits are provided to eligible claimants. This is accomplished by working collaboratively with other VA offices; Federal, State and local government agencies; and non-profit community and private providers. The Gulf War Veterans program staff also serve as VHA's liaison to the Persian Gulf Veterans Coordinating Board, an interagency organization co-chaired by the Secretaries of Veterans Affairs, Defense, and Health and Human Services.

1997 Accomplishments:



Technical Quality:

- Began treatment trials for ill-defined conditions such as chronic fatigue and fibromyalgia
- VA led government research efforts to sponsor or conduct more than 120 research projects on Gulf War veterans' illnesses
- Activated four environmental hazards research centers enabling VHA to broaden its activity from descriptive evaluations to greater emphasis on hypothesis-driven research

Access:

- Encouraged all Gulf War veterans with concerns about their health to contact the nearest VA medical center for a Gulf War Registry health examination
- Established the VA Gulf War Information (toll-free) Helpline to allow veterans and their families to obtain answers and information about their concerns
- More than 69,000 Gulf War veterans have participated in the ongoing VA Registry Health examination program, established in 1992
- Offered a free, complete physical examination with laboratory studies to all Gulf War veterans regardless of their health status
- Maintained a centralized registry of Gulf War participants to facilitate updating Gulf War veterans on research findings and/or new compensation policies through periodic newsletters

Plans for 1998-2003:

VA has contracted with the National Academy of Sciences' Institute of Medicine (IOM) for a review of scientific literature and evaluation of treatment provided to Gulf War veterans. An IOM committee will assess the effectiveness of and make recommendations for improvement of VA programs regarding the possible health consequences of military service in the Gulf War. VA will implement appropriate IOM recommendations.

Public Law 105-114, the Veterans' Benefits Act of 1997, authorized VA to select up to ten medical centers for demonstration projects on specialized Gulf War clinics and case management. VA plans to initiate these projects by July 1, 1998.

Examples of Network plans for this special program are:

Technical Quality:

- Implementing recently designed encounter form to collect uniform Gulf War veterans' Service Evaluation and Action Teams (SEAT) data (Network 8)

Access:

- Expanding (SEAT) for Gulf War and other veterans (Network 6)



HOMELESSNESS

The Homeless Veterans Treatment and Assistance program identifies and seeks to ameliorate the causes and effects of homelessness among veterans. The program:

- Provides direct services such as outreach, case management, residential treatment, therapeutic work opportunities and assistance with permanent housing for homeless veterans and those at risk for homelessness
- Coordinates the provision of care with other Federal, state and local agencies, as well as community non-profit organizations and private entities

Every VA regional office and/or medical and regional office center has appointed a staff member to act as the Homeless Veteran coordinator. This person is responsible for maintaining liaison with local governments, coalitions, shelters, homeless providers within the local jurisdiction, and other VA elements, including the medical centers, to ensure that other service providers are aware of the services available through the benefits offices, and that staff members of the benefits offices are aware of the offerings of other service providers. The Homeless Veterans Coordinator serves as a referral source for homeless veterans.

1997 Accomplishments:

Technical Quality:

- Achieved a 92% participation rate in the Community Homelessness Assessment Local Education and Networking Groups (CHALENG)
- Selected the new national Dental Homeless Coordinator.

Functional Status:

- Collaborated jointly with HUD on a project called HUD-VASH to provide thousands of formerly homeless veterans with stable housing

Access:

- Awarded 101 grants to non-profit organizations, state and local governments and to native American tribes over the past 4 years

Active support for programs for the homeless at the network level is shown by accomplishments last year. Some examples include:

Technical Quality:

- Developed a new strategic plan for homeless veterans (Network 1)
- Hired full-time social worker to lead and implement Columbus homeless services (Network 10)
- Appointed network staff member to coordinate assessment of current homeless resources (Network 11)

Access

- Developed a contracted residential care program for homeless veterans (Network 6)
- Established the Comprehensive Homeless Center in San Francisco, which is dedicated to providing a continuum of healthcare services to homeless veterans (Network 21)

Plans for 1998-2003:



The national goal for this program is to increase the percent of participation in the Community Homelessness Assessment Local Education and Networking Groups (CHALENG) by increasing facility participation in outreach activities. (Technical Quality) The increase in participation is expected to be 98% in 1998 and to reach 100% by 2000.

The Dental Homeless Coordinator will develop a three to five year plan. (Technical Quality)

At the Network level, some examples of significant actions planned are:

Technical Quality:

- Using case management as the primary treatment modality for homeless veterans (Network 1)
- Providing a comprehensive assessment for 90 percent of all homeless veterans referred to VA system (Network 1)
- Hosting annual VA/community homelessness assessment, local education and networking group to conduct needs assessment at Wilkes Barre (Network 4)
- Establishing VISN Homeless Veteran Advisory Council with community stakeholders (Networks 13, 20)
- Identifying network clinical coordinator for homeless (Network 19)
- Achieving clinical Center of Excellence designation for services to homeless veterans (Network 21)

Functional Status:

- Implementing \$68,000 grant from New York state to access and educate homeless veterans in central New York (Network 2)

Access:

- Developing referral agreements for homeless veterans and sustaining them through VA staff participation in local homeless programs as well as VA staff participation on subcommittees to coordinate services for the homeless (Network 7)
- Conducting a needs assessment of VISN homeless programs to identify unmet needs (Network 8)
- Collecting baseline data on the number of veterans in non-funded homeless programs receiving an assessment for veterans compensation and pension benefits (Network 8)

POST TRAUMATIC STRESS DISORDER (PTSD)

The PTSD program provides treatment for veterans suffering from PTSD syndrome including treatment to prevent relapse after reaching maximal functioning. The program serves veterans by providing supportive mental health services and by coordinating appropriate research and education projects.

1997 Accomplishments:



During 1997, two strategic objectives were established for the program:

- Enhancing primary care services for patients who have PTSD and other psychiatric or physical co-morbidity through the establishment of specialized PTSD primary care teams (Technical Quality)
- Incorporating PTSD clinical teams (outpatient) interaction with inpatient evaluation and brief treatment PTSD units and/or PTSD residential rehabilitation programs in order to improve functional status of veterans with PTSD (Functional Status)

Nationwide, there was a 1.6% increase in FY 1997 in the proportion of veterans receiving outpatient psychiatric care in the 30 days after discharge. This was accompanied by a decrease of almost two days in the time it took from discharge to the first outpatient visit. This analysis includes PTSD patients. (Technical Quality)

Locally, a standardized PTSD intake-screening questionnaire was developed for hospital and outpatient settings as well as Vet Centers (Network 8) (Technical Quality)

Plans for 1998-2003:



The Global Assessment of Function (GAF) measurement system will be applied to establish the baseline functional status of PTSD aggregate patients. This will allow targets to be established for measurable improvement and will allow review and assessment to be data driven in the future. (Functional Status)

Locally, Networks are pursuing actions related to this program, as evidenced by the following selected plans:

Technical Quality

- Developing PTSD standards of care, and expanding educational offerings in the VISN for assessment and treatment of PTSD (Network 8)
- Pilot testing PTSD criteria (Network 20)



Service/Satisfaction:

- Renovating treatment and medical space serving PTSD programs at Salisbury and Salem (Network 6)

Access:

- Expanding PTSD outreach in FY 98; including conversion of an in-house program at Batavia into a more cost effective PTSD residential treatment program (Network 2)
- Implementing a hoptel with formal outpatient PTSD programs throughout the network contingent upon local needs/circumstances (Network 7)
- Placing PTSD treatment staff in community agencies (Network 10)
- Expanding community-based treatment sites for PTSD (Network 12)
- Increasing portion of service connected veterans for PTSD who use VA mental health services to 85 percent (Network 13)
- Providing or arranging to provide ambulatory PTSD services at every facility (Network 15)
- Increasing accessibility to specialty care at VAMC Denver by shortening PTSD program from 11 to 6 weeks (Network 19)

PRESERVATION/AMPUTATION CARE AND TREATMENT (PACT)

The PACT program is focused on reducing the incidence of amputations and other complications due to diabetic foot ulcers and peripheral vascular disease. An interdisciplinary program of care and treatment is provided to patients. Patients with amputations and those identified as at risk for limb loss are tracked and monitored.

1997 Accomplishments:

- Expanded the application of Functional Independence Measures (FIM) for lower extremity amputees network-wide through continuing education of nursing personnel (Network 17) (Technical Quality)

Plans for 1998-2003:



VHA will evaluate the PACT program for effectiveness and efficiency in returning amputee patients to their highest level of function in a community setting (Functional Status), and assuring that diabetic patients identified as at-risk for limb loss are referred to a foot care specialist (Access).

Technical Quality

- Providing training to staff systemwide to facilitate expanding the number of patients treated

Access

- Establishing diabetic foot screening clinics systemwide to identify patients at risk for lower-extremity amputations at all facilities with a designated Amputee Clinic Team and PACT program

- Developing a telemedicine program for consultative services for amputees at smaller medical centers, improving accessibility to services (Network 19)

PROSTHETICS AND SENSORY AIDS

The Prosthetics and Sensory Aids Service provides case management with properly prescribed prosthetic equipment, sensory aids and assistive devices for the physically disabled veteran and provides quality prosthetic and sensory aids services.

1997 Accomplishments:

Procurement of artificial limbs was decentralized through a collaborative partnership of Prosthetic and Sensory Aids Service, the Office of Acquisition and Materiel Management, and the General Counsel. (Access)

The National Prosthetic Patient Database was completed. It contains all data on the Prosthetic Patient's Record at each VA facility and functionally replaces the AMIS reporting system. (Technical Quality)

The Prosthetic Benefits Management Plan was implemented to determine the best prescription practices, best pricing, and an effective distribution system of prosthetic devices. (Technical Quality)

An Orthotic Devices and Eyeglasses contract solicitation template was distributed to field and Network Directors to assist in contracting for these services. (Technical Quality)

The General Accounting Office's (GAO) audit of Medicare's payment rates for home oxygen use now utilizes VA as a comparison. This validated the fact that VA medical centers have done extremely well in implementing VA guidelines for the administration and management of the Home Oxygen Therapy Program. (Cost/Price)

Technical Quality:

- Developed a Network-wide service line for prosthetic services (Network 3)
- Integrated rehabilitation and physical medicine services at Brooklyn and New York (Network 3)
- Established Center of Excellence in prosthetics (Network 4)

Access:

- Met network-wide performance standard to provide 98 percent of prosthetics without delay (Network 14)

Plans for 1998-2003:



The primary strategy used to monitor service involves reducing the number of delayed prosthetic orders by identifying the causes for delays reported by the field and taking corrective action.

Technical Quality:

- Improving the integration of Compensated Work Therapy vocational rehabilitation (Network 2)
- Completing implementation of Automated Fabrication of Mobility Aids (Network 10)
- Standardizing policy development and providing technical guidance Network-wide for prosthetics and orthotics (Network 13)

Access:

- Reducing the waiting time for orthopedics to facilitate issuance of prosthetic devices (Networks 3, 8)
- Reducing the waiting time for rehabilitation medicine by 25 percent to 8 days (Network 3)



READJUSTMENT COUNSELING

The Readjustment Counseling program improves the psychological and social functioning of veterans who served in combat or were sexually assaulted or harassed during military service. Highly cost effective, community based Vet Centers accomplish this through state-of-the-art outreach and counseling. For many veterans, these Vet Centers are the community access points for VA healthcare and the point of after-care referral for veterans released from inpatient programs. These centers help high-risk groups such as minorities, women, the disabled, and high combat exposed veterans access available services.

1997 Accomplishments:

The Vet Center Program developed initiatives to promote responsive access to primary care by veterans and their families by:

Access:

- Developing and using telemedicine technology to promote linkage between both rural and urban Vet Center sites with VISN VAMCs and other community agencies and resources.
- Augmenting space and equipment at Vet Center locations to establish community points of care for identified high risk and/or under-served veteran populations.

Plans for 1998-2003:



VHA will identify and collect baseline data that will provide a measure of problem severity ratings. Future year goals call for a reduction in problem severity ratings from the base set in 1998. Achievement of the performance goals will be through the Vet Centers as easily accessible, non-medical facilities in the community maintaining continued outreach contacts with all aspects of the veterans' community and local service providers. (Service/Satisfaction)

The Networks will continue to coordinate care through the Vet Centers, especially for those located in rural or geographically remote areas. Some examples are:

Access:

- Providing psychiatric assessments and medication consultations to rural veterans residing more than two hours one way from VAMC Togus (Network 1)
- Providing mental health and health screening services at tele-health facilities at the Charleston, WV Vet Center and its Logan Outstation in areas with no other VA facilities (Network 6)
- Providing a tele-health program at the Vet Center Satellite in downtown Cleveland (Network 10)
- Using tele-health equipment for clinical consultations with Vet Center staff in Pine Ridge/Rosebud, SD (Network 13)
- Expanding space to provide primary medical care at the New Orleans Vet Center will allow familiar access in a community setting (Network 16)
- Providing additional medical consulting space at the Salem, OR Vet Center to provide primary care and psychiatric services to a rural veteran population (Network 20)

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Readjustment Counseling Service Increases Access in Rural Areas

To increase access to care for high risk minority veterans in a rural setting, the Readjustment Counseling Service established a Vet Center outpost on Native American Indian reservation lands at Chinle, AZ, on the Navajo Reservation. The outpost was activated following the successful pilot Vet Center outpost project begun in 1994 in Keams Canyon, AZ, on the Hopi Reservation. Two additional outposts are planned to open in late 1998 in Martin, SD, serving the Pine Ridge and Rosebud Reservations, and in Tahlequah, OK, to serve the Cherokee. Vet Centers are points of referral for many Native American veterans into the VA healthcare system, and case management and coordination of care across the spectrum of needed services are well-developed Vet Center functions. Vet Centers on Native American reservation lands are staffed by Native American service providers, and provide a broad base of outreach and case management as well as direct counseling for war trauma and family centered services. Vet Center services on reservation lands also maintains sensitivity to the local culture and collaborates with native healing philosophies and practices.

Reservation Outreach Serves Veterans Where They Live

by Alfonso R. Batres, Ph.D., M.S.S.W., Chief,
Readjustment Counseling Service, VAHQ
Washington DC
"Vanguard," May, 1997

SERIOUSLY MENTALLY ILL (SMI)

The SMI program provides state-of-the-art diagnosis and treatment to improve the mental and physical functioning of patients in need of mental health treatment across a continuum of inpatient and outpatient settings.

1997 Accomplishments:

Nationally, in general, there was a 1.6 % increase in FY 1997 in the proportion of veterans receiving outpatient psychiatric care in the 30 days after discharge. This increase was accompanied by a two-day decrease in the number of days from discharge to the first outpatient visit. (Access)

Networks were engaged in a number of activities focusing on outpatient care for this veteran population. Some examples from the network plans include the following:

Technical Quality:

- Established Center of Excellence in behavioral health (dual diagnosis) (Network 4)
- Developed a comprehensive model of mental health services (Network 5)
- Enrolled veterans into a Mental Health Service Line with a care manager/team/gatekeeper to direct care (Network 7)

Chapter 4: Special Emphasis Programs

Access:

- Opened a Mental Health Patient Care Center at the Bronx (Network 3)

Cost/Price:

- Developed a mental health business plan for each facility (Network 1)

Plans for 1998-2003:



The national strategic objective is defined as evaluating every mental health patient using the Global Assessment of Functioning (GAF) scale at least once; defining those who are seriously mentally ill, and calculating the index for the SMI population. This will establish a baseline. In future years, VHA plans to raise the average GAF index 5% by the year 2003.

Systemwide strategic goals:

- Fully described the SMI veteran enrollee population (Functional Status)
- Veterans with such conditions receive appropriate, quality healthcare using applicable treatment guidelines (Technical Quality)
- Routinely monitor the effectiveness of the care provided (Functional Status)

Technical Quality:

- Conducting a 30 day post-discharge follow-up for each mental health patient (Network 1)
- Assuring 70 percent or more of discharged patients for mental health disorders receive outpatient care within 30 days following discharge (Network 3)
- Refining the Intensive Case Management model for seriously mentally ill patients developed by the Northport facility (Network 3)
- Implementing Progressive Dementia Unit in Cleveland (Network 10)
- Establishing community case management teams for the seriously mentally ill in the three largest Network cities: Cincinnati, Dayton and Columbus (Network 10)
- Seeing 75 percent of mental health inpatients discharged from an inpatient bed within 30 days by 9/30/98 (Network 19)

Access:

- Including telemedicine services for mental health special emphasis patients in CBOCs (Network 7)
- Ensuring all psychiatric patients receive Global Assessment of Functioning (GAF) score to identify seriously mentally ill patients (Networks 8, 13)
- Finalizing agreement for referral of selected seriously mentally ill patients to long-term care program at VAMC Biloxi (Network 8)
- Supporting continuance of two existing intensive psychiatric community care (IPCC) programs (Miami and Gainesville) and assessing need to establish IPCC programs in central Florida and San Juan (Network 8)
- Evaluating methods for expanding residential care and/or community case management programs for the seriously mentally ill (Network 14)
- Developing an assertive community treatment program in conjunction with expanding CBOC in Colorado Springs (Network 19)

SPINAL CORD INJURY AND DISORDERS (SCI&D)

The SCI&D program assists veterans with SCI&D to develop the capacities needed to attain personal independence and life long health and well being. This is accomplished by providing initial functional rehabilitation, preventive care, sustaining care, and long-term care across a continuum of inpatient and outpatient settings.

1997 Accomplishments:

In 1997, VHA established a strategy to provide quality healthcare in this area aimed at successfully addressing stakeholders concerns about the VA's ability to maintain a viable SCI&D system at a time when this special population is becoming older and more vulnerable. (Technical Quality)

Acute SCI&D care improved from 41% in 1996 to 91% in 1997 in meeting the timeliness-for-admission standard (one day), and routine care improved from 87% to 100% during the same period in meeting the timeliness-of-appointments standard. (Access)

Technical Quality:

- Developed SCI health service line (Networks 1, 3, 6, 7)

Access:

- Increased from biweekly to weekly SCI/SCD clinic at Iowa City (Network 14)

Plans for 1998-2003:



VHA will establish a baseline of consumer satisfaction data by FY 1998 through the National Customer Feedback Center. The goal is to achieve 75 percent of respondents rating their care, both inpatient and outpatient, as very good or excellent and improve the percentage in the coming years. (Service Satisfaction)

Technical Quality:

- Establishing stronger links with PVA to investigate the feasibility of strategic initiatives to better serve the needs of veterans with spinal cord injury and disorders (Network 2)
- Extending training by staff from Albuquerque SCIS to teams at other network facilities (Network 18)
- Assigning a case manager to every SCI&D patient identified as having cognitive difficulties or special needs (Network 19)
- Establishing Integrated Continuum of Care for SCI&D patients (Network 20)

Access:

- Expanding dental service to target SCI population (Network 10)
- Implementing telemedicine project for SCI patients and Network professional staff (Networks 3, 8, 20)
- Expanding Outpatient SCI Program at the Central Texas System (Network 17)

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Model Program for SCI Evaluations Instituted

In keeping with current trends in VHA, VAMC Augusta developed an outpatient program for the provision of comprehensive annual evaluations for veterans with spinal cord injury. Careful attention was given to the clinical model, including: an in-depth phone pre-assessment; the development of an individualized plan of care; pre-scheduled appointments; and phone follow-up. The administrative coordination to insure access to core clinical services and consultative specialty services was critical to program success. Veterans receive an average of 16 clinical services in two to three days. Due to the distance many of the veterans travel for care, an SCI residential care home was developed through a community partnership. The VAMC entered a contractual agreement with this facility for lodging and personal care assistance, and ten veterans per week are now lodging while receiving their treatment. In its first year, the program provided outpatient annual evaluations for 349 veterans, and a minimum of 1047 bed days of care were avoided. Patients express satisfaction with the program's efficiency of scheduling, the comprehensive services provided, the lodging model, and staff attitudes. The program represents a cost-effective alternative to inpatient care and a successful service delivery model of preventive healthcare for individuals with spinal cord injury.

An Outpatient Model for Comprehensive SCI Annual Evaluations.

*by Helen T. Bosshart, Laura Johnson, and
Vidya Sridharan; VA Medical Center,
Augusta, GA*

*“Journey of Change” Leadership Conference,
Baltimore, MD. December 1997*

TRAUMATIC BRAIN INJURY (TBI)

The TBI Network of Care provides case-managed, comprehensive, specialized rehabilitation spanning the period from discharge from the acute surgical treatment unit until permanent living arrangements can be made for patients with Traumatic Brain Injury. Arrangements are made at the highest, independent living level and are confirmed through follow-up. A significant number of these patients are referred to VA facilities from the military, and, lead centers have been jointly established and cooperatively funded by DoD and VA to receive and screen all TBI patients and maintain a registry of these patients nationally. The Richmond (Network 6), Tampa (Network 8), Minneapolis (Network 13), Palo Alto (Network 21) healthcare facilities have been designated as lead centers for this program.

1997 Accomplishments:

The national strategy for this program was established. VHA plans to locate VHA-wide access points for veterans with TBI through designated TBI case managers in order to increase the percentage of patients able to live independently. (Functional Status)

Plans for 1998-2003:



Three goals were established with appropriate measurements for each in the FY 1998 Performance Plan. Technical adjustments since then have been included in the information below:

Goal 1. TBI care will increase discharge to community rates by three percent per year, with a FY 1998 baseline objective of 54% and a target goal for FY-2003 of 69%. (Functional Status)

Goal 2. Operate TBI Lead Centers at full capacity reaching the DoD and Veterans Head Injury Program (DVHIP) goal of having 60 patients evaluated per year at each Lead TBI Center and Meeting the three-year goal of having 350 patients included in the program protocol, FY 1999-2001. The FY 1998 measure is 93 patients in the TBI program Protocol. (Technical Quality)

Goal 3. Identify the volume of TBI cases within the three Networks where TBI case management is not in place. Determine the referral rate of TBI cases to the four Lead TBI Centers. (Access)

Chart 4-2

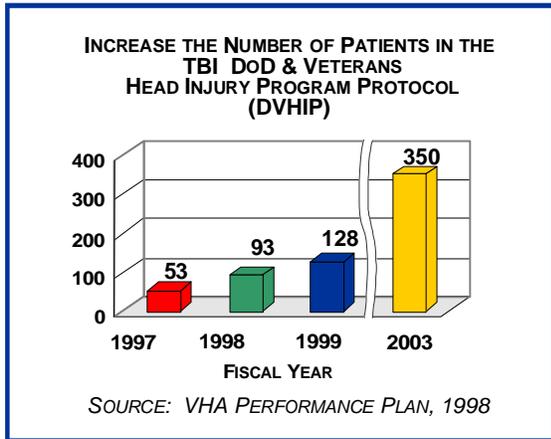
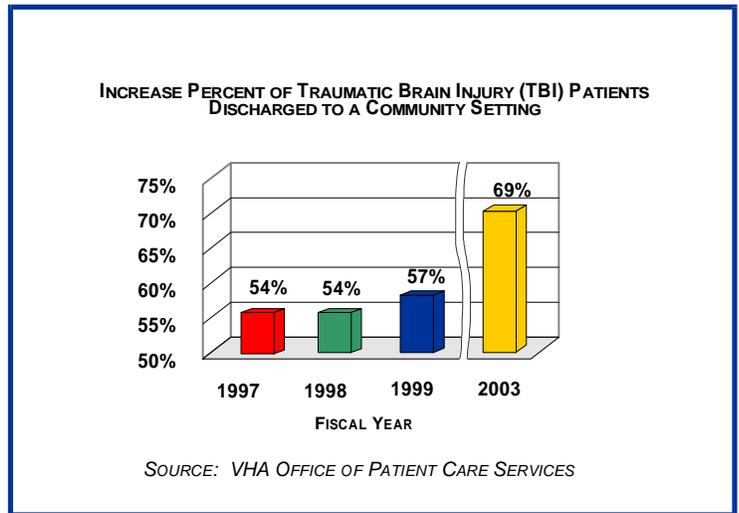


Chart 4-3



Selected Network plans include the following:

Technical Quality:

- Establishing TBI case managers to increase percentage of patients able to live independently (Network 16)
- Evaluating expansion of case management service to all TBI patients treated in the network (Network 20)

Access:

- Exploring the feasibility of re-establishing a traumatic brain injury program at Northport VAMC (Network 3)
- Evaluating need for dedicated TBI service (Network 10)

WOMEN VETERANS

The VHA Women Veterans Health Program ensures the integration of clinical care, education, and outreach efforts, and that the results of research on women veterans-related issues are utilized to improve women veterans' use of VA healthcare programs. Eight Women Veteran Comprehensive Health Centers offer local and national consultation and education services.

1997 Accomplishments:

The first Women Veterans Patient Privacy Survey required by Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, was completed. Each VA medical facility was surveyed to identify deficiencies relating to patient privacy for women patients in clinical areas that may interfere with appropriate treatment. Plans and interim steps to correct these deficiencies have been developed and incorporated into the Department's construction planning process. The annual inventory report of identified deficiencies and plans to correct these deficiencies was submitted to Congress. (Service/Satisfaction)

The overall results of scoring the 26 facility related women patient privacy issues showed that approximately half of the facilities do not have any deficiencies relating to women veteran privacy issues in the inpatient setting, and that approximately two-thirds of the facilities do not have any deficiencies relating to women veteran privacy issues in the outpatient setting. The overall results of scoring the seven program/policy related women patient privacy issues showed that approximately two-thirds of the facilities have or are in the process of developing written programs/policies addressing the women veteran privacy issues identified in the survey.

VHA established two clinical performance goals to improve the mammography and PAP smear examination rate among appropriate and consenting women veterans from the 1996 base rate identified as 81 percent and 83 percent, respectively. (Technical Quality)

A Women Veterans Health Computer Tracking Program is being developed. The initial step was to evaluate the changes necessary to collect utilization data on women veteran's use of healthcare services. (Technical Quality)

Technical Quality:

- Conducted a mini-residency program for newly appointed women veterans coordinators (Network 8)

Functional Status:

- Developed system for uniform data capture of Women Veterans Health program elements (Network 8)

Access:

- Increased the number of women veterans served by 5.9 percent (Network 3)
- Established a dedicated inpatient unit for women veterans at Salisbury (Network 6)
- Developed a draft business/marketing plan to reach more women veterans (Network 8)
- Proposed establishing a referral center for treatment of sexual trauma at VAMC Bay Pines (Network 8)
- Women's Health Centers activated in four medical centers (Network 18)
- Participated in 1997 Women Patient Privacy survey (All 22 Networks)



Plans for 1998-2003:

Women veterans currently enrolled in the VHA healthcare program will be targeted for aggressive prevention and health promotion activities. Progress in attaining this strategy will initially be measured by documenting the increase in rates for mammography and PAP smear examinations.

Chart 4-4

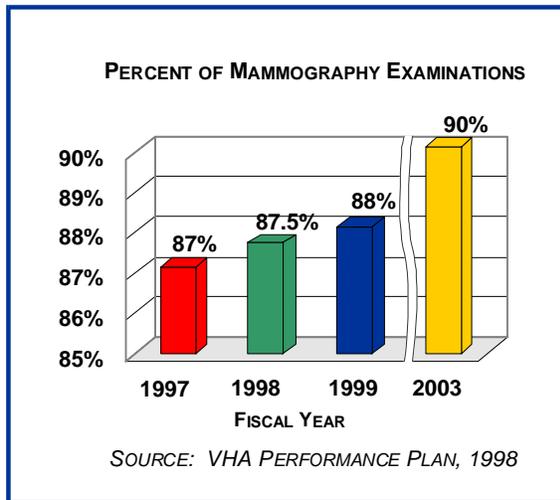
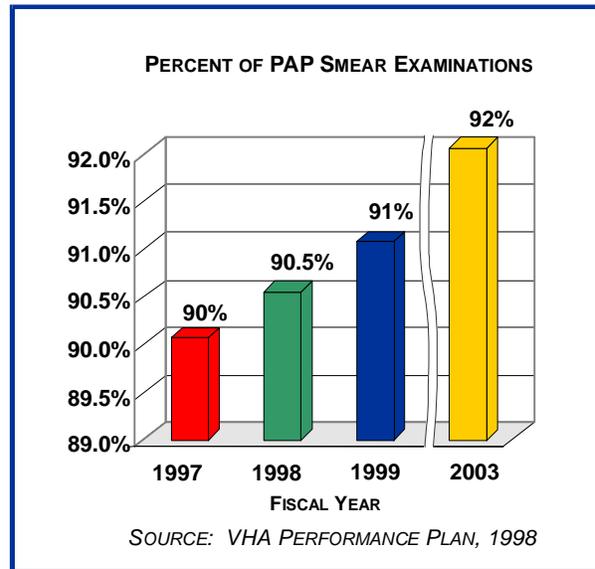


Chart 4-5



Technical Quality:

- Evaluating in Denver and Salt lake City to support Network with advanced specialized gender-specific services such as stereotactic breast biopsies, endometrial oblations, cryo procedures, etc. (Network 19)

Access:

- Increasing both mammography and Pap smear exam rates to 90 percent (Network 16)

Service/Satisfaction:

- Participating in 1998 Women Patient Privacy survey (All 22 Networks)

CONCLUSION

The Under Secretary for Health recognized in the *Vision for Change* that there has been and will always be a need to designate certain clinical activities for special program status. The Under Secretary designated the current list of services as special programs with the understanding that the list is likely to evolve over time. Each existing or new special program is different and requires different attention by management in the field and in headquarters until the administration and delivery of the program is institutionalized in the VA healthcare system.

VHA's approach to these programs, as well as other key activities, includes performance measures. Initially, some of these measures have been process measures that focus on inputs to care. New outcome measures that have been and are being developed will be more valuable as they help monitor health outcomes defined in terms of physical, psychological, and social functioning. VA's commitment to these special emphasis programs and the important veteran populations they serve is unwavering.

CHAPTER 5: ENROLLMENT AND IMPROVED ACCESS TO CARE

While simultaneously improving quality, VHA is also working to improve veteran access to services. We intend to provide services to the largest number of veterans possible within the available resources. To do so, VHA must efficiently deliver care by providing the right service, in the right place, at the right time. This chapter presents accomplishments and plans for:

1. Service - Appropriately matching services with healthcare needs
2. Place - Establishing additional options for access/convenience of care
3. Time - Ensuring that benefits are delivered in a timely manner

Our efforts to improve access are occurring in the midst of a fundamental transformation in the national healthcare system -- a focus on outpatient healthcare delivery; the delivery mode also emphasized by VHA since restructuring in 1995. Our continued reorganization has also opened the way for rapidly expanding and integrating VA healthcare programs internally and with community resources. In keeping with this evolution, both VHA and its community of stakeholders agree that VA healthcare must become more population-directed, community-based and prevention-oriented; all to ensure that veterans receive timely, accessible, and appropriate care.

VHA's four mandated missions are providing medical care, health professional training, research, and emergency management; and, the unstated but well understood responsibility of providing a medical safety net for poor and homeless veterans. However, the mandate for all care providers in today's healthcare environment is to deliver good value, defined by VHA as being the composite of achieving easy access, high technical quality, good service satisfaction, and optimal patient functionality at a reasonable cost. The VA is committed to utilizing its available resources in a manner to allow the maximum benefit to the greatest number of veterans. Improving access to care, especially access to the generally less expensive outpatient primary and preventive care, is directly related to the following two critical "10 for 2002" goals.

- *Increase the number of users of the veterans healthcare system by 20 percent*
- *Decrease the average cost (expenditure) per patient by 30 percent*

THE RIGHT SERVICE

Whether services are delivered in an outpatient, inpatient, or some other setting, they should be the correct intervention for the problem being addressed, ranging from purely informational interventions to acute inpatient care. Although VHA has enhanced practices for identifying and matching services to healthcare needs, eligibility reform has had the most significant impact on access to VA services. The first part of this section covers the overview, accomplishments, and forecasts related to eligibility reform. The second part then covers other efforts of VHA to match care to need such as screening for health problems, and case and disease management. (A more detailed report on eligibility is contained in the Report to the Committees on Veterans' Affairs of Senate and House of Representatives, Preliminary Report on Eligibility Reform Implementation.)



Eligibility Reform:

Public Law 104-262, the Veterans' Healthcare Eligibility Reform Act of 1996, has fundamentally realigned the access to VA for veterans, primarily by basing care delivery on patient need and by expanding the spectrum of care available to all eligible veterans.

Chapter 5: Enrollment and Improved Access to Care

Prior to eligibility reform, VHA was required by law to have different rules for who could receive outpatient and inpatient care – rules that favored inpatient settings and that often restricted treatment to limited health problems for certain veterans. As a result of the 1996 reform, VHA:

- can provide needed healthcare in the most appropriate setting – inpatient, outpatient, or in-home;
- can include preventive and primary care services;
- has expanded sharing authority; and
- is mandated to enroll veterans under the new eligibility standards.

As part of matching care to the health problem, VHA must enroll most veterans in the VHA healthcare system. Instead of basing the care of a veteran on his/her service-connected status, income, etc, VHA may now provide the full spectrum of services to each person – once they have enrolled in the system. Congress provided seven enrollment priorities upon which VHA can now manage its limited resources and improve equity of access for high priority veterans. Table 5-1 defines the seven categories in priority order.

Table 5-1

ENROLLMENT PRIORITIES FOR VHA HEALTHCARE	
1.	Veterans with service-connected (SC) disabilities rated 50% and above
2.	Veterans with SC disabilities rated 30% or 40%
3.	Former prisoners of war (POW), veterans with SC disabilities rated 10% or 20%, veterans discharged from active duty for a disability that was incurred or aggravated in the line of duty and veterans awarded special eligibility classification under Section 1151
4.	Veterans who receive increased pension based on a need for aid and attendance or house-bound benefits and other veterans who are catastrophically disabled
5.	Any veteran not listed above, including non-service connected (NSC) and any 0% SC veterans, who choose to be means tested and are unable to defray the expense of healthcare, i.e., annual income and net worth are below VA's means test thresholds
6.	All other eligible veterans who are not required to make co-payments for their care including: WWI and Mexican border War veterans, veterans solely seeking care for a disorder associated with exposure to toxic substances, radiation, or service in the Persian Gulf, and compensable 0% SC veterans
7.	NSC and non-compensable 0% SC veterans who agree to pay specified deductibles and copayments

We anticipate enrolling, on a priority basis, the number of veterans we will be able to treat within available resources. Congress intended that the enrollment process be the primary method for controlling access to VA healthcare and allowing VA to operate within budgetary limits. Previous eligibility rules supported a de facto tiered system of benefits that emphasized control of costs, in part, by limiting the care provided to certain categories of veterans. Under the new law, however, the emphasis has shifted from what care a patient may be eligible to receive to what care an enrolled patient may need.

To meet the legislative mandate that most veterans must be enrolled to receive services beginning October 1, 1998, a national system of “rolling enrollment” has been implemented. Under “rolling enrollment,” veterans may apply to enroll at any time during the year. The period October 1, 1997, through September 30, 1998, is being used as a test year to give veterans time to learn about the enrollment requirement and to apply for enrollment. It will also give VHA time to build an enrolled population and refine enrollment procedures prior to the mandatory implementation date for the enrollment system.

Under the new authority to match care to need, VHA has developed a benefits package and a working definition of medical “need” since the enrolled veteran is eligible for all needed hospital and medical care from VA. The uniform benefits package will be in effect starting October 1, 1998, concurrent with the official start of the enrollment system. It is VA’s goal that the uniform benefits package will be available within each VISN to ensure that all veterans cared for by VA receive a consistent level of quality care and services regardless of the VISN providing the care. The uniform benefits package will also enhance VA’s ability to project the resources required as well as the number of veterans for whom care can be provided under the medical care appropriation.

1997/1998 Accomplishments:

Technical Quality:

- Developed an Internet web page (www.va.gov) and several fact sheets highlighting the major changes in eligibility reform and answering frequently asked questions
- Developed a uniform benefits package for services to be available in every VISN
- Implemented the “Strategic Information Systems Plan (SISP) to Support National Enrollment,” which establishes the framework needed to support enrollment, including an in depth analysis of VA’s systems and business processes
- Installed *VISTA* FY 1998 enrollment test software designed to capture enrollment information for patients, produce reports, and communicate with the Health Eligibility Center (HEC) in Atlanta
- Conducted national meetings and satellite video conferences to identify needs, problems, and solutions

Service Satisfaction:

- Developed requirements for a national contract for consulting services related to developing an application for enrollment, information about benefits, and notification of enrollment or denial
- Implemented a toll-free Enrollment Service Center number, 1-877-222-VETS, to answer questions from veterans about enrollment
- Provided the Call Tracking System to the field for inquiry tracking, workload management, and decision support
- Developed major national initiatives for enrollment process, communications plan, test marketing, and employee education and training
- Developed public service announcements and an enrollment brochure to educate and inform veterans

Plans for 1998-2003:

Technical Quality

- Issuing final enrollment regulations
- Designing the VA Enrollment Operational Data Store (ODS) that will collect, refine and store enrollment data and serve as a source for downstream systems that utilize enrollment information
- Developing and installing end-user data models and end-user access to national enrollment data
- Identifying and obtaining reporting data for national and congressional requirements
- Submitting a preliminary report on eligibility reform implementation to Congress

Service Satisfaction

- Implementing customer support processes and technology for the new national enrollment service center to support legislative and service requirements
- Awarded national contract (National Marketing and Communication Plan) to provide VISNs with media/communications consultant assistance in preparing for full scale implementation of eligibility reform

Screening for and Management of Health Problems:



Along with the implementation of the new eligibility rules, VHA will continue to improve its preventive health medicine efforts. Early access to healthcare allows for more effective healthcare. Preventive screening tests received as part of a primary care practice approach increases access and improves health status through early detection and treatment. VHA has aggressively implemented preventive screening programs to ensure that healthcare providers identify problems before patient health is compromised.

(Prevention screening is also discussed in Chapters 2 and 4.)

VHA has made great progress in instituting care management to ensure that, once a problem has been discovered, the patient receives appropriate care. Care management in VA is a process for increasing the likelihood that a patient receives easily accessible, coordinated, continuous, high quality healthcare. Care management is that aspect of primary care that coordinates care across all settings, including the home. VA care management is patient-centered rather than disease-specific; the care manager assigned to a particular patient carries out coordination of care for all diseases and all episodes of illness. VA care managers especially focus on the patient in the context of family and community by integrating an assessment of living conditions, family dynamics, and cultural background into the patient's plan of care. Approximately 80% of VHA patient care is assisted by medical specialists ensuring that the right care is specifically focused on the medical condition in question.



1997 Accomplishments:

- Breast, cervical and colorectal cancer screening rates (87%, 90% and 62%) achieved for patients exceeded 1997 HMO national average performance (70%, 70%, and 55%), as well as U.S. goals for the year 2000
- Documentation of patient involvement in prostate cancer screening decision-making rose from only one percent in FY 1996 to 37 percent in FY 1997
- Counseling for tobacco consumption more than doubled rising to 79 percent, far exceeding the HMO national average performance of 61 percent
- 40% of outpatients are screened for alcohol abuse using a standardized instrument (typically the CAGE)
- VHA rates of aspirin administration (92%), and beta-blocker administration (83%) for ischemic heart disease continue to exceed 1997 private sector performance of 76% and 62%, respectively
- Counseling about lifestyle issues of nutrition and activity is now documented for 78% and 76% of patients with hypertension, and for 85% and 78% of patients with obesity. No private sector comparison is available. The U. S. goal for 2000 is for all patients to receive such counseling
- VHA's 69% rate of retinal eye exams for diabetics exceeds the 1997 HMO national average of 38%. 85% of diabetics have an annual Hemoglobin A1c. Sensory examinations of feet doubled to 69%. No private sector comparison is available

The networks have begun to focus on preventive medicine and care management. Some examples taken from their network plans include the following:

Technical Quality

- Began development of primary care screening and education standards (Network 5)
- Developed encounter form to electronically document patients receiving preventive services (Network 8)
- Instituted some form of wellness programs (e.g. smoking cessation, nutrition education, etc.) at all seven network medical centers (Network 11)
- Developed a network-wide tobacco cessation plan (Network 13)

Functional Status

- Developed a service line structure for primary care/preventive medicine and mental health/preventive medicine (Network 6)
- Designated case management coordinators and case managers at all medical centers (Network 13)

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Colorectal Cancer Screening Program Instituted

A process was used to establish standards and improve the timeliness of diagnostic and treatment processes for patients with potential, suspected, or confirmed colorectal cancer (CRC). The lack of a CRC screening program and anecdotal reports of treatment delays for newly diagnosed patients compelled a formal assessment of the availability, timeliness and mechanism of treatment. A multi-disciplinary team from Primary Care, GI, Oncology, Surgery, Radiology, Tumor Registry, Quality Management, and Medical Records gathered to examine the issues. Two were identified: CRC screening for average-risk persons and the management of new or suspected colorectal tumors. Data was collected, an algorithm and a case management model were developed. As a result, all system-related delays were corrected, a CRC screening program implemented, and a dramatic increase observed in the diagnosis of early stage colorectal cancers, from 6% in 1994 to 33% in 1997.

Process Action Team: Colorectal Cancer

by Marcia Gruber, Cynthia Watson, Gerald Logue, Monica Spaulding, Thomas Mahl; VA WNY Healthcare System, Buffalo NY

“Journey of Change” Leadership Conference, Baltimore, MD. December 1997

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Mobile Preventive Services Program Initiated

COPS (Community Outreach Preventive Services Clinic) is a preventive health activity for veterans in outlying communities, with a mobile, preventive services team approach. The highest level of patient care is the prevention of a disease before it has a chance to cause harm. We developed the criteria for a preventive health-screening tool (4-page questionnaire) using the Preventive Health Services Guide. The tool is written in an easy-to-understand format so veterans can answer the questions themselves with a pen (prior to seeing the nurse). Services provided at each COPS Clinic: cholesterol/glucose; oral cancer, nutrition, and mental health screenings; and a comprehensive preventive health screen conducted by registered nurses (including patient education). Follow-up care is provided at the medical center or at the VA community mobile clinics. Veteran service organization representatives in the community jointly coordinated location site and publicity. We developed a statistical report, and conducted “How to Coordinate a Preventive Health Screening” presentation to the other Network medical centers. Fourteen COPS Clinics have provided services to 692 veterans (214 new to VA). COPS has truly assisted many veterans with their medical needs. The program has received many complimentary letters and comments from veterans and community leaders. The Commander of an American Legion Post at a COPS Clinic told staff: “Years ago our Post voted the VA out. Please forgive us.”

Community Outreach Preventive Services Clinic (COPS)

by Robert W. Collins, Connie L. Johnson, Judy R. Rittenhouse, Carol T. Ward, VA Medical Center, Lexington, KY

“Journey of Change” Leadership Conference, Baltimore, MD. December 1997

Chapter 5: Enrollment and Improved Access to Care

Plans for 1998-2003:

Technical Quality

- Implementing mental health case management pilot program at Boston hospitals (Network 1)
- Strengthening of care/case management resources to enhance seamless continuum of care and to ensure the best linking, managing, and coordinating of services to meet veteran needs (Networks 2, 5)
- Emphasizing primary and preventative care, case management, and shared decision-making; identifying and treating medical conditions earlier (Network 5)
- Implementing service line management for primary care and preventive medicine (Network 6)
- Capturing preventive health data at primary care access points and displaying electronically for practitioners (Network 8)
- Developing a standardized case management model at each medical center; adopting large case management for high risk patients and episodic case management of inpatients (Network 9)
- Providing case management training (Network 10)
- Expanding patient case management in primary care, surgical services, addictive disorders, and long term care (Network 12)
- Refining implementation of case management and evaluation based on continuity of care, patient satisfaction, readmission rates and length of stay (Network 13)
- Implementing 100 percent pre-admission certification and concurrent review, critical pathways, and other case management tools network-wide (Network 14)
- Selecting and implementing case management guidelines with particular attention to multi-system disease and special emphasis programs (Network 17)
- Conducting network-wide training of case managers for each primary care team (Network 19)

Functional Status

- Initiating disease management as an extension of case management (Network 2)
- Ensuring that a single care manager is assigned to monitor and guide patient care across all settings, including the home (Network 3)
- Piloting a Wellness Center at each facility to centralize specific prevention/health promotion procedures (Network 3)
- Piloting a rural health initiative identifying needs of the frail elderly and providing intervention using a case management model (Network 7)
- Designating case managers for select patient populations (e.g., terminally ill) (Network 8)
- Expanding community case management for the seriously mentally ill (Network 10)
- Initiating network-wide influenza/pneumococcal vaccine program (Network 10)
- Developing a prioritized list of wellness initiatives with emphasis on minority populations (Network 11)
- Implementing the U. S. Preventive Services Task Force recommendations that apply to all veterans in the network (Network 14)
- Evaluating and refining a primary care model in chronic disease management being piloted at Iowa City (Network 14)
- Establishing case management and clinical protocols/pathways for cancer patients (Network 16)
- Developing a patient case management process across the continuum of care; expanding use of case management for patients with multi-system disease for longitudinal services (Network 16)
- Assigning case manager to all high risk patients (Network 18)

Access

- Activating a preventive medicine telecare program at the North Texas System (Network 17)
- Establishing outreach primary care teams to conduct twice-a-week medical health screenings at seven Vet Centers (Network 17)

THE RIGHT PLACE

VHA has increased healthcare delivery access points nationwide by expanding community based outpatient clinics (CBOCs), increasing contracting with community providers, using mobile clinics, implementing telephone triage programs, and using various outreach programs. These efforts support the VA Strategic Plan objectives to increase the number and types of access points for services; to increase interactive, electronic access for veterans and their families; and to improve telephone access to information.

VHA operates over 270 CBOCs nationwide, and maintains numerous contracts for obtaining services from community providers. It is VHA's belief that all veterans, especially those in rural and isolated areas, can benefit from the use of contracted services within the community. We also have contracts for providing VHA services to beneficiaries of other organizations, such as CHAMPUS and TriCare agreements. The proportion of VA medical centers with one or more DoD Managed Care Support Contracts (TriCare) grew from 8.7% in 1996 to 30.2% in 1997. Additionally, VHA has increased capabilities in telemedicine, with activities in pathology, nuclear medicine, radiology, psychology, dermatology, and dentistry. Today, not only do patients now have more places where they can physically go to receive care, they can receive more care without ever leaving home.

Community Based Outpatient Clinics (CBOCs) and Other Access Improvements:

Our goal in establishing these clinics is to provide veterans with optimal patient care at the right time, in the right place, and at the right cost. In order for the networks to establish a clinic, they need to analyze the need for community based primary care, plan CBOCs as an integral component of existing VA sponsored healthcare networks, compile demographic information to upgrade and refine CBOC planning efforts, and incorporate "Make or Buy" principles and procedures in deciding whether to activate a VHA operated clinic or to contract with a local community resource.

A variety of other initiatives improve access to VA services for veterans and their families. These include, for example, expanding clinic hours, expanding the number of primary care teams, improving patient transportation options, and expanding telephone triage hours.

1997 Accomplishments:

Access

- Expanded after hours clinics (Networks 1, 4, 5, 21)
- Implemented patient transportation system (Networks 1, 5)
- Initiated toll-free, centralized access to primary care (Network 2)
- Successfully initiated pilot for veteran health resource center at Elmira (Network 2)
- Established a primary care clinic at the Atlanta Readjustment Counseling Center to provide better access to veterans in midtown, downtown, and south Atlanta (Network 7)
- Made primary care appointments in less than 30 days at all network clinics (Network 2)
- Increased telephone triage calls by 250 percent (Network 3)
- Began working with Vet Centers to increase outpatient services access (Network 5)
- Established additional primary care teams (Network 6, 12)
- Identified outreach strategies to increase Category A veteran users (Network 8)
- Assessed implementation status of telephone care (Network 8)
- Established four primary/preventive care contracts and have five additional awaiting approval (Network 9)
- Expanded tele-nurse program to include veterans from VISNs 2 and 17 (Network 10)
- Standardized definition and performance expectations for telephone care/triage (Network 12)
- Improved equity of access: all Category A patients are treated at VAMC Minneapolis (Network 13)
- Improved access to primary care with establishment of Grafton Primary Care Clinic in North Dakota area (Network 13)

- Expanded access to care by mobile screening programs, mental health outreach efforts to homeless, residential group homes, and similar programs (Network 16)
- Developed a CBOC placement model to determine key locations within Network to expand access points (Networks 16, 21)
- Established centralized after hours telephone care to provide emergency referrals, routine medical advice and eligibility information after regular hours and on weekends (Network 21)
- Conducted outreach efforts to blind veterans and established support groups for blind veterans in State Veterans Homes (Network 21)

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VA Healthcare Takes to the Road – Labmobile Offers Hometown Service

The idea that veterans had to travel far to the VA Medical Center in Albany to participate in VA healthcare was challenged and re-defined with the conceptualization, development, and execution of the mini-LABMOBILE. The mini-LABMOBILE Team, three employees of Pathology and Laboratory Medicine Service, believed they could help raise the awareness of veterans who had rarely or never used any VA facility for their healthcare by bringing part of the VA to them, right in their own home towns. Initially, the Team traveled through the Albany catchment area offering cholesterol and occult blood testing which created an opportunity to speak with veterans about the benefits of using VA healthcare and eligibility. The Team soon recognized the need to expand its membership to be able to provide potential customers with immediate medical support, preventive care, and referral. Home Based Primary Care, whose focus and experience in delivering medical care outside the hospital, agreed to partner with the Lab Team to provide flu and pneumonia vaccines, blood pressure, pulse oximetry, and general consults. Immediate referrals to Primary Care Teams were also made. In a little over a year of operation, this mini-LABMOBILE Team, all who have other full time responsibilities, have made over 27 trips seeing over 1,000 veterans. This was accomplished without spending large amounts of money or overwhelming veterans with government bureaucracy. The Team remains focused on bringing VA service and information to those in areas that are lower than average on the income scale, where there is little or no medical care easily accessible, or where there is significant VA under-utilization.

VA Healthcare on the Road: mini-LABMOBILE...Driven to Serve Veterans
by Adrienne S. Frank, Joan M. Augustyn, Karen H. Kivelin, Roberta N. Miller, VA Medical Center, Albany NY
“Journey of Change” Leadership Conference, Baltimore, MD. December 1997

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VA/Kaiser Permanente Agreement – An Experiment in Partnership

The VA currently operates a small Community Based Outpatient Clinic on Maui which is limited to primary and mental health outpatient care, and purchases other needed care from many non-VA providers and institutions. Problems include high costs of fee basis care, difficulties in coordination and continuity of care, and uncertainties in quality of non-VA providers. The VAMROC Honolulu and Kaiser Permanente plan to provide an alternative for eligible veterans who may soon choose to receive the majority of their healthcare from Kaiser. Positive outcomes envisioned from purchasing care for veterans using Kaiser's well established, integrated healthcare delivery system include: expanded healthcare services and quality of providers; 24-hour medical care including urgent care; increased access to care at multiple, convenient locations; potential expanded veteran market share; and potential cost savings. Improvements in coordination and continuity of care, and availability of more specific data in utilization, management and patient satisfaction will occur. The agreement will include Kaiser providing primary, specialty, ancillary and hospitalization care and the VA providing all mental health and VA Special Emphasis Program care. A VA/Kaiser Health Benefits Plan specifies the amount and type of care to be provided. Reimbursement per veteran will be via capitation. This model may be transferable to other VA facilities seeking to increase access and market share, while controlling costs and assuring quality.

The VA and Kaiser Permanente: Partners in Providing Healthcare Services to the Veterans of Maui

by Craig Oswald, Steven MacBride, Barry G. Raff, VAMROC Honolulu, Donna McCleary, Mary Hew, Kaiser Permanente
"Journey of Change" Leadership Conference, Baltimore, MD. December 1997

Plans for 1998-2003:

VHA remains firmly committed to the strategy of developing new outpatient access points as part of the 22 integrated delivery system plans. This strategy has been tested over two planning cycles and has proven to be completely workable.



To significantly increase access for veteran users, VHA plans to operate over 650 community-based clinics by the year 2003. These clinics are being financed through existing resources that have been reallocated from inpatient care to the generally less expensive outpatient care setting. This supports the VA Strategic Plan objective to increase the number and types of access points for services, as well as the goals of encouraging preventive medicine, increasing outpatient treatments, and reducing overall costs.

Chapter 5: Enrollment and Improved Access to Care

The networks' plans for achieving this goal, summarized in Chart 5-1 and Table 5-2, are reviewed and adjusted on a continuing basis as circumstances in the marketplace warrant.

Chart 5-1

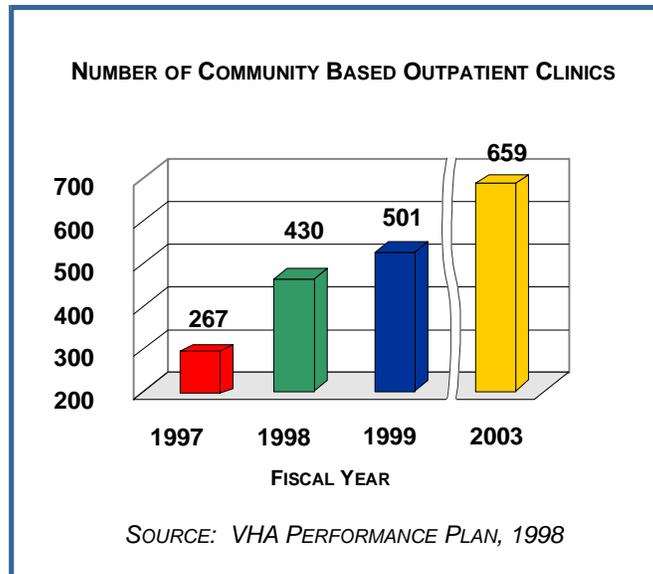


Table 5-2

**NEW COMMUNITY BASED OUTPATIENT CLINICS
IN THE ACTIVATION OR PLANNING STAGES – FY 1998-FY 2002**

VISN	FY 1998	FY 1999	FY 2000-2002	No FY SPECIFIED	TOTAL
1	18	3	2	0	23
2	2	0	0	7	9
3	5	0	0	3	8
4	19	6	0	0	25
5	3	0	0	0	3
6	4	4	12	0	20
7	6	0	0	0	6
8	9	8	10	0	27
9	4	1	0	2	7
10	6	6	9	0	21
11	5	0	0	12	17
12	2	5	8	0	15
13	8	2	1	0	11
14	1	0	0	7	8
15	0	0	0	17	17
16	12	12	5	0	29
17	13	4	4	0	21
18	12	3	0	22	37
19	15	2	0	5	22
20	8	9	5	0	22
21	0	0	0	20	20
22	11	6	7	0	24
TOTAL	163	71	63	95	392

SOURCE: FY1998 TO FY2002 STRATEGIC PLAN FOR EACH VISN AS SUBMITTED IN OCTOBER 1997.

Improved Access through TriCare and Other Contracts:

Public Law 104-262, The Veterans Healthcare Eligibility Reform Act of 1996, significantly expanded the VA’s healthcare resources sharing authority. It eliminated existing barriers and disincentives to the sharing of healthcare resources with non-VA entities. Besides providing additional flexibility in the acquisition of services, the law expands the opportunity for VHA healthcare facilities to sell services and generate revenue (discussed in Chapter 7) as well as to maintain and expand services and access to veterans. This also supports the VA Strategic Plan’s objective to increase the number and types of access points for services.

VHA may enter into sharing agreements or contracts with any healthcare provider, or other entity or individual. These sharing contracts may be to acquire (“buy”) healthcare resources, to provide (“sell”) healthcare resources, or to exchange healthcare resources. The decision to acquire services through a sharing contract is complex. VA management must make this decision based not on any one factor, but by carefully weighing all issues, such as quality of care, ease of access, cost-effectiveness, non-monetary costs, and other issues.

1997 Accomplishments:

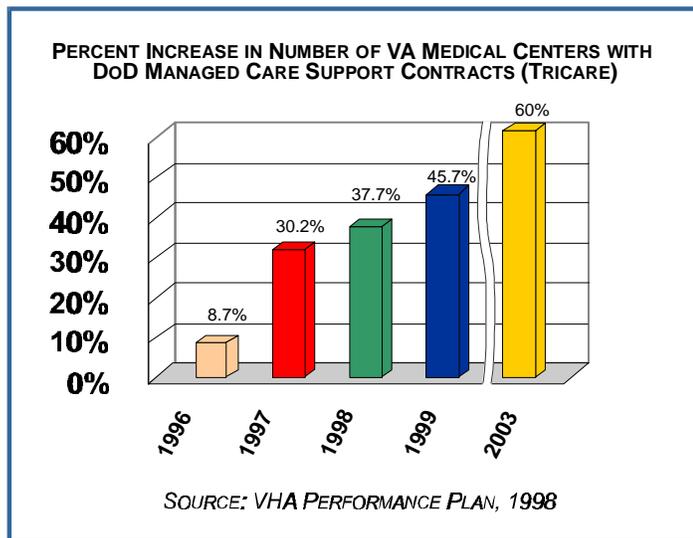
- Began treating TriCare patients in April. About 140 TriCare visits provided during six months of 1997 with \$33,342 in claims billed (Network 13)
- Established Tri-Care contracts at Nebraska and Iowa sites and provided services to 56 participants (Network 14)
- Expanded TriCare medical/surgical services to South Texas' Kerrville and San Antonio medical centers and North Texas' Bonham medical center (Network 17)
- Negotiated four TriCare contracts with network facilities (Network 18)
- Earned national TriCare designation at Albuquerque as a specialized treatment service for neurological disorders and brain injury (Network 18)
- Negotiated contracts for all medical centers to treat TriCare/CHAMPUS patients (with Merit Behavioral Care Corporation) for mental healthcare (Network 19)
- Established TriCare contracts in all network markets (Network 21)
- Reached agreement with DoD contractor for TriCare Military Region 2 Office to provide care to eligible TriCare beneficiaries (Network 6)
- Opened CBOC at Pease Air National Guard Base (Network 1)
- Expanded DoD sharing agreements in Connecticut to include laboratory and radiology (Network 1)
- Increased gross revenue from sharing agreements by \$683,797 (Network 3)
- Enrolled veterans into either a Primary Care or Mental Health Service Line with a care manager/team/gatekeeper to direct care (Network 7)
- Signed letter of intent for contract for TriCare status in Kentucky and West Virginia (Network 9)
- Established VA/DoD sharing agreements with the Third Medical Group at Elmendorf Air Force Base and Bassett Army Community hospital to permit sharing of resources and capabilities (Network 20)
- Implemented sharing agreements for Boise Medical Center with Mt. Home Air Force Base, Indian Health Service, U. S. Forest Service, State of Idaho, Idaho State Veterans Home, and community health facilities as well as the 92nd Medical Group at Fairchild Air Force Base (Network 20)

Plans for 1998-2003:

Chart 5-2



Chart 5-2: VHA will continue to expand TriCare participation through an increase in the number of facilities with DoD Managed Care Support Contracts. The VHA performance plan includes these goals:



The networks plan many other initiatives to increase access through sharing contracts of all types. Some examples are:

- Exploring expansion of sharing with Newport Naval Hospital (Network 1)
- Exploring sharing with Fletcher-Allen Healthcare System (Network 1)
- Becoming a preferred provider for Tri-Atlantic (DoD managed care contractor) (Network 6)
- Establishing a mechanism for coordinating all sharing agreements with DoD, TriCare, and CHAMPVA (Network 9)
- Implementing VISN-wide TriCare contracts (Network 16)
- Activating TriCare medical/surgical agreement at the Central Texas System and activating TriCare pharmacy agreements at the Central Texas System and South Texas System (Network 17)
- Negotiating a contract with Sierra Military Services, Inc. to provide CHAMPUS care (Network 1)
- Pursuing subcontractor status to TriCare's prime contractor for CHAMPUS beneficiaries' healthcare (Network 10)
- Finalizing a contract with Foundation Health Federal Services for CHAMPUS recipients (Network 20)
- Implementing a sharing contract with U.S. Navy for medical and dental services (Network 1)
- Developing a partnership agreement with the F. F. Thompson Hospital whereby they will provide mammography and clinical autopsies, Canandaigua VAMC will provide therapeutic pool time and chaplain mentoring (Network 2)
- Utilizing or leasing Griffiss Air Force Base Hospital space (Network 2)
- Exploring the alternative of including the angiography suite at Syracuse in a future sharing agreement with community providers (Network 2)
- Establishing a Sharing Council to advocate for additional sharing relationships, to direct development and to monitor progress (Network 3)
- Developing VISN-wide sharing agreement with Fort Monmouth, NJ; West Point, NY; and other Army, Navy and Air Force operations (Network 3)
- Pursuing additional sharing agreements involving textile care (Network 3)
- Implementing Mental Health Service Line strategy that includes partnerships with community resources including half-way houses and residential care centers (Network 7)
- Consolidating facility VA/DoD sharing agreements into a single VISN agreement with Naval Office of Medical/Dental Affairs (Network 8)
- Investigating opportunities for sharing agreements with Coast Guard (Network 11)
- Developing State Veteran Home sharing initiatives including one in the area of adult day care (Network 14)
- Evaluating potential sharing arrangements between Amarillo and Cannon Air Force Base (Network 18)
- Activating VA/DoD Joint Venture Hospital now under construction at Elmendorf, Alaska (Network 20)
- Expanding DoD sharing agreements for inpatient, outpatient, and dental care, for veterans, military personnel, and recent retirees (i.e., Tripler Army Medical Center in Hawaii; Travis Air Force Base in Northern California; Fallon Naval Air Station in Nevada) (Network 21)

Improved Access through Telemedicine Technology:

Telemedicine, defined as the use of electronic information and communications technologies to provide healthcare when distance separates the participants, has the potential to improve access, timeliness and convenience of healthcare for veterans. VHA has played a leadership role in the innovative use of multiple technologies for telemedicine such as telephone-based technologies, interactive videoconferencing, and digital imaging technologies to enhance healthcare service delivery.

1997 Accomplishments:

- Established the Telemedicine Strategic Healthcare Group in the Office of Patient Care Services in headquarters to advise and coordinate VHA telemedicine planning
- Conducted a systemwide survey of VA facilities regarding telemedicine activities initiating the development of a national strategic plan for VA telemedicine
- Disseminated information regarding telemedicine issues/planning via creation of a VHA telemedicine web site at <http://www.va.gov/telemed> and regular educational teleconferences/reports
- Ongoing collaboration and planning with DoD telemedicine offices and other federal agencies through the federal Joint Work Group on Telemedicine

Clinical telemedicine achievements in VHA include:

- **Teleradiology** – VA has led the way in the development and implementation of filmless digital radiology systems in clinical settings. The Baltimore, MD medical center implemented the first filmless radiology department in the U.S. in 1993 and currently links facilities in Network 5 for teleradiology support
- **Telepathology** – The National Performance Review Hammer Award winning telepathology project linking the Milwaukee, WI and Iron Mountain, MI medical centers in Network 12 provides unique service utilizing a hybrid dynamic/store and forward telepathology system
- **Telecardiology** – The Pacemaker Surveillance Center Programs located on the East Coast at the Washington, D. C., medical center and on the West Coast at the San Francisco medical center provide timely, cost effective, pacemaker monitoring for thousands of patients annually
- **Telemental health** – A clinical research project is underway at the Baltimore medical center to examine and evaluate the use of distance videoconferencing in the assessment/treatment of mood disorder. A demonstration project at the Milwaukee and Iron Mountain medical centers provides improvement in access to rural mental health care using telepsychiatry. Telepsychiatry linkage was established between the Denver, CO medical center and a satellite clinic in Colorado Springs with positive outcomes reported
- **Teledermatology** – Dermatologists at the Baltimore medical center utilize videoconferencing and store and forward imaging to assess skin conditions. Researchers at the Durham, NC Health Services Research and Development facility have initiated a two year project evaluating and examining teledermatology
- **Telecare in Diabetes** – Researchers at the Boston, MA medical center are using a home-based telemedicine clinical workstation to examine the ways to improve home services for patients with chronic diabetes
- **Teledentistry** – Innovative uses of digital imaging/dental radiology to enhance overall delivery of dental services and ongoing education
- **Telenuclear medicine** – For over twenty years, nuclear medicine images have been shared regularly between a number of medical centers utilizing cost effective image transmission to facilitate consultative services in nuclear medicine
- **Telephone Liaison Care Program (TLCP)** – Telephone liaison care programs are in place at all medical centers to provide information, guidance, and direction for patients. TLCP has proven to be effective in improving customer satisfaction, reducing clinic waiting times both for appointments and the time to be seen by a team member.

There is widespread support across the networks to expand use of this technology. Networks reported the following accomplishments in their network plans:

- Installed telecommunications equipment providing telepathology capability in the VISNs three tertiary care medical centers (Network 2)
- Implemented telemedicine and teleconferencing (Network 5)
- Implemented teledermatology and telepsychiatry (Network 15)

Plans for 1998-2003:

- Providing dermatology consults to Togus via high-resolution computer link from Providence (Network 1)
- Developing a telematics program (telemedicine, teleradiology, teleimaging, telenuclear medicine and telepathology) (Network 7)
- Expanding teleradiology capabilities network-wide (Network 12)
- Installing mental health teleconsultation capability between Moline and Cedar Rapids to the Iowa City VAMC; installing teleradiology and telepathology services between Des Moines and Knoxville, IA (Network 14)
- Providing telemedicine and other related health services to the Bureau of Prisons (Network 15)
- Conducting a medical staff telemedicine needs assessment (Network 17)
- Developing an information and communication migration plan that will address strategies for telemedicine (Network 18)
- Accessing telemedicine and telepsychiatry applications (Network 19)
- Defining funding requirements and implementation strategies for telemedicine at all facilities to include cardiology, dermatology, neurology, and oncology (Network 20)
- Starting the teleradiology and PACS project between the Portland and Vancouver campuses (Network 20)
- Developing Phase I of a network-wide Image Management System for storage and transmission of digital images at each facility (Network 21)
- Expanding use of telemedicine throughout the network (Network 21)
- Implementing PACS and teleradiology; install computed radiography (Network 22)

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Telepsychiatry Successfully Uses Telemedicine Link to Provide Healthcare

During a 13-month period beginning August 1996, a telemedicine link between the Denver VAMC/University of Colorado Health Sciences Center (UCHSC) Campus was used for delivery of direct patient care to a VA community based outpatient clinic in Colorado Springs, CO, some 70 miles to the south. PictureTel Model 4000 equipment was installed in the Colorado Springs clinic, and the UCHSC video studio was used on the Denver end. A Denver-based psychiatrist provided a total of 340 interactive sessions involving 137 patients (115 male, 22 female) during the 13-month time period. The telepsychiatry link was used 4 days per week, with patients scheduled for 30-minute appointments. Diagnostic categories included PTSD (66), dysthymia (21), paranoid schizophrenia (16), bipolar disorder (10), major depression (6), generalized anxiety disorder (8), organic mood disorder (3), schizoaffective disorder (3), other (1). A total of 18 patients had active addictive disorders as well. Difficult clinical situations were dealt with, e.g., three suicidal patients without adverse outcomes, interviews of acutely psychotic patients with arrangements being made for emergent hospitalizations and couple crisis intervention. We found this to be a clinically useful and cost effective modality providing physician psychiatric service to a remote clinic staffed by non-physician psychiatrically trained staff.

Telemedicine (Telepsychiatry) Project Providing Direct Patient Care From Denver VAMC to a Satellite Clinic

By *John L. Wiberg, Martin Reite, Berry Charles,*
VAMC and University of Colorado Health
Sciences Center, Denver CO
“Journey of Change” Leadership Conference,
Baltimore, MD. December 1997

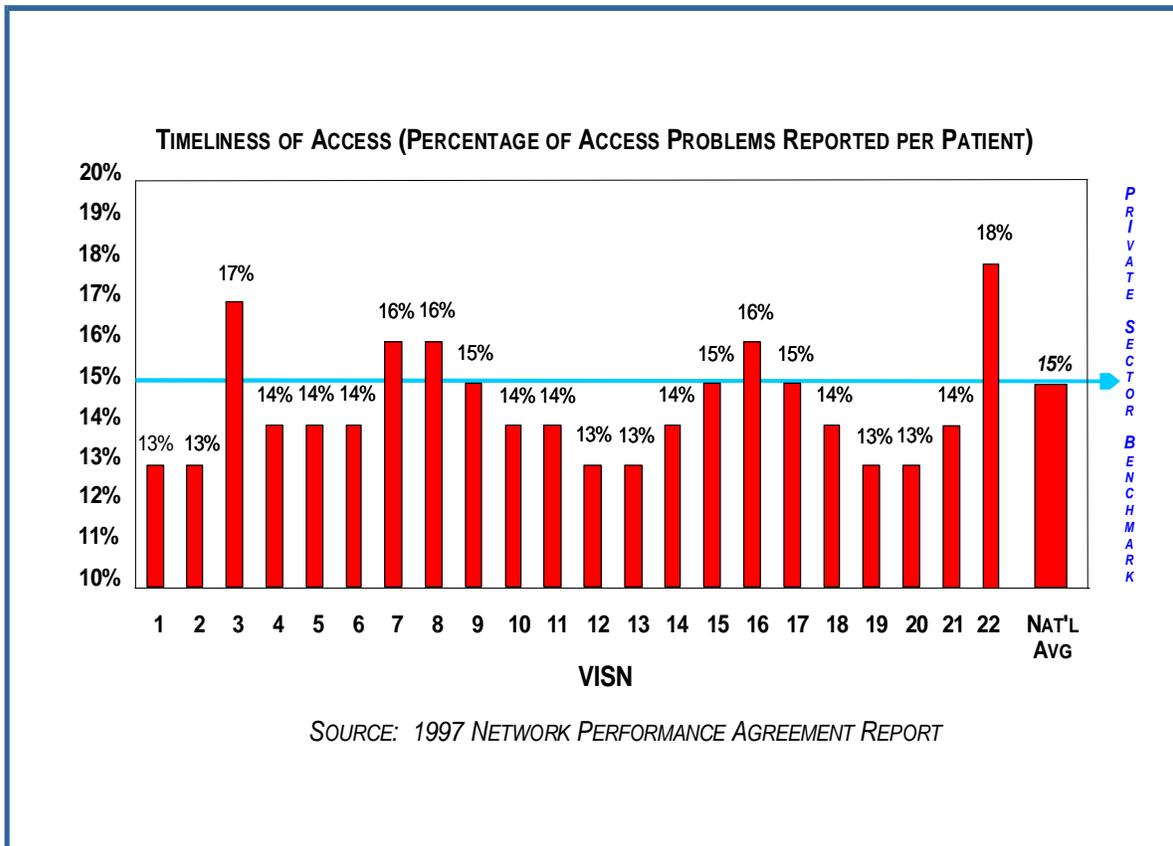
THE RIGHT TIME

Timeliness of care relates not only to medical intervention for persons already using the VHA healthcare system, but also to informing non-users about potential benefits in order to increase the number of eligible users (a “10 for 2002” strategic target). This section covers accomplishments and forecasts for providing timely medical care and benefits information, both directly related to the VA Strategic Plan objectives to improve customer satisfaction with timeliness of service and to improve the awareness and knowledge of VA benefits and services.

1997 Accomplishments:

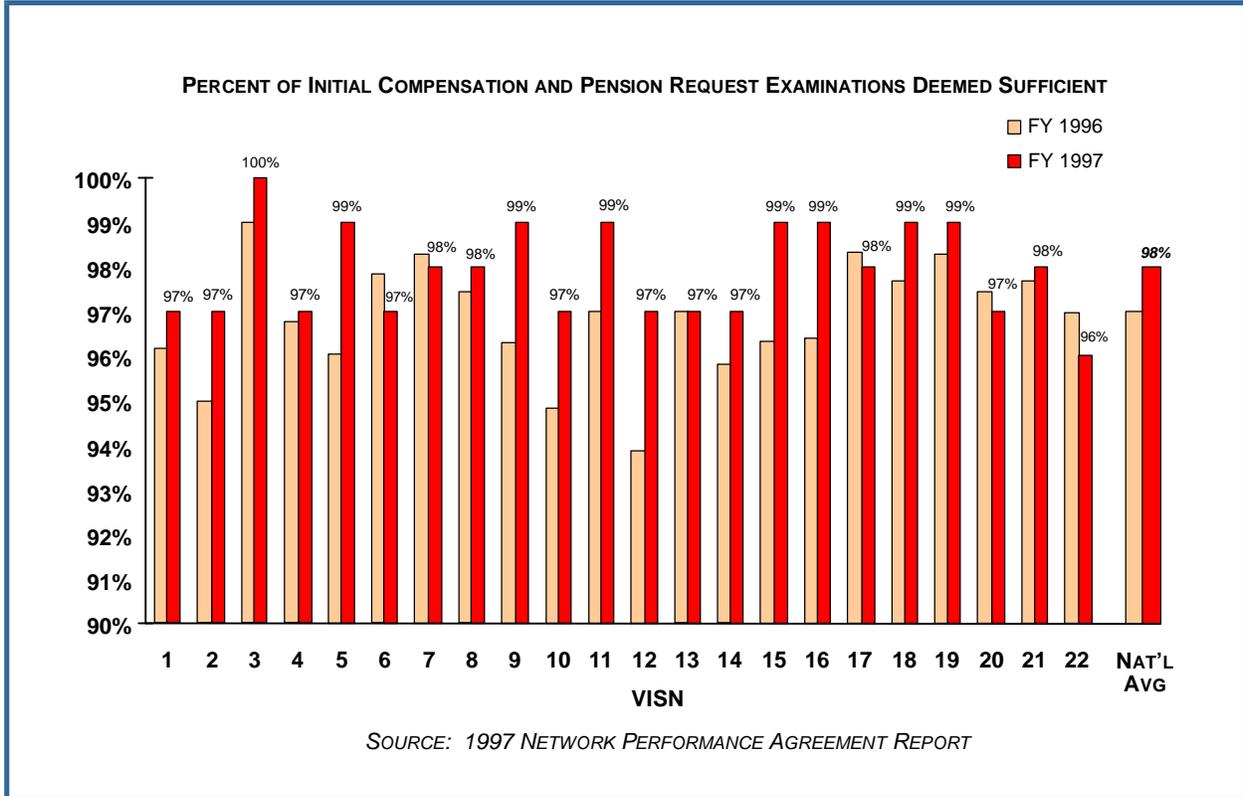
- Met the private sector Picker Institute benchmark of 15% for timeliness (only one problem reported per six questions answered). (Picker Institute benchmarks are described in Chapter 3)

Chart 5-3



- Increased the number of Compensation and Pension (C&P) examination reports accepted by VBA on a first request. The sooner a veteran's claim is decided, the sooner eligible veterans will obtain access to VA healthcare services and benefits. This accomplishment also supports the VA Strategic Plan's goal to improve the quality of C&P medical examinations so that 99% are sufficient for adjudicating claims.

Chart 5-4



- Increased (from 1994-1996 to 1995-1997) the number of new service connected and low-income veterans (Category A) by 81,500 for a total of 3.6 million veteran users. This accomplishment supports the “10 for 2002” strategic target to increase system users by 20%.

**Table 5-3
CHANGE IN CATEGORY A USERS**

VISN	1994 – 1996 CATEGORY A USERS	1995 – 1997 CATEGORY A USERS	NET CHANGE	% CHANGE
1	175,070	178,919	3,849	+ 2.2%
2	95,771	99,661	3,890	+ 4.1%
3	172,743	174,188	1,445	+ 0.8%
4	175,493	196,747	21,254	+ 12.1%
5	108,829	111,742	2,913	+ 2.7%
6	190,371	194,553	4,182	+ 2.2%
7	224,385	226,792	2,407	+1.1%
8	299,669	311,376	11,707	+ 3.9%
9	185,225	191,583	6,358	+ 3.4%
10	131,753	140,618	8,865	+ 6.7%
11	161,039	163,164	2,125	+ 1.3%
12	168,699	168,440	-259	- 0.2%
13	101,050	100,033	-1,017	- 1.0%
14	72,770	72,880	110	+ 0.2%
15	158,337	159,269	932	+ 0.6%
16	344,469	346,876	2,407	+ 0.7%
17	172,366	173,546	1,180	+ 0.7%
18	169,429	174,174	4,745	+ 2.8%
19	109,943	110,264	321	+ 0.3%
20	167,472	170,633	3,161	+ 1.9%
21	162,852	165,087	2,235	+ 1.4%
22	223,698	227,077	3,379	+ 1.5%
NAT'L	3,450,740	3,532,287	81,547	+ 2.4%

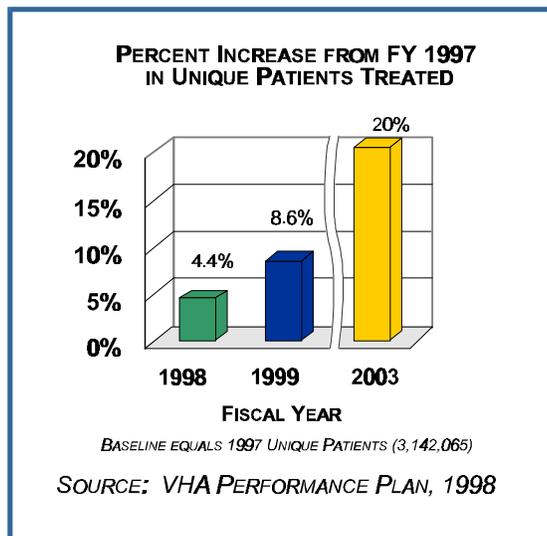
SOURCE: 1997 NETWORK PERFORMANCE AGREEMENT REPORT

Plans for 1998-2003:



VHA's "10 for 2002" sets a stretch goal for the VISNs to increase the number of unique patients treated by 20% from the 1997 baseline. This supports the VA Strategic Plan's general goal to improve the overall healthcare of veterans. The intervening percentage targets, including the specific 1998 target, are illustrated below. Based on projections by VHA's finance and policy and forecasting offices, increasing market penetration annually by 1.24% will enable VHA to reach the goal of increasing users by 20% by 2002.

Chart 5-5



CONCLUSION

VHA has successfully increased access for veterans to VA services. One demonstration of this success is the 2.4% increase (81,500 veterans) in the number of new Category A (service-connected and low-income) veterans served in 1997. VHA has accomplished this by implementing the strategies discussed in this chapter as well as those found in other chapters.

VHA is providing the right service to the veteran based on the needed healthcare in the most appropriate setting, whether that is inpatient, outpatient, or in-home. The enrollment of veterans to receive VA healthcare should allow VHA to better understand the healthcare needs of the population served and, thus, improve the planning and execution of targeted healthcare programs. The uniform benefits package will ensure that all veterans cared for by VHA receive a consistent level of quality care and services no matter how they come to VA. Preventive medicine programs and care management of individual patients will increase access to the right healthcare service at an earlier stage to ensure that problems are identified before patient health is compromised.

Chapter 5: Enrollment and Improved Access to Care

VHA is improving access to care by establishing additional access points where veterans can receive care. VHA operates over 270 community-based outpatient clinics and plans to operate over 650 by the year 2003. Expanded sharing and contracting authority was used to increase the number of such contracts from 15 to 52 in 1997. A variety of improvements have been made such as expanding after-hours clinics, expanding telephone access to triage and care, initiating mobile screening programs, and conducting other outreach efforts.

VHA is improving the timeliness of care. In 1997, VHA met the Picker Institute private sector benchmark for number of problems reported by patients. VHA also improved the overall percent of acceptable medical compensation and pension examinations performed for VBA with fewer being returned by VBA and, thus, speeding access to healthcare and benefits for more veterans.

VHA will continue implementing proven strategies to provide veterans with the right service, in the right place, at the right time.

CHAPTER 6: MEDICAL EDUCATION AND RESEARCH

VHA is extensively involved in the nationwide training of physicians and associated health personnel and in conducting medical research that greatly enhances the quality of care provided to veterans within the VA system, as well as enhances the level of American healthcare generally. This chapter covers accomplishments and forecasts for medical and associated health education and for the research program.

VA benefits from its education and research programs in myriad ways. Research investigations are targeted on specific veteran problems and are firmly involved with the continuing evolution of healthcare. Many of those educated in the VA system remain with the VA following completion of their educational requirements and provide a valuable source for a continuing, "State of the Art" work force. Current and planned actions in the education and research programs are focused directly in support of the following "10 for 2002" goals.

- *When asked, 95% of physician house staff and other trainees would rate their VA educational experience as good or superior to their other academic training.*
- *Increase to 99% the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of the Department.*

All of VHA's educational and research activities contribute to improvements in healthcare and to technological advancements not only for the benefit of the veteran population, but also for American healthcare generally.

MEDICAL AND ASSOCIATED HEALTH EDUCATION

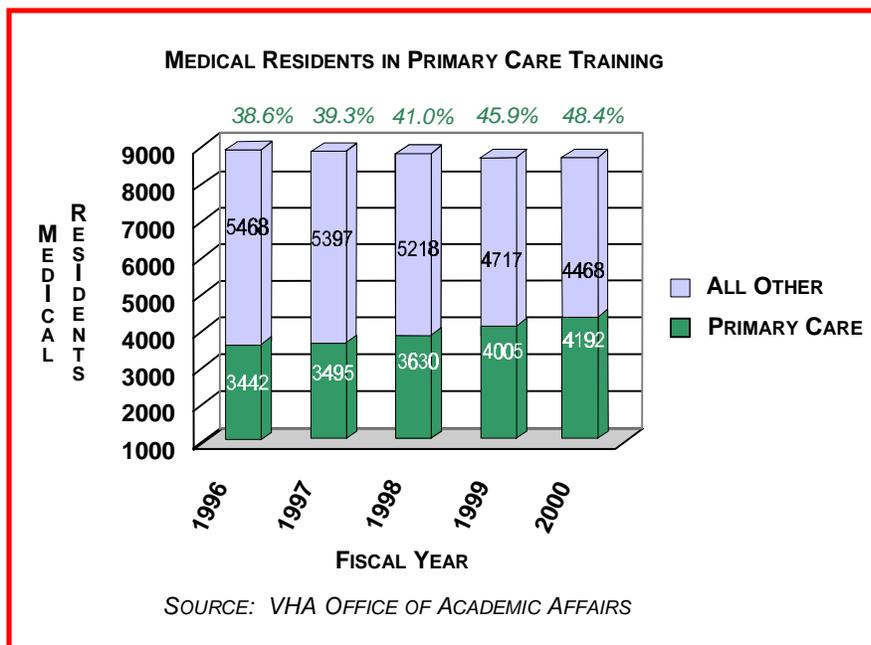
VHA conducts the nation's largest education and training effort through partnerships with its affiliated academic institutions for health professionals. It supports 10% of the nation's graduate medical education annually. Training also includes approximately 54,000 personnel in over 40 allied health professions, including nursing, dentistry, optometry, podiatry, pharmacy, psychology, social work, audiology and speech pathology, etc. VHA's overall goal is to assure an adequate supply of clinical care and allied health providers for veterans and the nation. The presence of health professional trainees also creates an academic milieu and strengthens staff recruitment and retention. The accomplishments and expectations for health education programs are directly linked to the "VA Strategic Plan" objective to realign academic training programs and place a greater emphasis on primary care to better meet the needs of VHA, its patients, students, and academic partners.

1997 Accomplishments:



A major part of VHA's effort is the reshaping of the education of future healthcare professionals by increasing the proportion of medical residents that receive training in primary care. In 1996, the Residency Realignment Review Committee (RRRC), an advisory committee to the Under Secretary for Health, called for a reduction of 1000 specialty residencies and an increase of 750 generalist residencies. This process is being phased in over three years (25% reduction in Academic Year (AY) 97/98, 50% in AY98/99, 25% in AY99/00.) VA and its academic affiliates expanded positions in general internal medicine as well as other primary care fields that have not traditionally supported large numbers of trainees in VA; e.g., family practice, geriatrics, preventive medicine, occupational medicine, and obstetrics and gynecology. VA is now on its way to leading effective change in the national graduate medical education community—training a greater proportion of generalist physicians while protecting specialties that are particularly important for VA's special programs. Chart 6-1 shows the actual (FY96, 97, 98) and planned (FY99, 00) number of medical residency positions in primary care training versus all residency positions for VA.

Chart 6-1



The future healthcare environment will be characterized by many changes. While one change will be an increased focus on primary care and general practice, another will be the need for health systems to provide chronically and seriously ill patients with easy primary care access that is supported by high levels of clinical expertise. Based on the premise that for many severely ill patients the best primary care will be provided or managed by a medical specialist or sub-specialist, VA initiated the following two Primary Specialist Programs.

- Access and Continuity in Education of Specialists (ACCESS) provides a targeted experience within medical subspecialty residencies that focus on the development of primary care management skills. This training experience takes advantage of patient care settings in which subspecialty physicians serve as the primary care physicians for patients with major health problems.
- Psychiatry Primary Care Education (PsyPCE) provides a training environment in which psychiatrists serve as the primary care physicians for patients with major mental health problems.



The educational impact of VA is closely linked to its partnerships with many of the nation's leading academic institutions. To help chart the future course of these partnerships, in 1997 VHA executed new affiliation agreement documents with its academic partners and initiated a review of academic affiliations. The new affiliation agreements will be the basis for long-term planning, will identify measurable outcomes to track future progress, and will provide a solid foundation for moving through this period of rapid change in medicine and medical education. The review addressed the mission and vision of the partnership, physician faculty issues, medical care of veterans and the education and research partnership, network-wide issues, VA/university governance, and business relationships. This valuable review enabled VA and its affiliates to:

- provide an accounting of the strengths and weaknesses of each partnership;
- prepare an agenda for the future that should serve to strengthen the affiliation over time; and
- strengthen lines of communication/working relationships benefiting patients, students, faculty, and staff.

VHA is also working to ensure that the 54,000 associated health trainees who receive clinical training annually in VHA facilities are better prepared for their future roles in the nations healthcare system. The Associated Health Professions Review Committee, appointed by the Under secretary for Health, recommended a broad-reaching

strategy that will shift education resource priorities to patient-focused criteria. Following a survey of 52 professional and accrediting associated health organizations for information and advice regarding trends in a wide range of issues, the Committee made several recommendations.

1. Associated health education programs should be patient focused.
2. Training programs that address areas of high priority for VA and the nation should be emphasized.
3. Professions that address the greatest needs of veterans should be given preference for training.

Plans for 1998-2003:



During the second year implementation phase of the RRRC recommendations, VHA plans to downsize an additional 50 percent of the target for specialty programs while developing additional primary care training opportunities. The following three goals, from the “VHA Performance Plan 1998,” have been established to direct progress:

- Increasing the proportion of residents trained in primary care from 39.3% in FY 1997 to 48% in FY 2000
- Eliminating 250 specialty resident positions by FY 2000
- Reallocating 750 specialty resident positions to primary care by FY 2000

Additional goals are:

Technical Quality:

- Refining and implementing a strategy defining VA as the benchmark health system for healthcare professional education and training
- Establishing a process to monitor progress toward the goal that 95% of physician house staff and other trainees rate their VA educational experience as good or superior to their other academic training opportunities
- Implementing revised associated health trainee allocation methodology based on the Associated Health Professions Review Committee’s recommendations

Service Satisfaction:

- Developing an orientation for new medical trainees that addresses the unique aspects of veterans as patients
- Providing a targeted experience through Access and Continuity in the Education of Specialists (ACCESS) within medical subspecialty residencies that focus on the development of primary care management skills. This training experience takes advantage of patient care settings in which subspecialty physicians serve as the primary care physicians for patients with major health problems.

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On the Electronic Road - Internet Used for Nurse Training Program

An educational initiative between VISN 8, St. Louis University (Missouri), and HQ healthcare Staff Development and Retention Office created a distance learning website program using the addictive disorders World Wide Web to prepare advanced registered nurse practitioners to meet the future primary care needs of veterans. This initiative was fast tracked in two months (July-August, 1997), from idea formulation to implementation and subsequent enrollment of the students. The VA Medical Centers provide on-site clinical experiences and preceptors to meet the clinical requirements of the program. Currently, twenty-six VA nurses from all VA Medical Centers in the Florida and Puerto Rico area are enrolled part-time in this innovative distant learning collegiate program.

**Distance Learning: A Nurse Practitioner/
Advanced Practice Nurse Program**
By Sandra K. Janzen, MS, RN, CNAA,
Nursing Representative, Executive
Leadership Council, VISN 8 – Sunshine
Healthcare Network Project

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**VA and DoD Faculty Train Nurse Practitioners
via Two-Way Video Teleconferencing**

The distance learning project, which involves learning via live video conferencing and the Internet, successfully links VA and DoD assets to collaboratively implement an accredited academic nurse practitioner program. Designed for clinical nurse specialists, the program will award a certificate in nurse practitioner education and the graduates will be eligible for national certification. Through this joint effort now implemented at 7 VA sites, Uniformed Services University and VA faculty teach all courses via two-way video teleconferencing. In 1997, a VA/DoD pilot study indicated that the clinical skills and academic grades of distance learning students were equal to those of traditional students. Video teaching will be supported by on-site clinical laboratories and practica, as well as Internet activities.

Both VA and the uniformed services are undergoing bold and significant changes in healthcare delivery increasing the need for non-physician primary care providers. This innovative educational program is one vehicle to ensure that VA is responsive to healthcare challenges for the next century.

**VA/DoD Distance Learning Project for
Nurse Practitioner Education**

*By Charlotte F. Beason and Mary Ann
Tatman, VAHQ Washington D.C.;
Kathy S. Burkhart, VAMC Washington
D.C.; and Virginia Saba, Uniformed
Services University of Health Sciences,
Bethesda, MD*
“Journey of Change” Leadership Conference,
Baltimore, MD. December 1997.

Future plans at the Network level include:

Technical Quality:

- Publishing a brochure summarizing changes occurring within VHA to provide information and understanding to assist our academic partners (Network 6)
- Establishing an affiliation council & developing recommendations on relevant affiliate issues (Network 7)
- Establishing resident “continuity” clinics and assigning panels of patients to residents for a minimum of ½-day per week for at least two years (Network 9)
- Initiating a prosthetics residency program at the North Texas System (Network 17)

Service Satisfaction:

- Establishing a uniform process to measure trainee satisfaction, and implementing solutions for a minimum of 10 of the issues identified for improvement (Network 12)

Access:

- Providing advanced training (master’s level) for advanced practice nurses to expand utilization in primary care delivery (Network 8)

MEDICAL RESEARCH



The mission of the research program is “to discover knowledge and create innovations that advance the health and care of veterans and the nation.” VHA’s research and development activities have historically been a major asset in efforts to improve the health of veterans. In 1995 the Under Secretary for Health established the VA Research Realignment Advisory Committee (VARRAC) to advise him on potential improvements for marshalling research resources toward veteran health problems. As a result, VA expanded health services research; created an epidemiologic research capacity; revitalized cooperative studies; refocused medical rehabilitation research services; and clarified the vision, mission, and goals of the research program.

As the VA healthcare system moves from an inpatient to an outpatient orientation, the physician mix is moving from a specialist to a more primary care orientation, and changing research from a primarily laboratory to an increasingly clinical orientation. Consequently, epidemiological studies, the science of disease in populations, have risen in popularity. To increase the number of epidemiology investigators, VHA established three new Epidemiology Research and Information Centers (ERICs). The ERICs will serve as focal points for investigator initiated epidemiology research, career development for new investigators, and centers for VHA directed research.

Because of the unique similarity of VA medical centers, the VHA healthcare system is ideal for multi-site clinical trials – one of the things VA does best. To revitalize cooperative studies, VHA began providing resources for numerous previously approved but unfunded projects. This encourages clinical trial investigators to develop proposals, a complex and time consuming task, as funding delays for meritorious proposals decreased. Additionally, through aggressive interaction with private industry and with other government agencies, new partnerships are bringing additional resources and patient population bases to enlarge VHA’s cooperative studies program.

Rehabilitation research and development will emphasize work on sensory aids for the visually or hearing impaired and on outcomes research. The portfolio of projects will be further evaluated and modified with the arrival of a new Director of Rehabilitation Research and Development in 1998.

1997 Accomplishments:

Technical Quality

- Created Designated Research Areas that cut across the traditional boundaries of Medical, Health Services, and Rehabilitation research programs to recognize and stimulate the synergy of these activities for addressing veterans’ healthcare needs
- Implemented systematic approaches to link research results, clinical care and health systems operations; such as developing targeted solicitations for research emphasizing organizational needs, adding specific plans (and resources) to cooperative studies for results implementation, and disseminating selected research results to those who can best apply them
- Established outcomes-based performance measures for headquarters personnel and incorporated the measures in leadership performance plans
- Developed, expanded and enhanced career development programs to build research expertise, to better link career development opportunities with research priorities, and to encourage investigators who routinely bridge patient care and research activities



Chapter 6: Medical Education and Research

Highlights in research from 1997 include the following:

- Determined that “Clot-busting” drugs are as effective as angioplasty in opening blocked arteries. Drug therapy spares patients the risk associated with the invasive procedure and costs about \$3,000 less per patient than surgery
- Developed the SMART wheel, a movement-sensing device that is now in use in assessments of wheelchair propulsion mechanics. These studies may lead to new ways to reduce the arm pain that often results from the repetitive motion of manual wheelchair operations
- Identified the genetic basis for Werner’s syndrome, an inherited disorder that causes premature aging in multiple organ systems
- Developed and published Clinical Practice Guidelines for cholesterol screening; these were written by HSR&D researchers for the American College of Physicians and published in *Annals of Internal Medicine*
- Implanted first dual Functional Electrical Stimulation hand grasping system in a SCI patient allowing for increased function over previous implants in one hand
- Perfected a breath test for identifying the organism responsible for 90% of peptic stomach ulcers. The new test is more accurate than blood tests and is expected to reduce the need for endoscopies; and
- Advanced an implantable insulin pump that offers patients with adult onset diabetes the prospect of eliminating daily injections. The pump offered more of a constant rate of insulin delivery, lower incidence of clinical insulin reactions, elimination of the weight gain common among diabetics, and greater patient satisfaction and quality of life

Plans for 1998-2003:



The Office of Research and Development established the following major goals to monitor progress toward achieving their mission.

Chart 6-2

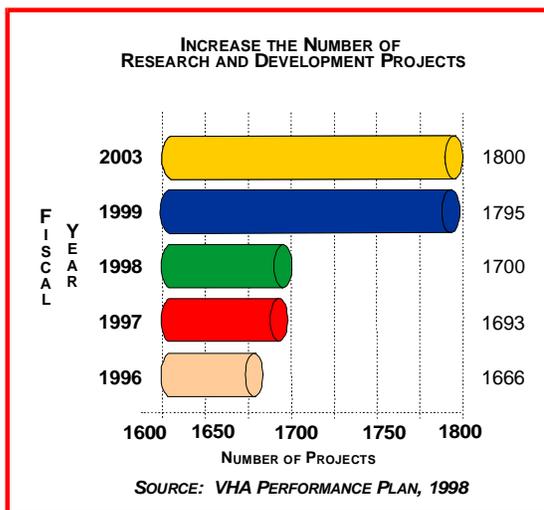


Chart 6-3

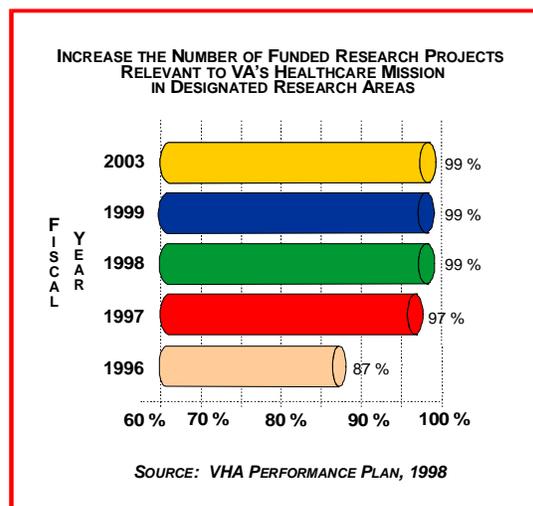
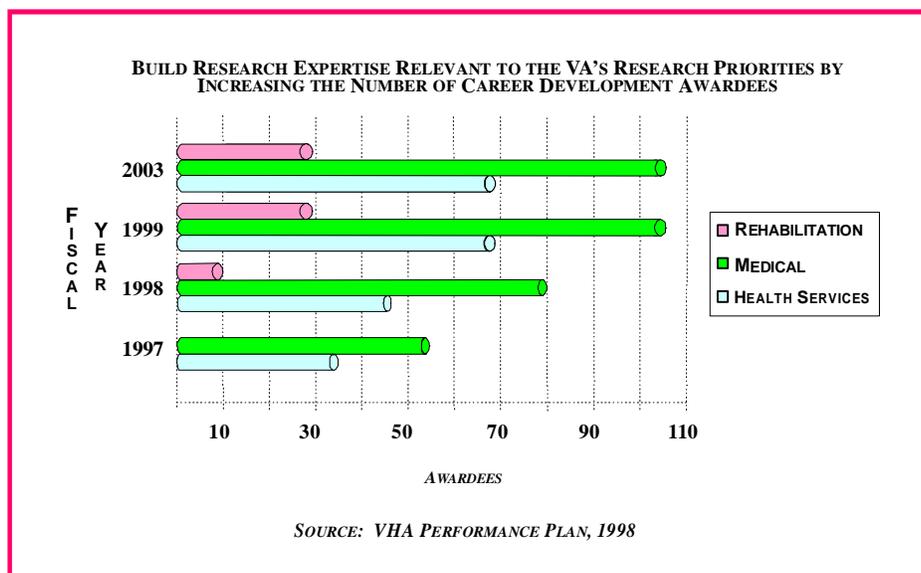


Chart 6-4



The Networks are planning to achieve these goals through a variety of activities, including:

Technical Quality:

- Conducting a VISN-wide research conference to collaborate on research projects (Network 6)

Functional Status:

- Planning research initiatives that specifically address the needs of special populations (Network 12)
- Developing a VISN level health services research and development study targeting 2-3 direct patient care issues (Network 19)
- Conducting research to study genetics and molecular biology, psychopharmacology and health services in post-traumatic stress disorders and in schizophrenia (Network 20)

Cost/Price:

- Expanding research opportunities by seeking funding opportunities beyond the traditional VHA and NIH sources (Network 1)
- Fostering pharmaceutical industry sponsored clinical trials through the Research Entrepreneurial Group (Network 2)
- Reimbursing all VISN facilities for individual investigator and co-investigator salaries proportional to their involvement in specific veterans' issues (Network 4)
- Obtaining and disseminating information describing research opportunities to study alternative therapies (Network 11)
- Expanding participation in Facilitators of Applied Clinical Trials to increase the pool of scientific projects for Network investigators (Network 17)



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**Ambulatory Care Groups - Evaluating Outpatient Care
Cost and Quality with Standardized Tools**

As VHA moves towards managed care, the importance of accurately predicting healthcare resource utilization is critical for assessing quality of care. Ambulatory care case-mix measures are currently being used by healthcare organizations to describe the illness burden of their patients in terms of predicting resource utilization, evaluating the costs and quality of care, and providing equitable reimbursement to providers. We examined one such measure, Ambulatory Care Groups (ACGs), by testing its feasibility for measuring illness burden in VHA. We randomly selected 500 veterans who had at least one ambulatory care visit at a Boston-area facility from October 1 to October 15, 1996. Using local DHCPs, we pulled all outpatient ICD-9-CM codes on selected outpatients for a one year period (12/1/95-11/30/96), along with age and gender, to identify ACGs for each patient. We found an average of 12 diagnoses per patient. All but 800 (13.2%) of the diagnoses could be grouped; the most frequently non-classifiable codes represented post-traumatic stress disorders and drug dependence. Only six patients could not be placed in an ACG. The patient sample was heavily weighted towards the more complex ACGs, with only 78 (16%) falling into ACGs specified for individuals with a single Ambulatory Diagnostic Group (ADG), and 318 (64%) falling into ACGs with four or more separate ADGs. These results are indicative of the high illness burden of patients in these complex groupings. Once this occurs, ACGs should be useful tools with which to profile and monitor quality of care in VA ambulatory settings.

Importance of Ambulatory Care Case-Mix Tools for VHA

By Amy Rosen, Dan Berlowitz, Jennifer Anderson, Larry Curran. Center for Health Quality, Outcomes and Economics Research, Bedford VA HSR&D Field Program, Bedford MA

CONCLUSION

In re-engineering the medical and allied health education program and the research program, VHA has successfully aligned training and investigation capabilities to more effectively address veteran needs and problems.

VHA is a leader in effectively changing the national graduate medical training/academic healthcare system and has strengthened its partnerships with academic affiliates. We have increased generalist residencies and created unique training opportunities for specialist/sub-specialists to develop primary care management skills. Concomitantly, we have established programs that enable medical specialists or sub-specialists to provide primary care in addition to specialty care for chronically and seriously ill patients. In educating allied health personnel, we have reaffirmed our commitment to patient focused programs that emphasize areas of high priority to VA, and have established state of the art computer aided mechanisms for obtaining advanced training.

The Office of Research and Development is targeting research efforts in areas where VHA can make a unique contribution or where a special opportunity exists. We are capitalizing on collaborative opportunities with other organizations (National Institutes of Health, pharmaceutical companies, etc.) and are effectively and extensively leveraging resources. By expanding health services research and by creating an epidemiological research capacity, VHA research continues to lead to healthcare practices that improve outcomes for patients.

VHA's accomplishments and forecasts in the education and the research programs represent a firm commitment to addressing the needs of the Nation within the context of priorities for veterans.

CHAPTER 7: RESOURCE MANAGEMENT

VHA operates the largest integrated healthcare delivery system in the United States, providing care to over 3.1 million unique patients (a single individual enrolled in the system regardless of the number of times the person was treated) with nearly 827,000 inpatient stays and 32 million outpatients in 1997. The efficient management of resources is imperative in order to achieve the mission goals and strategic targets set for this enormous healthcare system. This chapter presents accomplishments and plans for (1) monitoring the shift in resources and patient treatment modalities from inpatient care to the generally less costly outpatient care and (2) tracking the financial management indicators that monitor cost and funds acquisition, allocation, and expenditure.

Healthcare systems will increasingly focus on disease prevention and promotion of community wellness, in addition to treating individual cases of illness. Non-physician caregivers will be more widely used in healthcare systems of the future to provide focused patient care and reduce cost. Accountability in healthcare and an increased emphasis on outcomes and measurements will be demanded.

VHA is decreasing its reliance on appropriated funds and is increasing its efforts to secure additional revenue through alternative sources (a "10 for 2002" strategic target). Third party insurance reimbursement through the Medical Care Cost Fund, sharing contract reimbursements and, potentially, Medicare reimbursements are all sources that VA will rely on in the future.

Technological innovations will continue to revolutionize clinical practice. The trend of providing care in non-hospital settings will continue, and even accelerate, as concern about healthcare costs continues and as new medical devices and pharmaceutical products allow even more medical care to be safely and effectively provided at home or in ambulatory settings. The high costs associated with these new technologies and pharmaceutical products need to be balanced with healthcare delivery strategies that are designed to be more cost effective than institutional care.

In all of these areas (shifting to outpatient care, tracking resources, community wellness, and accountability), advances in information systems will be essential keys to success. Advances in information and communications technology, and imaging systems in particular, will open many new opportunities for improving the delivery of quality healthcare. These industry trends will also be important in improving the management and utilization of resources in VHA.

Effective resource management impacts all of the "10 for 2002" strategic targets, but has significant impact on two of them:

- *Decreasing the systemwide average cost per patient by 30%*
- *Increasing the percent of the operating budget obtained from non-appropriated sources to 10% of the total*

MONITORING THE SHIFT TO OUTPATIENT CARE



VHA continues to monitor and track several performance indicators under the cost/price Domain of Value that relate to the shift of resources from inpatient care to generally less costly outpatient care. These are (1) bed days of care per 1,000 unique patients served, (2) the total number of operating beds, and (3) the percent of surgeries and procedures done in an ambulatory setting rather than an inpatient setting.

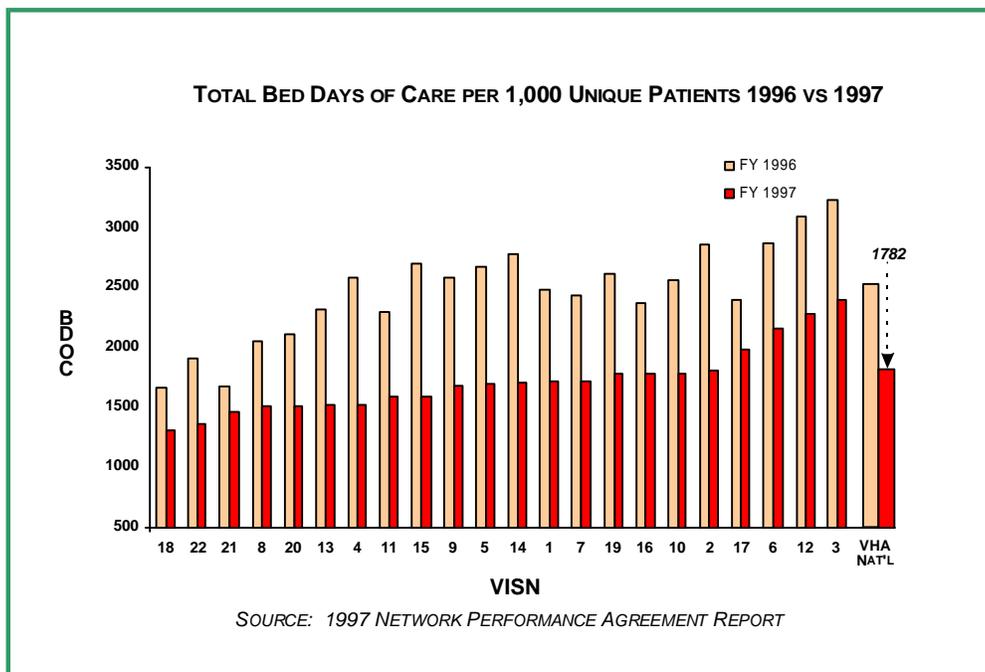
Bed Days of Care per 1,000 Unique Veteran Users:

VHA has used this measure as a proxy for the efficiency of its healthcare system until more refined unit cost measures are identified and developed. A baseline for average cost per patient in terms of obligations per unique patient was established in 1997 and is discussed later in this chapter. However, bed days of care continues to be tracked as an indicator of the shift from inpatient to outpatient care. Reducing bed days of care is a key Performance Goal in the VA Strategic Plan to reduce costs and improve the revenue stream for the healthcare system.

1997 Accomplishments:

VHA continued to reduce the level of operating beds during 1997 demonstrating the increasing move from inpatient care to more cost-effective outpatient care. Acute bed days of care per 1,000 unique users dropped 29% from the 1996 level. The 1997 ratio of 1,782/1,000 users is almost half the 3,430/1,000 users of 1994.

Chart 7-1



Plans for 1998-2003:



Bed days of care are expected to continue to decline, and this decline, in light of historical experience, will enable the system to shift resources in order to meet projected demand arising from an expanded and improved eligibility system. Further gains will depend upon the enrolled patient population and external stakeholder support and VHA's ability to create the cultural climate necessary to bring about extensive changes in clinical processes.

Shifting the focus of healthcare delivery from inpatient to outpatient care is a key strategy to meet the stated VHA goal of reducing the average unit cost per patient by 30 percent. VHA's goal for 2003 is to reduce the number of bed days of care to 1,300 per 1,000 users.

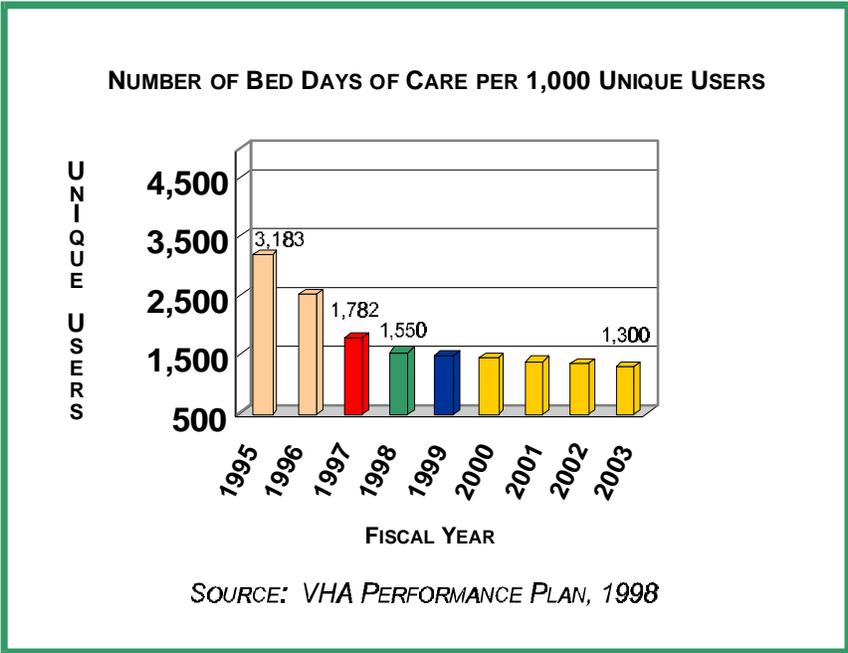


Chart 7-2

See Appendix C for the 1998 3rd Quarter Network Performance Report for progress on this measure.

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Bed Utilization Analysis Refined

Analysis of 100% concurrent review of inpatient days changed our perception of what really causes poor bed utilization. Program nurses counted bed days exceeding the HCFA standard and categorized them by cause. The causes are associated with the dollar cost (CDR per diem) – a more meaningful concept to both management and physicians than “days” or “delays.” Monthly, trended data are reviewed jointly by management and Service Chiefs. Expectations for improvement are articulated and progress is monitored.

Before review began, Service Chiefs maintained that discharge delays were due to patient transportation, nursing home placement, or closed labs on weekends. Data for Medical and Neurology Services during January 1997, however, demonstrated that waiting for procedures (radiology or cardiology) or specialty consultations at bedside accounted for 64% of extra days and represented \$151,254 in unnecessary costs. With Surgery and Mental Health data included, our inefficient systems cost us millions each year.

After ten months, trended graphs of the dollars lost demonstrated that some areas had improved; the others were closely analyzed. Ultrasound caused 40% of Radiology delays, not MRI as expected. 67% of extra Radiology days were weekdays, not weekends. Consultation and Coordination of Care delays doubled in January and July associated with the influx of new residents. Services must improve their orientation and increase staff support during these months.

Trended concurrent review data shows that management and Service Chiefs are the real causes of poor bed utilization and documents improvements made.

Concurrent Review Shatters Myths About Utilization

By Robert E. Henry, Marylee Rothschild, Jody Brown, VAMC Louisville, KY
“Journey of Change” Leadership Conference,
Baltimore, MD. December 1997

Operating Bed Level:

VHA is continuing to reduce operating bed levels across the system with a goal of achieving optimal capacity. This is described as having the actual number of beds required to meet the needs of the enrolled veteran population. The planning basis for a projection of the number of actual beds needed is an average daily census of 85% for acute hospital beds and 95% for domiciliary and nursing home beds.

FY 1997 Accomplishments:

Total operating beds declined 21% (13,840) to 52,706, which exceeded the original 1997 target level of 61,654. VA occupancy rates rose to 78%, which are a full 12% higher than the private sector.

Table 7-1
TOTAL OPERATING BEDS
(INCLUDES HOSPITAL, DOMICILIARY AND NURSING HOME)

VISN	1996 Actual Beds	1997 Actual Beds	Actual Reductions from 1996 – Beds	Actual Reductions from 1996 - %
1	3,584	2,490	-1,094	(-31%)
2	2,377	1,961	-416	(-18%)
3	4,633	3,614	-1,019	(-22%)
4	4,100	3,904	-196	(-5%)
5	2,199	1,770	-429	(-20%)
6	3,429	3,028	-401	(-12%)
7	4,239	3,676	-563	(-13%)
8	3,763	3,297	-466	(-12%)
9	3,548	2,645	-903	(-25%)
10	2,594	2,019	-575	(-22%)
11	3,163	2,267	-896	(-28%)
12	4,186	3,066	-1,120	(-27%)
13	1,891	1,458	-433	(-23%)
14	1,338	962	-376	(-28%)
15	2,793	1,566	-1,227	(-44%)
16	4,315	3,194	-1,121	(-26%)
17	3,120	2,974	-146	(-5%)
18	1,800	1,419	-381	(-21%)
19	1,597	1,161	-436	(-27%)
20	2,787	2,228	-559	(-20%)
21	2,133	1,741	-392	(-18%)
22	2,957	2,266	-691	(-23%)
Nat'l	66,546	52,706	-13,840	(-21%)

SOURCE: 1997 NETWORK PERFORMANCE AGREEMENT REPORT

Plans for 1998-2003:

Consistent with the decline in inpatient bed days of care, it is expected that the number of beds needed and operated will continue to decrease over time.

Table 7-2

Bed Type	1997 Bed Levels	Beds Needed at Full Occupancy*	Proposed Percent Reduction
Hospital	31,323	28,278	9.7%
Domiciliary	6,417	5,780	9.9%
Nursing Home	14,966	14,149	5.5%
Total	52,706	48,207	9.0%

SOURCE: 1998 NETWORK DIRECTORS' PERFORMANCE MEASURES DEFINITIONS, DATA COLLECTION STRATEGIES
 DECEMBER 4, 1997

(*PLANNED AT OCCUPANCY RATES OF 85% FOR HOSPITAL BEDS AND 95% FOR DOMICILIARY AND NURSING HOME BEDS)

Operating bed projections based on 1997 workload and planning level occupancy rates are shown. This level represents an overall additional reduction of 9% systemwide.

Chapter 7: Resource Management

Locally, the networks are aggressively managing this resource to achieve the stated goals, as evidenced by the following examples:

- Consolidating bed capacity and purchasing community-based services where it is cost effective and promotes both access and quality (Network 1)
- Adjusting operating beds to assure 85 percent hospital occupancy and 95 percent in NH/Domiciliaries (Network 3)
- Closing approximately 250 acute care beds, as a result of improved efficiency, over the next 5 years (Network 9)
- Closing 116 operating beds (from 1,458 to 1,342) (Network 13)
- Matching total network operating beds to total network workload requirements. Close 90 operating beds throughout the network (Network 17)

See Appendix C for the 1998 3rd Quarter Network Performance Report for progress on this measure.

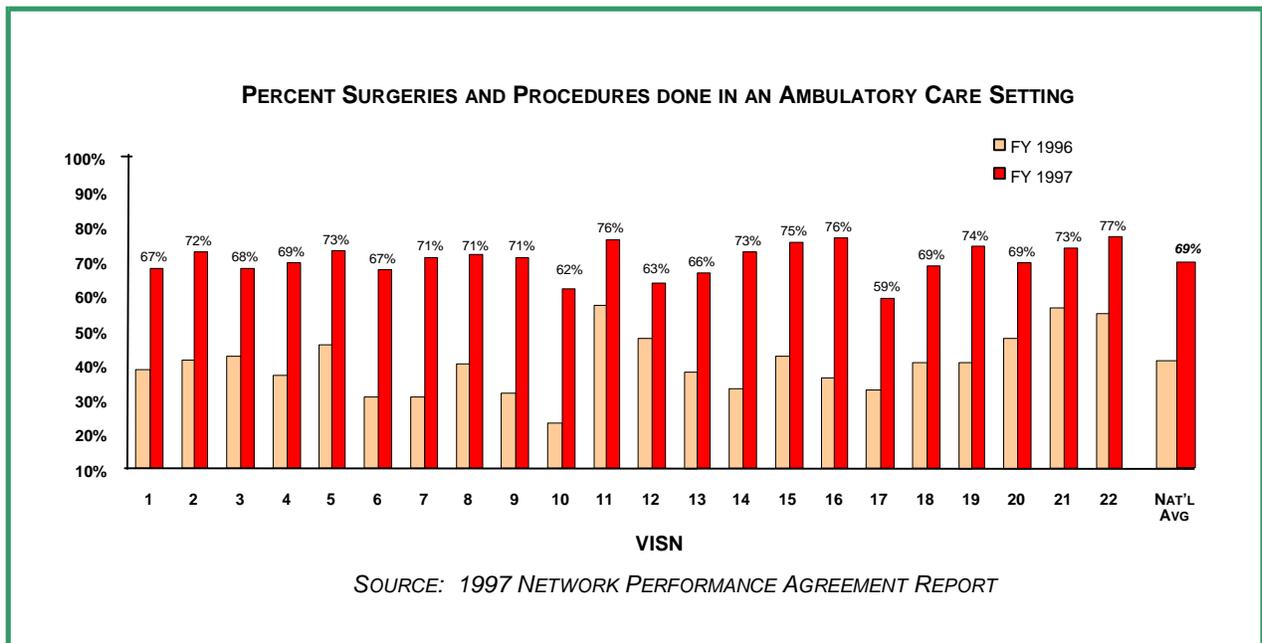
Ambulatory Surgery:

Networks are shifting the focus of healthcare delivery from the inpatient, hospital-based setting to ambulatory settings in an effort to enhance both quality and patient satisfaction, reduce cost and increase efficiency. All networks are increasing the number of surgeries and other procedures performed on an ambulatory basis at the same time that they are decreasing the number of operating beds and bed days of care. In doing so, productivity has increased and surgical complications have decreased (see Chapter 2).

1997 Accomplishments:

69% of VHA surgeries and procedures are now performed in an ambulatory setting. This reflects a 33% improvement from FY 1996.

Chart 7-3



The networks have energetically pursued this strategy and have made remarkable progress as noted in the chart above. Networks highlighted these accomplishments in their network plans as noted below:

- Increased outpatient cardiac catheterizations to 45 percent (Network 3)
- All facilities performed 50 percent of procedures on an ambulatory basis (Network 4)
- Expanded ambulatory surgery as needed to meet/exceed performance measures (perform 58 – 70 percent of appropriate surgery in an ambulatory setting) (Network 5)
- Increased ambulatory surgery (on HCFA list) from 38 percent in '96 to 71 percent in '97 (Network 8)
- Expanded ambulatory surgery and invasive diagnostic procedure capacity by 30% (Network 17)
- Developed Service Line in Clinical Surgery in LA Basin (Network 22)

Plans for 1998-2003:

In general, 75% or above is considered exceptional performance with regard to the percent surgeries and procedures done in an ambulatory setting and all VISNs will strive for this performance level over time.

- Increasing ambulatory surgery rate to 75 percent (Network 2)
- Increasing percentage of surgery and invasive diagnostic procedures performed in an ambulatory care setting to 80% (Network 12)
- Constructing/upgrading ambulatory surgery facilities at VACHCS Lakeside and Westside, Iron Mountain and Milwaukee and increasing percent of surgery and invasive diagnostic procedures performed in ambulatory care setting (Network 12)
- Increasing total ambulatory surgery from 52% to 65%, a step working toward the 75% goal (Network 13)
- Activating the ambulatory surgery expansion project at the South Texas System (Network 17)
- Creating ten 23-hour stay beds to support expanded ambulatory surgery at the North Texas System (Network 17)
- Providing 250 contract ambulatory surgery procedures to Lower Rio Grande Valley patients (Network 17)
- Providing locally at each network site a core set of outpatient surgical services to include general surgery, urology, ophthalmology, orthopedics, ENT, GYN and hand surgery (Network 20)
- Exceeding the national VHA level of performance in ambulatory surgery (Network 21)
- Completing minor construction (Phase II), ambulatory surgery, at San Diego (Network 22)

FINANCIAL MANAGEMENT INDICATORS



VHA recognizes that the role of the Federal government in American society will continue to be re-evaluated and competition for Federal government funding will become even more intense than it is now. Cost will continue to be a major driving force in the future in the healthcare industry. At the same time, quality of care and customer service are becoming increasingly more important issues and these elements will continue to place additional pressure on the healthcare delivery system resources.

This section presents the accomplishments and plans for six indicators that are keys to meeting VHA's financial goals:

1. The increase in the level of spending on outpatient care;
2. The decrease in the average cost per patient by 30% (a "10 for 2002" strategic target);
3. The increase in the percent of the operating budget obtained from non-appropriated sources to 10 percent of the total (a "10 for 2002" strategic target);
4. Refinements in the resource allocation methodology, the Veterans Equitable Resource Allocation model (VERA), to equitably fund the patient care at the VISN level;
5. Reductions in acquisition expenses through implementation of the new procurement policies; and
6. Design of a new capital investment policy to ensure the best possible selection and funding of cost effective capital investment projects.

Spending on Outpatient Care:

The increased level of spending on outpatient care versus acute inpatient care is a financial indicator of the shift from the traditional inpatient healthcare delivery to the generally more cost-effective outpatient treatment. This indicator is monitored at the national level and is included in the VA Strategic Plan as a Performance Goal to assist in reducing costs and improving the revenue stream for the healthcare system. VHA recognizes that this is a process measure focused on the financial inputs to care. It has established and will contemporaneously rely upon additional, other patient care outcome measures to define progress in the areas of access, quality, patient satisfaction, and the like, as noted in other chapters.

1997 Accomplishments:

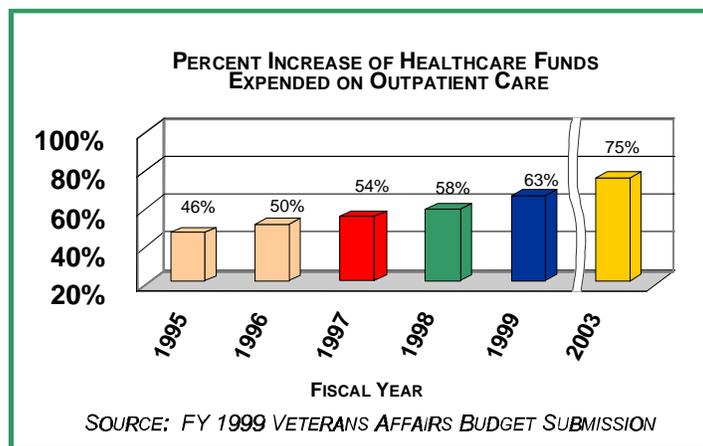
There has been a steady increase in the percent of healthcare funds expended on outpatient care since 1995 as noted in the Chart 7-4. This expenditure has increased from 46% in 1995 to 50% in 1996 and to 54% in 1997.

Plans for 1998-2003:



As VHA continues to increase the number of veterans served on an outpatient basis, the percent of healthcare funds directed toward outpatient care is expected to continue the trend indicated in the chart below and to rise significantly over time.

Chart 7-4



Decreasing the Average Cost per Patient by 30%:

This “10 for 2002” strategic target is a key component of VHA’s 30-20-10 strategy. In addition to the 30% decrease in cost per patient, VHA is working to increase the number of veterans we serve by 20% (discussed in Chapter 5) and increase the percent of the operating budget obtained from non-appropriated sources to 10% of the total, as discussed later in this section. Our goal of reducing the cost per veteran treated by 30 percent by 2002 is dependent on our ability to utilize our resources more effectively, to more efficiently redefine and restructure how we provide care, and on the co-dependent goal of increasing the number of veterans that we serve by 20 percent. Accomplishment of these goals will be measured as improvements from actual 1997 baselines. To accomplish our goals, VHA has re-invented its approach to healthcare delivery and implemented a new national network management structure. Duplicative services have been and are being consolidated and overlapping administrative functions are being eliminated. Decreasing the average cost per patient has also been identified as a key performance goal in the VA Strategic Plan, Fiscal Years 1998-2003, to meet the general goal of reducing costs and improving the revenue stream for the healthcare system.

1997 Accomplishments:

In 1997, a baseline average expenditure (obligation) per patient was established at \$5,458. This is the baseline from which the 30% decrease will be measured.

Plans for 1998-2003:

VHA expects that the average expenditure per patient will be reduced by 30% (in constant dollars) by 2002, or 4 to 6 percent with an assumed inflation of 3.5 to 4 percent per year. This is a “stretch goal” and is interdependent both upon the other elements of the 30-20-10 strategy and upon the enactment of the Medicare subvention legislation (discussed in Chapter 5).

Increasing the Amount of Funds Obtained From Non-Appropriated Sources to 10% of the Total:

This “10 for 2002” strategic target is another key component of VHA’s 30-20-10 strategy. VHA has decreased its reliance on appropriated funds because of a five-year freeze on the VA medical care appropriation in the Balanced Budget Agreement. To replace this prior reliance, VA has been proactive in its efforts to secure future funding by supplementing the medical care appropriation with alternative revenue sources. Faced with 3.5 to 4 percent inflation each year (which will be partially funded by anticipated revenues from third-party collections through the Medical Care Cost Fund, sharing reimbursements, and management efficiencies), Medicare revenue is a logical source of additional funds. This VHA strategic target has also been identified as a key performance goal in the VA Strategic Plan, Fiscal Years 1998-2003, to meet the general goal of reducing costs and improving the revenue stream for the healthcare system.

Medical Care Cost Fund (MCCF):

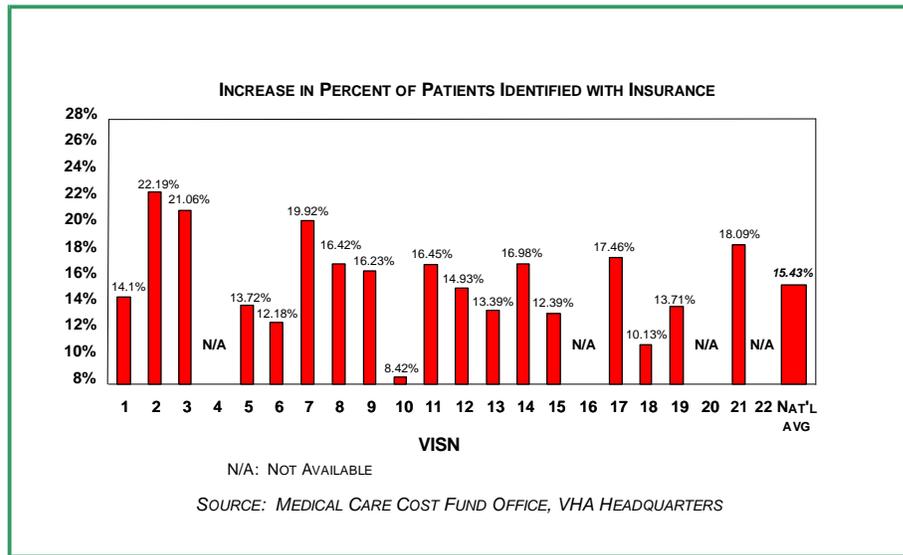
A critical element in the process of increasing recoveries from third party insurance carriers is assuring insurance identification. Public Law 105-33 allows networks to retain their MCCF recoveries. A pre-registration software package was developed and implemented that is used to obtain insurance/employment information from the patient at his/her residence prior to the scheduled outpatient visit. The Application for Medical Benefits, Form 1010, was changed to include more comprehensive questions regarding insurance. Each medical center is encouraged to use this package and some VISNs mandate use of the tool. A diagnostic report was developed to monitor progress in the intake process of both registration and pre-registration.

1997 Accomplishments:

In the last two years, MCCF re-engineering of a pre-registration process was pilot tested in the field. Pre-registration involves contacting patients prior to a scheduled hospital admission or a scheduled outpatient visit and correcting “demographic” data defined to include insurance coverage information. Pre-registration over 18 months resulted in 102,155 “demographic changes” made in the MCCF database which in turn resulted in an increase in collections of over \$11.5 million.

The 1997 diagnostic report listing the percent of patients identified with insurance is shown in Chart 7.5.

Chart 7-5



BEST PRACTICES OR INNOVATIONS



Collections Process Improved

Information Resource Management Service and Medical Care Cost Recovery Service continues to research innovative ideas for increasing collections. They have teamed up with a private sector, third-party debt collection agency to take advantage of a legal aspect of the Fair Debt Collection Practices Act, which states that when a third-party debt collection agency gets involved in the collection process, all portions of the claim shall be assumed valid unless disputed within thirty days.

Due to budget and time constraints, the Services were determined to automate the entire process by developing a computer system program which captures all bills delinquent over ninety days. These bills are sent daily to the collection agency for collection action via the Internet. The collection agency is then responsible for sending five letters to the insurance companies, fourteen days apart, for each delinquent receivable. This referral action puts the burden on the insurance company to notify the VA on the status of the claims instead of the VA having to initiate the call. To enhance this program, a transactions comment is entered into the profile reflecting each letter that is sent by the collection agency and a comprehensive daily report is delivered in a VISTA mail message.

A minimal per claim charge is assessed to the facility. This program has assisted the Houston VA in personnel and overtime cost savings while collecting more than \$342,000 in delinquent reimbursable claims. Less than 1% of the dollars collected represents the collection cost.

Increasing Collections: Implementation of Automated Electronic Data Interchange Program with Third Party Debt Collection Agency

By Marshall Leach, Teresa Baccus, VAMC Houston, TX

“Journey of Change” Leadership Conference, Baltimore, MD. December 1997

Plans for 1998-2003:



The strategic target for 1998 is to maximize the outside insurance recovery available to the VA healthcare system. With complete interviewing of patients, effective pre-registration and similar efforts, VHA expects to increase the number of eligible, unique patients with reimbursable insurance by 8%. The new enrollment process for veterans in the VA healthcare system, discussed in Chapter 5, will assist in this endeavor.

Seven medical centers continue to work on the MCCF re-engineering initiative to improve the core processes of cost recovery activities. This business process redesign initiative to improve the MCCF program has proved beneficial for VA overall, and is now being shared with all VA medical centers and networks with the goal of streamlining business processes, eliminating inefficiencies, and increasing revenues.

Sharing Reimbursements:

New sharing arrangements and alliances within and outside VHA are crucial to the implementation of the VISNs as virtual networks of care. Under the expanded healthcare resources sharing authority granted to VHA in the Eligibility Reform legislation, VHA may enter into sharing agreements or contracts with any healthcare provider, or other entity or individual. VHA may enter into sharing contracts to acquire (“buy”) healthcare resources, to provide (“sell”) healthcare resources, or to exchange healthcare resources. These arrangements can be between neighboring VHA medical centers, with other governmental providers such as DoD, and with private sector providers. VHA already has a long history of maintaining beneficial sharing agreements with its medical school affiliates and allied health partners. Increasing sharing agreements and contracts has also been identified as a key performance goal in the VA Strategic Plan, Fiscal Years 1998-2003, to meet the general goal of reducing costs and improving the revenue stream for the healthcare system.

1997 Accomplishments:

The Under Secretary for Health established a new Award for Strategic Alliance to support the values set forth in the *Vision for Change* and to recognize the activities that exemplify those values. This program recognizes exemplary achievements in implementing strategic partnerships and alliances with community partners that benefit the VA healthcare missions. This annual award targets activities that promote improved teamwork and collaboration within VA medical centers and VISNs that result in cooperative relationships with community partners. These relationships should result in innovative sharing agreements, enhanced use projects (discussed later in this chapter), or joint research initiatives (discussed in Chapter 6) and could involve one or more VA medical centers or VISNs. Examples of community partners include other federal, state and local agencies, educational institutions, public and private healthcare providers, and research institutions. These efforts are critical as the “new VHA” changes business practices to provide better, more cost-effective services to VA patients

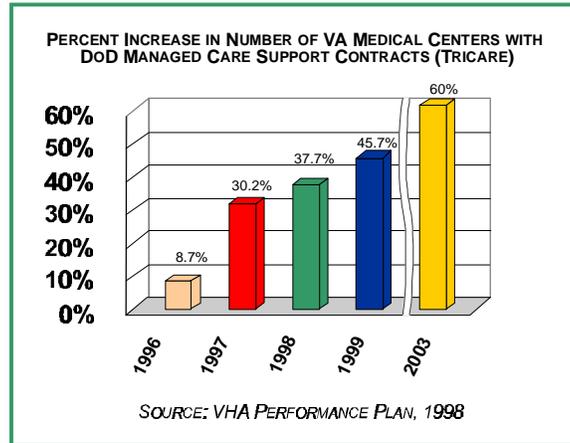
- Increased the number of facilities with CHAMPUS or TriCare agreements from 15 to 52
- Established a marketing team at Brockton/West Roxbury to expand DoD offerings (Network 1)
- Improved revenue at Manchester by renting space on their tower to cellular phone companies (Network 1)
- Increased gross revenue from sharing agreements by \$683,797 (Network 3)
- Signed letter of intent for contract for TriCare status in Kentucky and West Virginia (Network 9)
- Developed non-appropriated revenue streams by selling laboratory test services to DoD facilities (Marines at Camp Pendleton and 29 Palms, and Air Force at Vandenburg). TriCare Medical/Surgical contracts were executed at VAMC Loma Linda and 80 Prime patients enrolled, for total billing including prescriptions of \$15,400 (Network 22)

Plans for 1998-2003:

Chart 7-6



VHA has proposed increasing the number of Medical Centers with DoD TriCare contracts from 30% to 60% by 2003



The VHA Strategic Target for 1998 is to increase the number of facilities with CHAMPUS or TriCare agreements to 65 from 52 in 1997.

The networks are taking full advantage of the opportunity to partner with the federal, state, and local organizations and businesses to increase revenue from non-appropriated sources. Some examples are:

- Testing a pilot program to sell educational services to the community (Network 1)
- Exploring feasibility of filling mail-out prescriptions for DoD (Network 1)
- Fostering pharmaceutical industry-sponsored clinical trials through the Research Entrepreneurial Group (Network 2)
- Analyzing excess space for possible enhanced use, sharing the use of space, etc. (Networks 3, 9, 10)
- Investigating possibilities for providing laundry services to other organizations (Networks 3, 5, 10)
- Becoming a preferred provider for Tri-Atlantic (DoD managed care contractor) (Network 6)
- Expanding the Energy Savings Performance Contract (ESPC) through DoD to include additional VAMCs (Network 6)
- Pursuing agreement to provide medical examinations for active reservist personnel (Network 10)
- Exploring possibilities to provide viral load testing for other VISNs or non-VA organizations (Network 10)
- Evaluating potential to offer excess advanced food preparation to other government agencies (Network 10)
- Negotiating a contract with the Great Lakes Naval Center to provide healthcare to active duty personnel (Network 10)
- Soliciting private vendors for VA nursing home services at VAMC Indianapolis (Network 11)
- Collecting proceeds from contracted operation of recreation facilities, rental of space to day care provider and health services provider (Network 11)
- Expanding and consolidating agreements with DoD/others to generate new revenues (Network 13)
- Allocating MCCF collections to the medical centers according to the Budget by Population formula (Network 15)
- Providing healthcare services to active DoD personnel (Network 15)
- Expanding the Missouri Veterans State Home Contract and offering similar services to the Kansas Veterans State Homes (Network 15)
- Establishing revenue work groups at each VAMC and network (Network 19)
- Engaging in enhancing revenues: laundry services; energy contracting; fuel tax refund (Network 20)
- Improving DoD/TriCare revenues 15% over FY97 (Network 22)

Enhanced Use Leasing:

The Enhanced Use Leasing program was created by special legislation to assist VA in utilizing excess assets to the benefit of VA. Under this program, VA can issue a long term lease of its excess buildings or land (up to 30 years) and receive in return various forms of compensation including income, services, shared space, or other creative consideration that provides VA benefits it would not otherwise be able to obtain. The program's near term focus is to develop and explore projects in support of medical center and network initiatives to generate additional revenues, achieve operational savings and obtain needed facilities/programs which otherwise would be unaffordable. To date, these programs include: assisted living centers, hospices, transient lodging, child care centers, parking garages, medical and administrative office buildings. Ongoing studies that span several fiscal years include the following:

- Undertaking a review of the VISN 12's capital assets to determine potential revenue centers as part of that Network's Strategic Plan. One of the objectives of this effort is to create a model program analysis that can be applied nation-wide.
- Developing and marketing solicitations for privatizing energy plants at VAMC North Chicago, IL and VAMC Mt. Home, TN resulting in an estimated \$1 million dollar annual savings and potential revenues to these medical centers.
- Privatizing operation and maintenance of recreation facilities resulting in approximately \$1 million savings in annual medical care appropriations.
- Developing and marketing VA solicitations for services and facilities, including:
 - nursing/assisted living center at VAMC Indianapolis, IN
 - research and clinical facilities at VAMC Durham, NC
 - administrative office space at Atlanta, GA and Salt Lake City, UT
 - homeless housing facility for veterans and others at VAMC Portland, OR
- Structuring financing opportunities with state and local entities to provide low-cost financing to these types of projects.
- Anticipate FY 1998 Enhanced-Use lease awards in excess of \$100 million in present value of benefits over the lease term.

Medicare Subvention Pilot:

VA is in position to expand coverage of the veteran population and at the same time make a significant contribution to reducing the cost of care for Medicare patients. VA can do this by making full use of currently underutilized capacity that will allow the treatment of additional patients at the marginal cost (total cost – fixed cost). VA has the critical assets needed to provide quality care to Medicare-eligible veterans at a reduced price and, in doing so, it would also give veterans more healthcare provider choices. Medicare reimbursement has also been identified as a key performance goal in the VA Strategic Plan, Fiscal Years 1998-2003, to meet the general goal of reducing costs and improving the revenue stream for the healthcare system.

1997 Accomplishments:

VA and the Department of Health and Human Services signed a Memorandum of Agreement establishing the terms of a pilot project, including the eligible population, site selection, covered services, reimbursement, level of effort, and evaluation. It is estimated that Medicare collections could range up to \$50 million per year during the demonstration pilot phase.

Plans for 1998-2003:

Assuming authorization, successful pilot testing and national rollout, the combination of Medicare reimbursement, management efficiencies and medical collections (transfers from the Medical Care Collection Fund) would support a goal of increasing the number of veterans served with 10 percent of the VA healthcare budget provided from collections and revenue sources by 2002.

To this end, VA is working with the Administration and Congress to begin a demonstration program as soon as possible to test the feasibility of Medicare subvention; that is, billing Medicare for healthcare provided to Medicare eligible category C veterans and possibly certain category A veterans.

Refining the Resource Allocation Methodology:



In 1997, VHA implemented a new system to efficiently and effectively allocate its \$17 billion Congressionally appropriated healthcare budget to its 22 networks. This new methodology, the Veterans Equitable Resource Allocation (VERA) system, was created to address previously documented problems and to improve the resource allocation system in order to support VHA's goal to provide excellence in healthcare value. VERA helps VHA to treat the greatest number of veterans having the highest priority for healthcare. It

accomplishes this by:

- Allocating funds fairly according to the number of veterans having the highest priority for healthcare
- Recognizing the special healthcare needs of veterans
- Creating an understandable funding allocation system that results in having a reasonably predictable budget
- Aligning resource allocation policies to the best practices in healthcare
- Improving the accountability in expenditures for research and education
- Tracking and complying with congressional mandates

VERA is an important component of VHA healthcare to ensure that veterans across the country have equal access to VA healthcare and that tax dollars are spent wisely. In combination with improvements in the network organizational structure, eligibility reform, authorization to retain third party collections, and other changes underway in the veterans healthcare system, VERA will help ensure the long-term financial viability of the VA and will allow it to serve as a model of integrated healthcare delivery.

1997 Accomplishments:

VA implemented the VERA system in second half of FY 1997. Full implementation of the 1997 model would have resulted in VISN resource shifts ranging from a loss of 15 percent to a gain of 16 percent, as compared to the FY 1996 budget allocations. Because such funding shifts cannot realistically occur in a single fiscal year, the methodology will be implemented over a three- to four-year period. During this period, most networks will see an overall budget increase under VERA. In FY 1997, 55 percent of the networks saw funding increases that were greater than that total rate of increase. No network was reduced below 1.26 percent of their FY 1996 funding level and 16 networks received more funding than in 1996.

Also in 1997, VHA issued a formal policy directive to the networks establishing network resource allocation principles that will move the organization toward accomplishing its systemwide goals and objectives. The five factors that significantly affect local healthcare environments are:

- Size, mission and location of facilities
- Levels of affiliations with academic institutions
- Efficiency of operations
- Proportions of “shared patients”
- Patient complexity and case mix

Plans for 1998-2003:

Based on VERA, 13 networks received FY 1998 increases over FY 1997 funding and nine received less funding. The largest network reduction was 4.21 percent, while the largest network increase was 5.16 percent. Comparing FY 1998 funding with FY 1996, the last full year before VERA was implemented, six networks increased ten percent or more with the greatest increase at 12.3 percent. The table below, “FY 1996 – FY 1998 Resource Allocations by Network,” shows the impact of VERA on network allocations. Funding decreases were limited to 5 percent for each year when compared to FY 1996.

Table 7-3

FY 1996 - FY 1998 RESOURCE ALLOCATIONS BY NETWORK (\$ IN MILLIONS)						
VISN	FY 1996	FY 1997	FY 1998	% CHANGE		
				FY 1996 - 1997	FY 1997 - 1998	Total
1 BOSTON	\$854	\$845	\$809	-1.0%	-4.2%	-5.2%
2 ALBANY	\$437	\$434	\$416	-0.7%	-4.1%	-4.8%
3 BRONX	\$1,022	\$1,017	\$974	-0.5%	-4.2%	-4.7%
4 PITTSBURGH	\$775	\$779	\$779	0.5%	0.0%	0.5%
5 BALTIMORE	\$424	\$442	\$460	4.2%	4.1%	8.5%
6 DURHAM	\$682	\$707	\$704	3.7%	-0.4%	3.3%
7 ATLANTA	\$778	\$815	\$856	4.7%	5.1%	10.0%
8 BAY PINES	\$960	\$1,018	\$1,071	6.1%	5.2%	11.6%
9 NASHVILLE	\$688	\$700	\$704	1.7%	0.6%	2.3%
10 CINCINNATI	\$511	\$530	\$535	3.8%	0.9%	4.8%
11 ANN ARBOR	\$655	\$657	\$632	0.4%	-3.8%	-3.5%
12 CHICAGO	\$834	\$828	\$795	-0.8%	-4.0%	-4.7%
13 MINNEAPOLIS	\$417	\$426	\$415	2.0%	-2.6%	-0.6%
14 OMAHA	\$291	\$288	\$277	-1.1%	-3.8%	-4.8%
15 KANSAS CITY	\$585	\$616	\$616	5.3%	0.1%	5.4%
16 JACKSON	\$1,074	\$1,135	\$1,194	5.7%	5.1%	11.1%
17 DALLAS	\$587	\$623	\$652	6.2%	4.7%	11.2%
18 PHOENIX	\$485	\$518	\$545	6.8%	5.1%	12.3%
19 DENVER	\$367	\$385	\$394	4.8%	2.4%	7.3%
20 PORTLAND	\$584	\$622	\$652	6.4%	4.9%	11.7%
21 SAN FRANCISCO	\$688	\$720	\$733	4.7%	1.7%	6.5%
22 LONG BEACH	\$900	\$918	\$943	2.0%	2.7%	4.8%
VHA	\$14,598	\$15,022	\$15,157	2.9%	0.9%	3.8%

NOTE: THIS REFLECTS THE IMPACT OF VERA WITH CAPS, IN RELATION TO FY1996. THE TOTALS INCLUDE EQUIPMENT AND NON-RECURRING MAINTENANCE AFTER THE CAPPING. THE NUMBERS MAY NOT ADD DUE TO ROUNDING.

Additional Resources:

Congress included provisions in the FY 1998 budget that allow VA to retain medical care collections rather than return them to the U. S. Treasury, as previously required. A total of \$688 million in collections was projected to be available for FY 1998. When the estimated FY 1998 medical collections and \$104 million in other reimbursements, including sharing and TriCare, are added to the VERA allocations, the largest increase in total funding for any network is 10.38 percent. See the table below, “FY 1998 VERA Allocations and Estimated Receipts.”

Table 7-4

FY 1998 VERA ALLOCATIONS AND ESTIMATED RECEIPTS (\$ IN MILLIONS)								
	NETWORK	FY 1997 VERA	FY 1997 VERA AND RECEIPTS	FY 1998 VERA	MCCF	REIMBURSE- MENTS	TOTAL	PERCENT CHANGE FY 1997 TO FY 1998
1	BOSTON	\$845	\$848	\$809	\$39	\$9	\$858	1.21
2	ALBANY	\$434	\$435	\$416	\$24	\$3	\$443	1.89
3	BRONX	\$1,017	\$1,019	\$974	\$43	\$3	\$1,020	0.10
4	PITTSBURGH	\$779	\$781	\$779	\$37	\$7	\$822	5.30
5	BALTIMORE	\$442	\$444	\$460	\$22	\$2	\$484	8.99
6	DURHAM	\$707	\$713	\$704	\$45	\$5	\$753	5.73
7	ATLANTA	\$815	\$816	\$856	\$43	\$0	\$900	10.23
8	BAY PINES	\$1,018	\$1,021	\$1,071	\$42	\$7	\$1,119	9.66
9	NASHVILLE	\$700	\$703	\$704	\$34	\$8	\$746	6.07
10	CINCINNATI	\$530	\$533	\$535	\$25	\$2	\$562	5.63
11	ANN ARBOR	\$657	\$659	\$632	\$33	\$4	\$669	1.49
12	CHICAGO	\$828	\$832	\$795	\$41	\$5	\$841	1.05
13	MINNEAPOLIS	\$426	\$428	\$415	\$22	\$3	\$440	2.85
14	OMAHA	\$288	\$290	\$277	\$15	\$2	\$294	1.52
15	KANSAS CITY	\$616	\$618	\$616	\$28	\$3	\$647	4.77
16	JACKSON	\$1,135	\$1,139	\$1,194	\$59	\$5	\$1,257	10.38
17	DALLAS	\$623	\$630	\$652	\$31	\$7	\$690	9.62
18	PHOENIX	\$518	\$528	\$545	\$25	\$11	\$581	9.95
19	DENVER	\$385	\$386	\$394	\$18	\$1	\$413	6.98
20	PORTLAND	\$622	\$626	\$652	\$26	\$6	\$684	9.26
21	SAN FRANCISCO	\$720	\$724	\$733	\$16	\$3	\$752	3.77
22	LONG BEACH	\$918	\$921	\$943	\$20	\$10	\$974	5.73
	VHA TOTALS	\$15,022	\$15,092	\$15,157	\$688	\$104	\$15,949	5.68

NOTE: THESE MCCF TOTALS INCLUDE FY 1997 4TH QUARTER COLLECTIONS. THE NUMBERS MAY NOT ADD DUE TO ROUNDING.

Further refinements of the VERA methodology are being made in 1998 for application to the FY 1999 allocations based upon a review of the following issues:

- Developing a transfer pricing strategy for care provided in more than one network to be tested in FY 1999
- Incorporating changes in research and education support, equipment and NRM components of the model
- Developing improvements to the labor adjustment
- Establishing a one-time visit price component
- Eligibility reform enrollment

Price Waterhouse, LLP, evaluated VERA in 1998 and concluded that VERA is ahead of most global budgeting systems, that its conceptual and methodological frameworks are sound, and that it is largely meeting its objectives. Price Waterhouse did recommend some technical and process changes to improve VERA. Some of those recommendations have been incorporated into VERA and others are being evaluated for possible incorporation in the FY 2000 allocation process.

BEST
PRACTICES
OR
INNOVATIONS



Private Sector Rates Used to Analyze Fund Allocations

The Atlanta Network has developed a unique approach to allocating funding based on private sector rates. We emphasize assigning revenue generation and expenditures that correlate to the locations of the service or product delivery. We extracted Cost Distribution Report (CDR) data for our Network and assigned specific locations to each CDR account as well as group cost centers within the CDR to overall “family components.” These family core components are dynamic and can be easily adapted to represent service lines or other groups. This system of allocating revenues and expenditures will allow the viewer to look at costs from delivery of care locations.

The revenue simulation was generated by using basic Health Care Financing Administration rates for the associated discharge Diagnostic Related Groups per patient for the inpatient portion. A capitated price was used for outpatient episodes. Once this data was compiled in a database, we then developed a forecasting application to develop scenarios using Dr. Kizer’s goals of 30-20-10 by the year 2002. Our funding model allows users to more adequately address the issue of national rates for prorated persons being implemented at the local facility.

This allocation system can be modified based on the uniqueness of the hospitals in your network. Adjustments to the model can now be made for long term care and affiliated hospitals that have historically been inadequately funded. By applying benchmarking rates external to VHA, comparisons can be made for the costs of delivery of similar services across the Network. Service Line Budgets can be generated by aggregation of location specific budgets. Facility Budgets can be generated by aggregation of specific location budgets. This model is fluid and can be modified quite rapidly.

Network Funding Methodology: Using Standardized Reimbursement Rates for Facility Specific Funding

*By James F. Trusley III and Brian P. Comstock,
Network 7, Atlanta, GA
“Journey of Change” Leadership Conference,
Baltimore, MD. December 1997*

Implementing The New Procurement Policies:

A number of initiatives are being developed to streamline the procurement process and organization in VHA to effect cost savings. Two initiatives in particular that are assisting VHA in streamlining the procurement process and saving dollars that can be redirected to direct patient care activities are: (1) The International Merchant Purchase Authorization Card (IMPAC) program and (2) the standardization of medical products. These programs, which are discussed below, are key elements in the VA Strategic Plan, Fiscal Years 1998-2003, toward meeting the general goal of enhancing the departmental procurement system.

1997 Accomplishments:

The International Merchant Purchase Authorization Card (IMPAC) program was fully implemented in 1997 and changed the way that VHA manages procurements and payments for micro-purchases. Rebates for prompt payment are also available and VA earns a significant rebate. The rebates are distributed to the various VA facilities based on their proportionate sales volume. The IMPAC cards are issued throughout the organization so that each office or service manages its own budget and small purchases. These purchases are limited to \$2,500. In 1997, more than 90 percent of VHA's micro-purchases were made using these cards.

A policy of standardization of medical products allows VHA to use single award contracts and its concentrated buying power to secure high quality products at the best possible prices. About 36 contracts were awarded that cover over 500 medical and surgical products. The value of these contracts is nearly \$21 million. The projected annual cost avoidance as a result of these contracts is estimated at \$5.3 million.

The VISNs are studying, and where cost effective, are consolidating administrative functions associated with procurement. Acquisitions is one organizational area where the VISNs have effectively streamlined operations and effected operational savings. Networks that included these accomplishments in their network plans are noted below:

- Centralized equipment purchases greater than \$50,000 for service lines (Network 5)
- Implemented a virtual A&MM section for central contracting for leases, nursing homes, halfway houses, preventive maintenance services and supply contracts greater than \$25,000 (Network 5)
- Established a Network Acquisition Center (Network 7)
- Consolidated home oxygen and durable medical equipment of four medical sites into one unique standardized contract (Network 12)
- Consolidated contracting and purchasing under the new Acquisition Center (Network 12)
- Consolidated/centralized functions at VAMROC Fargo, VAMC Minneapolis and VAMROC Sioux Falls (Network 13)
- Consolidated purchase and contracting functions in Administrative Service Center (Network 14)
- Completed 22 consolidated contracts and eight special pricing agreements within the network (Network 20)
- Consolidated purchase of four pharmacy automated prescription-dispensing machines with a cost savings of \$355,000 (Network 22)
- Developed VISN standards for "Charting Locations" and negotiated best prices for leading technology under Procurement of Computer Hardware and Software (PCHS) contract (Network 22)

Plans for 1998-2003:

- Implementing network-wide consolidated procurement and contracting to maximize procurement savings while maintaining quality patient care (Networks 4, 5, 7)
- Using CARF standards in the blind rehabilitation program plans to allow the possibility of contract services and sharing agreements with those institutions that are CARF certified (Network 7)
- Consolidating purchase of utilities (gas and electricity) VISN-wide (Network 8)
- Developing partnerships with other VISNs to consolidate common contracts (Network 8)
- Developing state- or VISN-wide contracts for home health services (Networks 8, 10)
- Evaluating network-wide contract with a maintenance management organization for the maintenance of all Network medical, ADP, building services equipment, and office equipment (Network 9)
- Consolidating contract-marketing efforts on a statewide basis for therapeutic work program (Network 10)
- Evaluating and using, as appropriate, consolidated fee basis contract for women's healthcare, psychiatry, readjustment, specialty clinics, visiting nurses, home health services, and compensation and pension exams (Network 12)
- Developing, through the Consolidated Contracting and Procurement Work Group, performance standards measuring the effectiveness of each contracting activity (Network 18)

- Implementing consolidated contracting to achieve discounts through bulk purchasing and competitive bidding: 1998 Contract Transcription, Hazardous Waste Disposal, Customer Service Training, Air Ambulance, 1999 Home IV Therapy, Home Oxygen, Durable Medical Equipment (Network 20)
- Increasing standardization of supplies, services and equipment to reduce duplication of inventories and provide one level of care throughout the network (Network 20)

Designing a New Capital Investment Policy:

Capital investments including both construction of real property and procurement of information technology systems are subject to the Capital Programming Guide of the Office of Management and Budget. The Guide requires that capital investments be directly tied to program plans and that each capital project be evaluated to determine how much it would contribute to achieving predetermined strategic program goals. A Capital Asset Plan to include both construction and information technology investments is required on an annual basis. In order to meet the general goal to establish a VA capital policy which ensures that capital investments reflect the most efficient and effective use of resources to meet the Department's mission, the key performance goal in the VA Strategic Plan incorporates this approach.

1997 Accomplishments:

VA established the Capital Investment Board (VACIB) to oversee the Department's capital planning process. In addition, VA contracted for a study of best practices in capital acquisition. This study was completed and was used to establish a priority scoring system applicable to capital investment projects throughout the Department.

- Completed the first VA Capital Asset Plan with VHA including all investment proposals approved by the VACIB
- Applied the new VA priority scoring system to all major construction and information management capital investment projects proposed for the FY 1999 budget
- Awarded 22 design or major construction project contracts, totaling \$187.3 million by the Office of Facilities Management in Headquarters
- Physically completed 18 major construction projects, which were managed by the Office of Facilities Management, totaling \$414.8 million
- Published capital planning guidance for use by the VISNs in formulating their own capital asset plans
- Implemented centralized construction planning/implementation for service lines (Network 5)
- Established a network Infrastructure Management Service Line to plan and implement capital initiatives based on network goals and actions (Network 7)
- Established a network NRM/Equipment Board to prioritize equipment and projects based on healthcare value in the five domains of access, technical quality, patient satisfaction, functional status and cost effectiveness (Network 14)

Plans for 1998-2003:

The VACIB will continue to manage the Department's capital investment programs in compliance with the OMB requirements and will ensure that proposed investments support the program goals in the strategic plan. In addition, ongoing capital investments will also be reviewed according to the post-implementation guidelines issued by OMB.

Chapter 7: Resource Management

The FY 1998 Appropriation, Public Law 105-65, provided funding in the amount of \$93,500,000 for five capital construction projects and authorization to use \$70.8 million in previous appropriations funds. The VACIB also identified the 18 construction projects of highest priority during the 1998-2003 planning period. The estimated costs for these projects, totaling \$453.6 million, range from a low of \$10 million to a high of \$50 million.

Network plans include:

- Establishing a Capital Asset & Investment Board for the network (Network 6)
- Investing in increased capital maintenance to enhance capital assets and improve quality of care (Network 21)

CONCLUSION

This chapter has presented VHA accomplishments and immediate plans in the areas of resource management. The focus in these areas has been to meld activities of VHA with the strategic goals and objectives of VA, especially in the areas of reducing costs and enhancing revenues, making VA the national model for integrated healthcare delivery, assuring the most efficient and effective use of resources to meet VA objectives and to provide service as “One VA.”

The efforts in resource management will include increasing emphasis on outpatient care, using financial management indicators to monitor cost and evaluate cost reductions, maximizing the capture and use of outside revenue sources, and fully implementing VERA to assure equitable allocation of available resources. The overarching goal of VHA in these areas is to assure the absolute best use of all available resources and new technologies for the greatest number of eligible veterans possible.

CHAPTER 8: INFORMATION MANAGEMENT

At the heart of the “One VA” concept is the requirement for continuous, reliable, flexible communication among all VA programs, including the Veterans Health Administration, the Veterans Benefits Administration and the National Cemetery System. Seamlessly integrated care, information transmission and management systems are necessary to ensure instant access to relevant data at any time. The VA Strategic Plan states that seamless service “means that veterans who approach the Department are provided the information requested without multiple referrals and handoffs no matter which VA office or facility is initially contacted.” To achieve that goal, VA has established four objectives for information technology management:

- Strengthen ties between Information Technology (IT) planning and Department strategic planning, capital investment planning, budget formulation and execution to ensure that IT investments further the Department’s goals;
- Provide leadership in the use of IT to improve customer service;
- Provide cost effective telecommunications, computing capacity and services to meet VA’s current and future needs; and,
- Ensure VA mission critical information systems will provide uninterrupted service supporting benefits delivery and medical care for the year 2000 and beyond.

VA is establishing a Department information content management function and organizational infrastructure, the Corporate Information Repository (CIR). The CIR is expected to be available on the Department Intranet by 1998. This section reviews VHA’s progress in and next steps for supporting the information management goals and objectives of the VA.

VA IT objectives are also in line with the information requirements at the heart of current healthcare delivery information requirements. Many of the central tenets of “One VA” are also essential elements of modern healthcare delivery with its emphasis on integration of care and access to services.



Along with the rest of the healthcare industry, VHA is relying more heavily on information technology to improve patient care quality, efficiency and cost effective delivery of services. Reliable and timely information is a critical resource for all daily clinical and administrative decisions.

VHA information technology planning is based on meeting the VA objectives and in maintaining a leadership position in healthcare information management nationwide.

This section discusses VHA’s current involvement in:

1. Improving its technology infrastructure, i.e. the Telecommunications Infrastructure Project (TIP), MS Exchange implementation, and the Internet/Intranet functionality project
2. Developing its interface with VBA to provide “One VA” service where patient information is necessary, i.e. the automated medical information exchange project
3. Expanding support for clinical operations, i.e. the clinical information resources network, the computerized patient record system, the government computer-based record, and the imaging project; and
4. Expanding support for administrative decision-making, i.e. the Decision Support System (DSS), the enrollment system, and the non-VA care project.



IMPROVING VHA'S TECHNOLOGY INFRASTRUCTURE

VHA is enhancing the telecommunications infrastructure for the VISNs, healthcare facilities, and headquarters in order to improve the electronic means by which VHA employees communicate with each other. The telecommunications infrastructure addresses sending and receiving of voice, data, video and images at acceptable speeds over local and wide area networks, and to provide the communications foundation to promote effective management within the VISN structure. The infrastructure includes fiber optic backbones, local area network hubs/switches, and multimedia mail servers and software for all VA medical facilities, as well as upgrades of the IDCU wide area network nationwide that are necessary to link all VHA facilities together. The infrastructure serves as the foundation for VHA's enterprise information systems interconnectivity, and is a vital element in providing the faster and more reliable communications necessary in today's healthcare business environment.

Telecommunications Infrastructure Project (TIP):

This project is designed to provide an enhanced telecommunications structure that provides primary support for all areas of VHA. These include primary care, CD-ROM applications, the computerized patient record system, *VISTA* imaging, the Decision Support System, drug utilization, electronic document imaging, desktop video-conferencing, telemedicine, MS Exchange, office automation, and access to the Internet and the World Wide Web. The goal of TIP is to make more complete, timely, and accurate clinical and management information available to VHA healthcare providers and managers.

1997 Accomplishments:

- Phase I, upgrading the Frame Relay Wide Area network national backbone, was completed in May 1997.
- Phase II, implementing MS Exchange hardware/software for e-mail among all facilities, was completed in November 1997.
- Phase III, consisting of surveys of the telecommunications infrastructure at 266 VHA facilities to document as-is conditions, proposed recommendations and estimated costs were completed in November 1997. Those reports are being used as a basis (along with business and mission objectives) for each VISN to plan improvements that meet the minimum TIP objectives.

Networks have also been aggressive in implementing improved technology infrastructure. Those networks reporting actions completed in their network plans are noted below. Some of these activities may be included in the Phase I, II or III work noted above.

- Implemented an Information Technology Service Line (Network 7)
- Developed a telecommunication linkage between the eight major care sites (Network 12)
- Installed and refined technology that allows for network-wide scheduling, sharing of patient data, expanded telemedicine, and video training capabilities (Network 15)
- Installed technology to support a network level nurse call system (Network 15)
- Invested \$30 million in information technology to improve clinical and administrative data driven decision making (Network 16)

- Developed software program to effectively monitor waiting times and give feedback to all facilities (Network 16)
- Developed an integrated IRM plan that promotes a coordinated approach to information systems development (Network 17)
- Completed bulk purchases of 267 PC clinical workstations and four pharmacy automated prescription-dispensing machines, saving \$200,000 and \$355,000, respectively (Network 22)
- Developed Informatics Plan and invested \$11 million in plan actions (Network 22)
- Designed new telecommunications networks at all facilities, using state-of-the-art fiber optic vertical backbone and Category 5 cable to all workstation locations (Network 22)
- Procured electronics to support high-speed networking throughout the network (Network 22)
- Upgraded telecommunication hubs to Asynchronous Transfer Mode (ATM) standard for 155 megabits per second backbone networking (Network 22)
- Upgraded **VISTA** hardware at all network sites to support clinical computing (Network 22)

Plans for 1998-2003:

- Phase IV, the facility improvement phase of TIP has been decentralized to the 22 VISN CIOs. VISN implementation plans have been submitted to headquarters and implementation efforts are in progress with a targeted completion date of September 1998.

Specific infrastructure actions in network plans are:

- Investing in information systems infrastructure in support of mission-critical initiatives, e.g. PAY VA, enrollment systems, DSS, telemedicine, etc. (Networks 2, 3, 4, 5, 6, 8, 9, 11)
- Fully integrating VISN databases assisted by the National Database Integration Team (Network 5)
- Implementing an Informatics Service Line (Network 7)
- Coordinating network information technology and information systems through a network Chief Information Officer (Network 13)
- Completing the installation of standard hardware and software for the local area network and wide area network (Network 15)
- Developing coordinated plan to accomplish information infrastructure improvements (Network 16)
- Establishing automated processes to capture and monitor provider profiles (Network 17)
- Ensuring a quality user support system by recruiting staff for critical positions and standardizing software and specified hardware capabilities/configurations at all facilities (Network 18)
- Installing horizontal and vertical cabling; installing necessary networking and peripheral components; developing a network-based plan to implement TIP at each network facility (Network 18)
- Establishing network-wide area network for teleconferencing (Network 19)
- Developing an integrated information system and processes for management of patient flow among Oregon Alliance facilities (Network 20)
- Developing PC-based video teleconferencing throughout the network (Network 21)
- Activating Hub electronics purchased in 1997 (Network 22)
- Investing in new workstations to activate clinicians charting locations and for administrative activities (Network 22)

Implementing Microsoft Exchange:

Microsoft Exchange is a system that allows all VHA facilities, VISNs and headquarters offices to be connected via e-mail. With roots in the original Microsoft Mail project for the VISNs, this project was later expanded under the Telecommunication Infrastructure Project to cover all Medical Centers and related facilities. This project was the first of its kind to focus directly on the implementation of “One VA” to tie all of VA together with one mail system (VBA, VHA, NCS) electronically in that it not only required close coordination and cooperation from VHA facilities but also was completed in coordination with similar projects that were being completed in VBA and Headquarters. Since it originally was started, many other VA groups such as the NCS have joined the network allowing integrated communications among VA administrations and staff offices, thus supporting the concept of “One VA.”

1997 Accomplishments:

The project actually extends far beyond Exchange, since the infrastructure that was needed had to be installed first. This infrastructure now allows VHA and VA to expand its use of distributed client/server technology that is now available.

- In March 1997, VA’s first National Naming Convention was accepted by the VA CIO Council and approved by the Deputy Assistant Secretary. This document was essential in establishing the basic framework that VA would work within to ensure that each node on the network is named uniquely and that the national NT network is stable and reliable.
- By mid-April 1997, the 22+N National NT Domain structure was completed forming the foundation of VHA’s distributed Client/Server technology. All future implementations, including electronic e-mail, distributed clinical applications such as CPRS, GroupWare applications, remote training, and other applications that are still in the planning stage will build on this foundation.
- At the end of April 1997, the VISN offices were brought on-line using Exchange and the New NT Domain architecture. This dramatically improved the way that management and staff in the VISN communicated with top management staff in Headquarters.
- When implementation at the VISN offices was completed, implementation at the VAMC level was started. The implementation team ramped up to implementing Exchange at 12 sites per week and completed all fieldwork by mid-September 1997 as planned.
- Medical centers were not brought online until the week of December 5th in order to allow for correction of a software problem in Exchange. When the medical centers came on line, VHA had installed and had 203 active Exchange sites with about 10,000 active users. Again, this dramatically changed the way that VHA’s top management communicates within all levels of VHA and even the VA.

At the network level:

- Implemented MS Exchange across the network within the national system (Network 7)
- All networks connected with MS Exchange software (Network 13)
- Activated MS Exchange at six of seven network facilities (Network 18)
- Installed MS Exchange servers and activated “VHA22,” the emerging personal network inter-linking all network computing resources (Network 22)

Plans for 1998-2003:

The next phase of the Microsoft Exchange project will encompass not only upgrading all VHA components to Exchange V5.5 but also will include the implementation of the System Management Server (SMS) and Microsoft Clustering Software along with the procurement of additional hardware to support SMS. The upgrade to Exchange V5.5 will provide a more stable environment for the user community and will take advantage of web-based software. Implementation of SMS will allow VHA to distribute and install software on the user's desktop rapidly without user intervention. SMS will also provide local support staff with many support tools to allow them to provide better customer service. Another advantage of SMS will be the central depository that it provides to help VHA maintain an accurate inventory of all PC/server hardware and software that is installed. Microsoft's clustering software will be added to provide a higher level of redundancy and is expected to reduce any Exchange downtime to near zero. Listed below are the milestone actions for this project, subject to the availability of funding.

- Completing the SMS architecture as well as the implementation and training plans.
- Installing the equipment in the CIO Field Offices to test the implementation plans, changes will be made at that time with all installs completed 6 weeks later.
- Validating and refining the training curriculum through the CIO Field Offices.
- Training field staff within 5 months of development of final training curriculum.
- Timely completing national implementation. (National implementation will begin and is slated to be completed within 6 months.)

Internet/Intranet Functionality Project:

VHA is enhancing the way it communicates to veterans, employees, and other stakeholders in an effort to provide the most up to date information in the most user-friendly manner possible. VHA maintains both an Internet presence, targeted to external customers, and an Intranet, for employees. The VHA Internet presence enables the increasing numbers of veterans who use the web to interact with the VHA more easily and support the organizational goal of "One VA." The Intranet supports organizational communication and information exchange among managers and healthcare providers at geographically diverse facilities. VHA efforts are consistent with the VA objective of establishing and maintaining the CIR, which includes substantial and broad programmatic involvement in both the Internet and the Intranet. Effective use of the Internet and Intranet will assist ensuring that corporate data and information are maintained timely, accurately, and used consistently throughout VA, and are readily available within the Department and to external stakeholders, and the general public.



1997 Accomplishments:

- Clinician Credentialing is being set up on a VHA server
- An on-line Directives Management System has been established
- Phase I of on-line VA Forms is now available
- VISNs are able to edit the on-line VHA Facilities and Management Directory instantly, enabling them to keep information updated as it changes. This internal directory will be moved to the Internet for use by our external customers later in the year
- An advisory group of concerned VA and veteran constituents is being established to plan the redesign of the VHA Internet presence to be more veteran-centered and attuned to external user's needs
- Secure Socket Layer (SSL) protocol has been added to VA web servers, enabling our customers to send information to the VA web servers in a way that will protect their privacy and prevent hackers from capturing that information.
- New Program Office home pages established include Policy and Planning, Telemedicine, the Virtual Learning Center, and Research and Development; a GRECC page is in development
- The VAHQ phone directory is on-line and updated weekly
- A virtual conference archive of audio, video, and presentation materials from select VHA conferences is available continuously

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- With the input of management, technical, and content advisory groups, the VHA Intranet redesign project was started with the goal of making the Intranet more user friendly, providing employees with the information to do their jobs more effectively.

The networks are actively utilizing the Internet/Intranet technology for a variety of internal and external purposes.

- Created an Internet/Intranet web site that allows access to key information about the network including access points with maps and directions, veteran and employee services, and other helpful information (Networks 2, 8, 11)
- Implemented customer feedback and involvement mechanisms for improved communication via the Internet, “The Voice” newsletter and brochure “Journey to the Future” (Network 16)
- Developed Intranet plan (Network 22)

Plans for 1998-2003:

VHA will continue working with more internal and external constituents to improve its use of Internet and Intranet capabilities in furtherance of the agency’s communications goals. These plans include:

- Redesigning the VHA Internet presence to a more veteran–focused communications vehicle will continue, including projects such as a new approach for addressing “Frequently Asked Questions.” The web page will be reorganized and will be made more user friendly
- Implementing the redesigned VHA Intranet for VISN and VAMC directors’ offices by December 1998, and for VISN and VAMC staff by the end of FY 99
- Enhancing veteran and employee interaction with the web by the implementation of Public Key Infrastructure (PKI) certificates, which will allow individuals to have their unique identity validated, enabling them to communicate securely with the agency. PKI will apply to several current initiatives, including VA-DoD sharing and access from the Internet across the VA firewall, and will aid in the sharing of vital information.

Networks will continue to develop their Internet/Intranet capabilities; for example:

- Establishing a VISN Internet web page to provide information on VA services to patients (Network 19)
- Developing VISN Intranet (Network 22)

DEVELOPING AN INTERFACE WITH VBA

Automated Medical Information Exchange (AMIE) Phase II:

The AMIE system was developed in the mid-1980’s when the majority of VHA medical records were stored in paper form. Since its introduction, VHA has rapidly increased electronic storage of medical information. Now, the information linkage between VBA and VHA must shift away from electronic requests for paper documents, to mutual accessibility of electronic records.

AMIE II is an initiative aimed at resolving problems under the current AMIE system that have restricted user access, degraded performance, and prevented VHA staff from direct queries of VBA records. It will capitalize upon VHA systems record system enhancements to create an availability of VA clinical information that is crucial to resolving many veterans’ pending benefits claims. It will also upgrade and share communications linkages, and will ultimately lead to a revision to the development and processing of claims that rely on VA treatment records.

Implementation of AMIE II will be a significant step toward the “One VA,” objective to increase the ability to transfer records electronically moving toward a “paperless” process. Efforts in this area also extend to external sharing with other Federal departments and agencies as well as local and state governments and support the overall goal to provide prompt delivery of services and benefits.

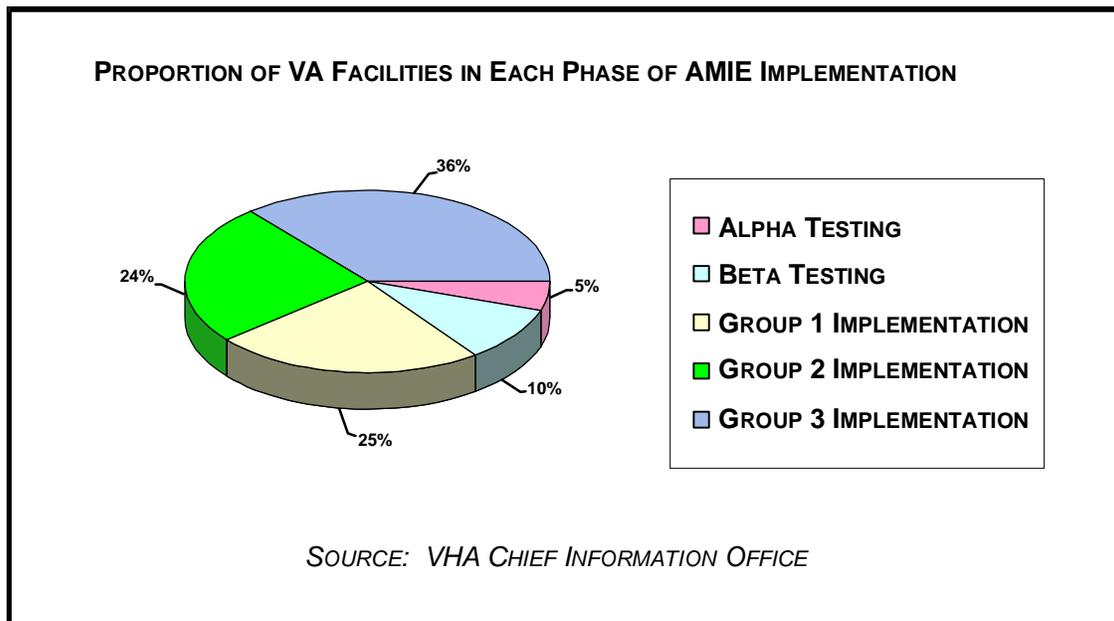
1997 Accomplishments:

- Pilot tested electronic record sharing with the Social Security Administration (Network 14)

Plans for 1998-2003:

- Implementing the memorandum of the Under Secretary for Health and Under Secretary for Benefits concerning the enhancement to information exchange between VHA and VBA. Chart 8-1 displays information on the implementation phases for the AMIE project (Alpha testing completion date – 9/97, Beta testing – 5/98, Group 1 – 7/98, Group 2 – 8/98, and Group 3 – 10/98)

Chart 8-1



EXPANDING SUPPORT FOR CLINICAL OPERATIONS

This section discusses several projects underway to enhance the management of patient care. The Clinical Information Resources Network is the system (analogous to a mail system) that is the conduit of data to and from the Computerized Patient Record System. The Government Computer Based Record is in a very early stage of development. It will set government-wide standards for patient records.

The Clinical Information Resources Network (CIRN):

The restructuring of VHA into Veteran Integrated Service Networks (VISNs) has resulted in a need for the integration and coordination of clinical data on a VISN-wide basis. The response to this need is the Clinical Information Resources Network (CIRN) software. The CIRN software supports primary care by providing clinicians with an integrated view of a patient’s care across sites within the VISN. It ensures that a patient’s identified "primary" source of care receives all data on that patient’s care at all points within the VISN. Because of its systemwide usage within VHA, the CIRN will also support the controlled exchange of data between VISNs. Full implementation will also allow creation of a comprehensive database reflecting patient care delivered throughout the VISN.

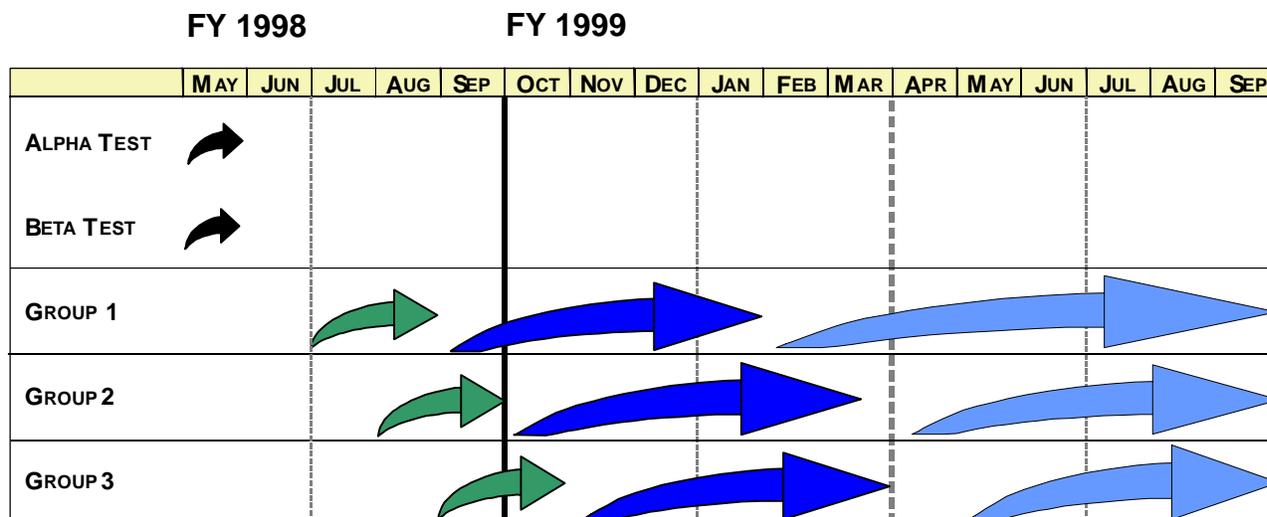
Once fully implemented, the CIRN software is a system to transmit, update and maintain both clinical information and a limited set of patient demographic data between all sites within the VISN. The clinical repository will store clinical essentials of data important to patient care, facilitate clinical decision support, manage data independently of departmental application storage policies, support longitudinal record growth, and support evolution of data classes stored. Future enhancements will allow CIRN to accommodate data from external sources.

CIRN directly supports the VA Strategic Plan strategy to stress primary care nationally and provides the clinical component of information systems supporting managed care. This strategy is one of several identified to assist in meeting the objective to decrease the average cost per patient by 30 percent to achieve the general goal to reduce costs and improve the revenue stream for the healthcare system.

1997 Accomplishments:

Clinical Repository software and historical backloads of each data class were completed and tested. A plan for implementation of the CIRN was drafted. The national CIRN implementation project will evolve in three phases. Phase I will begin with development, testing, and evaluation of CIRN by Technical Services with test activities at VISN 8 and VISN 11. Phase II will begin with implementation of CIRN Master Patient Index/Patient Demographics (MPI/PD) in six VISNs and Phase III will culminate with the CIRN Clinical Repository (CR) being implemented nationwide within VHA.

**Table 8-1
CIRN PROJECT IMPLEMENTATION SCHEDULE**



Source: VHA Chief Information Office

Pre-Implementation Phase: All pre-implementation and patient merge tasks are completed in October 1998

CIRN MPI/PD: Released nationally by September 30, 1998; CIRN MPI/PD implemented nationally by March 31, 1999

CIRN CR: Implemented in every VAMC in each VISN by September 30, 1999

- ALPHA TESTING: VISN 8
- BETA TESTING: VISN 11
- GROUP I: VISNs 2, 7, 9, 15, 17, 19
- GROUP II: VISNs 3, 4, 5, 6, 12, 18, 20
- GROUP III: VISNs 1, 10, 13, 14, 16, 21, 22

Plans for 1998-2003:

- Completing, by 4th Quarter FY 1998, the Technical Services development team Phase I development and testing of CIRN. Both Customer Services and Implementation and Training Services will assist Technical Services with the implementation of CIRN at the two VISNs that are pilot testing CIRN
- Completing Phase II; VISNs will implement CIRN MPI/PD at each of their sites during FY 1999. Implementation and Training Services will provide installation, training, and implementation management support needed by sites to complete the nationwide implementation. CIRN MPI/PD will first be installed at VAMCs in Group 1
- Completing Phase III; VISNs will implement CIRN CR by the 4th quarter FY 1999
- Table 8-1 provides information on the schedule for completing implementation of CIRN

The Computerized Patient Record System (CPRS):

The computerized patient record system (CPRS) is an application that will organize and present all relevant data on a patient in a way that directly supports clinical decision making. It is designed to present a patient's conditions, past treatment, problems and diagnoses, diagnostic and therapeutic procedures and interventions together in one place. With this system, physicians, nurses, pharmacists, social workers, quality assurance managers, discharge planners and clinical managers will be able to see and have input into the care process. Using CPRS, clinicians can create, edit and view problems, progress notes and orders, as well as view results data simultaneously. Care providers can quickly flip through electronic 'pages' of the chart to add new orders, review or document problems, write progress notes or see results. Alerts, notifications, cautions, warnings, advanced directives, future appointments, demographic data, medications, and orders are all available. The order entry process has been enhanced in a variety of ways, including quick orders, order sets, and order checking. Physicians can sign orders and clinical documents electronically, virtually eliminating the need for the chart entry.



CPRS directly supports the VA Strategic Plan to implement a computerized patient medical record system. This strategy is one of several identified to support the objective to decrease the average cost per patient by 30 percent and meeting the general goal of reducing costs and improving the revenue stream for the system.

1997 Accomplishments:

- A pilot test at four medical centers has been completed
- Nationwide implementation, which will start with a key site in each VISN, was begun
- The Iron Mountain facility began implementation of the CPRS and its staff accessed current patient information through *VISTA* (Network 12)
- VISNs 7 and 21 already have their key sites operational

Plans for 1998-2003:

After an initial VISN facility is implemented, each VISN can then put its implementation plan into effect.

- Proceeding with the implementation of CPRS (Network 13)
- Pilot testing optical imaging of patient records at VAMC Omaha (Network 14)

The Government Computer-Based Patient Record (G-CPR):

The Department of Veterans Affairs, Department of Defense, the Indian Health Service, and Louisiana State University Medical Center have partnered to develop the G-CPR to provide and protect worldwide health-related information at a level unachievable with a paper record. The partnership's vision is to improve public and individual health status by sharing clinical information. The G-CPR will provide the partnership accurate and accessible health records for tracking patients and for data capture and information sharing. It will contain an individual's health-related information, including health service encounter, health status and clinical problems,

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thereby forming the information foundation for the longitudinal patient record. The G-CPR will provide a means to access and update patient information and will document the medical status of an individual, facilitate health surveillance, and create a basis for analysis of health-related threats and illnesses. The G-CPR will adhere to appropriate standards and guidelines governing privacy, data and messaging required for communication between Government and civilian healthcare providers.

Plans for 1998-2003:

- Presenting the G-CPR Conceptual Model to industry
- Developing, revising, and finalizing the G-CPR Statement of Objectives (SOO) based upon solicitation of industry comments and the nature of comments received
- Releasing the final SOO
- Awarding the contract

The Imaging Project:

The VA's *VISTA* Imaging System is an extension to the Decentralized Hospital Computer Program (DHCP/*VISTA*) that captures clinical images, scanned documents and other non-textual data files and makes them part of the patient's electronic medical record. Use of the system will enable the VA to eventually operate in a "filmless" mode with electronic access to all veteran patient "images" (i.e. radiology, cardiology, dermatology, pathology, surgery, etc.) for diagnostics and education from virtually any location. The *VISTA* Imaging System is a revolutionary technological innovation that will vastly improve the information available for clinical practice and will support the goal of delivering the highest quality healthcare available. As such, this system directly supports the mission goals of the "new VHA" as defined in the *Prescription for Change*.

The *VISTA* Imaging System project supports the VA Strategic Plan, which includes a goal to expand telemedicine activities to improve access to care, (e.g. telepathology, telenuclear medicine, teleradiology, telepsychology, teledermatology, teledentistry). This expansion of telemedicine is one of several methods identified to support the objective of increasing the number and types of access points in order to provide customer service that meets or exceeds customer expectations.

EXPANDING SUPPORT FOR ADMINISTRATIVE DECISION-MAKING

The Decision Support System (DSS):

The Decision Support System is an executive information system that allows for improved resource management and patient care by providing data on patterns of care, patient outcomes, resource consumption, and the costs associated with healthcare processes. The VA Strategic Plan directly calls for implementation of the Decision Support System, one of several identified actions to support improvement of departmental cost-accounting.

1997 Accomplishments:

- 95 sites completed implementation with the remaining 53 sites in various stages of implementation

Network efforts to implement DSS include:

- Completed full implementation of DSS by all medical centers in the network (Network 9)
- Merged VAMC specific DSS databases to create the first network-wide DSS database (Network 13)
- Completed implementation of DSS at each medical center and educated medical center staff on utilization and application of DSS (Network 13)

Plans for 1998-2003:

- Focusing on training end user senior management and headquarters staff to effectively use the system
- Completing technical implementation of the system in July 1998
- Transitioning from the Cost Distribution Report to DSS, Physician Profiling, and advanced Management Use and Clinical training.

Network plans include DSS implementation at medical centers or integration of databases across the network.

- Using DSS for a facility level FY 1998 budget patient service line scenario (Network 13)
- Completing implementation of DSS and capture 100% billable workload by FY 2000 (Network 13)
- Implementing DSS at all network sites (Network 14)
- Integrating the DSS at Topeka-Leavenworth (Network 15)
- Expanding DSS to perform service line analysis, clinical performance measure modeling, and clinical quality management at Central Texas System (Network 17)
- Completing implementation of DSS program in all medical centers by FY 1999 (Network 19)
- Developing DSS mapping changes with the aid of the new network-wide nurse scheduler package to enhance nurse staffing costing with the DSS software (Network 21)

The Enrollment System Project:

Information technology will also be crucial to implementation of the enrollment system required by the Veterans Healthcare Eligibility Reform Act of 1996. The VHA CIO's office has already completed a number of steps and has additional efforts planned for 1998 and beyond.

1997 Accomplishments:

- A "Strategic Information Systems Plan (SISP) to Support National Enrollment" was developed in the spring 1997. This plan was a product of work specified by the Eligibility Reform Steering Committee's Management Systems Work Group. The Enrollment SISP provides VHA the framework needed to support enrollment and also included an indepth analysis of VA's systems and business processes.
- The *VISTA* software was released in the fall of 1997 to support a one-year nationwide test. *VISTA* will provide VA facilities with functionality to capture enrollment information for patients and to produce local reports. Additional software was developed in 1997 which will enable sites to forward the enrollment related data to the Health Eligibility Center (HEC) in Atlanta as an initial extract which will help seed a national enrollment database. Nightly updates will occur as information is added or changed. Results from this one year test will provide VHA with a better knowledge of the number of veterans likely to enroll in the VA Healthcare System and will give us important experience in building and managing a national enrollment system.
- Two national meetings were conducted in November 1997, focusing on identifying high-level business process issues and on national reporting requirements to support Congressional, Headquarters, VISN, and local needs. The outcomes of these two meetings generated requirements that are being defined further and which will improve the process.

Plans for 1998-2003:

- Selecting the government service provider for the VA Enrollment Operational Data Store (ODS) which will collect, refine and store enrollment data in a centralized repository and serve as a source for downstream systems that utilize this information. Working jointly with the selected provider, VHA will conduct planning and undertake initial steps to design and build the ODS.
- Designing end-user data models and end-user access to national enrollment data.

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- Identifying and designing reports and data that need to be produced for national and congressional requirements by October 1, 1998.
- Implementing customer support processes and technology for the new national enrollment service center in support of legislative and service requirements.
- Completing system design and development of the ODS with full implementation by spring, 1999.
- Designing and implementing long-term National Enrollment end-user analytical tools coordinated with access tools to VHA's planned National Patient Administrative Database.

The Non-VA Patient Care Project:

Veterans meeting eligibility criteria can receive healthcare benefits from non-VA care providers if required services are unavailable, or cannot be economically provided in a VA facility. A Non-VA Care Task Force made up of VA Headquarters and field personnel was established to redefine and reengineer the existing non-VA care process in order to make improvements for the reporting and processing of workload, clinical, and cost information from non-VA provided healthcare programs. This Task Force will implement, monitor, and evaluate a pilot test of commercially available solutions to non-VA care administrative, clinical and outcomes-based issues in VISN 19, Rocky Mountain Healthcare Network, and analyze the information identified above and develop alternative approaches to implementing a new non-VA care information and processing environment.

1997 Accomplishments:

- Implementation of the VISN 19 pilot began in October 1997

Plans for 1998-2003:

- The analysis and alternative recommendation phase of the project is scheduled to provide findings to management during the fourth quarter of FY 1998. This package will outline the benefits of various alternative approaches to managing non-VA care
- It is expected that a new non-VA care system will be available for implementation in FY 1999

CONCLUSION

The continuing revolution in information technology provides enormous opportunities to improve the quality of patient care, to improve cost effectiveness and to enhance administrative decision making. VHA is and intends to remain at the very forefront of these developments providing a national benchmark for their incorporation into the healthcare industry.

This chapter has presented VHA accomplishments and immediate plans in information management. The focus in these areas has been to meld activities of VHA with the strategic goals and objectives of VA, especially in implementing "One VA," and in reducing costs and enhancing revenues, making VA the national model for integrated healthcare delivery, and assuring the most efficient and effective use of resources to meet VA objectives.

As mentioned above, VHA efforts in this area include: the Telecommunications Infrastructure Project; implementation and expansion of the Microsoft Exchange system; maximization of both Internet and Intranet modalities; the Decision Support System; and the Enrollment System project. In addition, the chapter has outlined efforts in the Clinical Information Resources Network, the Government Computer Based Record project and the Imaging and telemedicine projects all aimed at improving the quality, efficiency and completeness of patient care. The electronic patient chart of the near future will be an enhanced tool beyond the imagination of caregivers and physicians of days gone by. All of these efforts mesh directly and seamlessly with VA goals of quality care, cost effectiveness and "One VA."

For VHA, the goal is to embrace and use new technology to better serve this nation's veterans and to provide them with the very highest quality of services and healthcare.

CHAPTER 9: EMERGENCY PREPAREDNESS

One of the four missions of the Veterans Health Administration is to ensure healthcare for eligible veterans, military personnel, and the public during Department of Defense (DoD) contingencies and during natural, manmade, and/or technological emergencies. This chapter reviews 1997 accomplishments and presents future plans for VA's emergency preparedness program. All of these activities directly support the VA Strategic Plan objective to provide medical backup to DoD in the event of a national security emergency, to provide medical and other support during Federal disaster response, and to provide for contingencies within VA to ensure continued service delivery for eligible veterans.

The Office of Emergency Management Strategic Healthcare Group (EMSHG) and its national network of Area Emergency Managers coordinate the planning, exercise support, and activation of the VA-DoD Contingency Hospital System in times of war or other military need. VA also assists individual states and communities in times of emergency by providing direct medical care to victims of disasters; by augmenting staff of community hospitals, nursing homes and other facilities; by providing stress and other types of counseling to disaster victims and responders; and by furnishing critically needed supplies, equipment, facilities and other resources.

To be prepared for both military and non-military emergencies, an organization must develop, test, revise, and continually update plans for many different disaster scenarios. These plans must be realistic and this requires close coordination and training with people from other medical facilities, the emergency medical systems and related personnel, staff of other state/local government agencies, and many volunteers. Through this contact and cooperative effort, the emergency preparedness program greatly strengthens VHA's ties to the community.

VHA possesses extensive medical training and educational capabilities, including a dedicated Emergency Management Training and Development Section, a nationwide video-teleconference system, medical libraries in each hospital, and the ability to secure professional accreditation for medical disciplines (RNs, MDs, etc.) for training received. Emergency preparedness drills and related activities provide an opportunity to test the effectiveness of these training programs and capabilities, and to keep skills honed for times when the first words of an emergency announcement are "This is not a drill."

The entire nation benefits from this program by having a nationwide resource that is easily deployed and strategically placed throughout the country. VA, as a large integrated healthcare system with a presence in every state, is able to respond rapidly with personnel, supplies, equipment and other resources in times of emergency.

1997 Accomplishments:

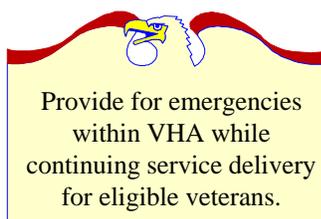
- Disaster Emergency Medical Personnel System (DEMPS) - established DEMPS database. Employees involved in disaster response are often working in a challenging and sometimes very austere environment. Not only must they possess the required medical capabilities, but they must be mentally prepared for a disaster situation. The DEMPS database was created to pre-identify and catalogue VHA healthcare personnel by name, job category, location, and other essential elements that enable the matching of the appropriate human resource to meet the critical medical requirement. It provides for the electronic collection of data on those employees who wish to volunteer, and have been approved by their respective medical facility director, for potential deployment to disasters and other emergencies that might occur within, or external to, VA. In addition to the personnel and demographic information, the system includes information on relevant specialized training or experience, physical limitations, allergies, and other factors that might affect the person's ability to function in certain environments. Pre-identification of those persons interested in, and qualified for, deployment targets them to receive advance information and training that will facilitate their readiness and performance as part of a response to any disaster or emergency

Chapter 9: Emergency Preparedness

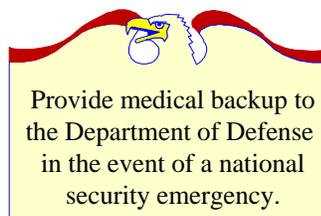
- North Dakota and Minnesota flood disaster - coordinated clinical and emergency management staff and medical equipment to provide medical care, pharmacy services and operational support including:
 - Fifty-nine emergency management, clinical, and support staff to the Grand Forks AFB, the Public Health Service (PHS) Disaster Field Office in Bismark Disaster Recovery Centers in Minnesota, and to other care/coordination sites
 - Diphtheria/tetanus serum to federal workers
 - Pharmaceutical and other supplies to flood victims
 - One mobile health clinic and three staff
- Presidential Inaugural - provided six emergency managers and other support staff to D.C. Fire Training Center, and coordinated pharmaceuticals and medical supplies acquisition, transportation, and placement in Washington D.C.
- G-8 Economic Summit - provided seven management and clinical staff to the Emergency Support Function Medical Support Unit in Denver, the PHS Disaster Regional Office in Denver, and the Denver VAMC; and coordinated the transportation and placement of pharmaceuticals and medical supplies
- Provided significant support to federal preparations for response to terrorist use of weapons of mass destruction, including coordinating procurement and placement of specialty pharmaceuticals at strategic locations to support the federal strike teams based at those locations
- Directed/participated in 70 emergency preparedness exercises involving approximately 31,000 participants
- Sponsored/co-sponsored training and education events for approximately 10,000 VA, DoD, PHS, community, and other personnel
- Each VAMC conducted one external (involving the community) and one internal disaster exercise in accordance with Joint Commission on Accreditation of Healthcare Organizations requirements
- Updated the national VA/DoD Contingency Hospital System Plan
- Established processes to implement, maintain and evaluate the Comprehensive Emergency Management program and worked with FEMA, DoD, USPHS and community agencies as appropriate in Network 19
- Established a Network Emergency Communications System and an Emergency Medical Preparedness Advisory Council in Network 21
- Established an Emergency Medical Response Team in Network 7

Plans for 1998:

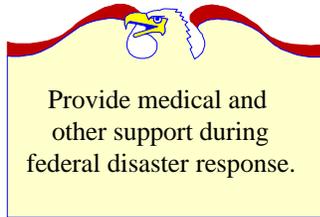
Preserving the capability to respond to any kind of incident, from a local event -- such as a small fire in a healthcare facility, to a major disaster -- such as the recent floods in the Midwest, requires vigilant preparedness coordination and training. The following goals were established to ensure that VHA dependably and efficiently meets its responsibilities to veterans and the public at large:



- Issue guidance and develop comprehensive disaster plans in all Networks
- Design and conduct risk-based response exercises with all Networks
- Conduct annual analyses of disaster exercises and revise Network plans



- Evaluate the VA/DoD Contingency Hospital System Bed Reporting Software
- Develop updated VA/DoD Contingency Hospital System plans within each Network
- Analyze contingency bed projections for VA and DoD planning



- Review and revise, as necessary, VA's roles in Federal Emergency Management Act coordinated disaster responses
- Maintain a roster of VHA employees with skills useful in disaster response to facilitate VA assistance for disaster victims
- Manage additional NDMS Federal Coordinating Centers as DoD downsizes its coverage in these areas

The Networks are planning to achieve these goals through a variety of activities, including:

- Establishing an Emergency Medical Response Team (Network 4)
- Deploying mobile clinics for assistance during disasters and supporting storage of emergency supplies (Network 6)
- Completing implementation of the Incident Command System network-wide and improving readiness through closer integration with local communities, especially in supporting development of Metropolitan Medical Strike Teams under Nunn-Lugar-Domenici legislation (Network 8)
- Recruiting volunteer disaster responders for support in emergencies (Network 10)
- Reviewing and revising the Emergency Medical Preparedness Plan and ensuring emergency preparedness readiness by conducting training sessions on comprehensive emergency management (mitigation, preparedness, response, and recovery) to include the incident command system (Network 12)
- Developing a Network Disaster Readiness Plan and coordinating emergency preparedness efforts with neighboring networks (Network 13)
- Planning and conducting a VA/DoD Contingency Exercise and a Network emergency response exercise, devising scenarios to test the Network's and VAMC's responses to emergency events. Evaluate exercises and revise plans accordingly (Network 16)
- Refining the Emergency Management Plan that delineates responsibilities of each participant, operations concepts, a notification system, reporting requirements, and education/training and exercises (Network 18)

BEST
PRACTICES
OR
INNOVATIONS



Workplace Safety Program

Unfortunately, the violence usually confined to the streets has moved into the once safe and secure sanctuary of the workplace. This newest epidemic plaguing the workplace is a tremendously complex issue that involves many variables. Preventing violence in and around the healthcare facility of today requires a proactive effort based on Safety and Emergency Preparedness. It is essential that a multi-disciplinary approach to problem solving be the order of business in addressing, preventing and preparing for violence in the workplace. As with any safety program, the risk is never eliminated, but with the training offered by the “Is Anyplace Safe?” program, the risk will be better managed and the organization will be able to respond appropriately in the event of an incident and to implement the recovery phase in a timely manner.

The cornerstone of a comprehensive violence prevention program is “Universal Zero Tolerance.” Simply stated, anyone at anytime can become violent given the right stresses and circumstances. Therefore, a strong program that supports and emphasizes a violence free environment based on “Universal Zero Tolerance” is essential to the health and well being of all staff, patient, clients, visitors and vendors.

Program Goals:

- Increase Awareness
- Provide building blocks/Tools for Program Development and Enhancement
- Incorporating Safety and Security into a Customer Service Program
- Stimulate Thinking/Action

The program trains employees on:

- Problem Awareness
- Crisis Response
- JCAHO/OSHA Regulations
- Warning Signs vs. Profiles
- Personal Safety
- Developing and Supporting a Risk Assessment Team

Workplace Violence Prevention – Safety and Emergency Preparedness Training Program, “Is Anyplace Safe?”

by Paul D. Kim, VA Albany, NY
“Journey of Change” Leadership Conference,
Baltimore, MD. December 1997.

CONCLUSION

Natural and manmade disasters are commonplace occurrences in today’s world and every year produces emergency events that call for coordinated response and relief efforts. VHA’s emergency preparedness capabilities are a fundamental component of local, state, and national resources established to timely provide coherent effective disaster response. During 1997, we responded in emergency situations ranging from the potential -- military emergency preparation for terrorist activity, to the actual -- civil disaster relief for flood victims. We also tested our ability to react quickly and properly to unexpected problems in our own facilities.

In 1998, VHA will not only continue to maintain its own capabilities, we will work with other public and private sector organizations in preparing and testing emergency response plans that are realistic, up to date, appropriate, and executable. Although it is not possible to prevent most disasters, we will continue to work to limit their impact by assuring that the right people, supplies and equipment will be in the right place at the right time.

CHAPTER 10: LEADERSHIP IN THE DELIVERY OF HEALTHCARE VALUE

The veterans healthcare system is unique in this country and in the world. It is not only the largest, fully integrated healthcare system in the U.S. but is also the most complex healthcare system in the world because of its multiple missions.

*Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health
Testimony before the U. S. House of
Representatives, Committee on Veterans
Affairs' Subcommittee on Health
June 17, 1998*



The Introduction and Chapter 1 of *Journey II* described the “new VHA” that is evolving in response to the rapid transformation taking place in U. S. healthcare today. Central to this continuing evolution is the intention to provide benchmark healthcare value by providing easy access, high technical quality, superior service satisfaction, and optimal patient functionality, all at a reasonable cost. This first part of *Journey II* also described the framework, guiding principles, and goals supporting VHA’s strategy to emerge as a leader in defining, measuring, and delivering healthcare value. The subsequent chapters then summarized the current progress of VHA programs in meeting those goals and profiled expected accomplishments for 1998 and beyond.

This final chapter focuses on where VHA sees its strategies and efforts headed in the future. It reviews the current role of VHA as a major element of the nation’s healthcare system. From the foundation of its current accomplishments, VHA’s potential and its projected directions are highlighted. The areas where VHA strengths, competencies, and recent achievements will provide potential leadership roles are noted - especially in the areas of delivering quality healthcare, being a healthcare employer of choice, conducting research and education, and in

implementing information technology. Specific elements of VHA strategic direction and performance goals for this upcoming five-year period are also presented.

VHA - A MAJOR CONTRIBUTOR TO THE NATION'S HEALTHCARE SYSTEM

In his testimony on June 17, 1998, before the House Committee on Veterans Affairs' Subcommittee on Health, the Under Secretary for Health outlined the impact of the VHA missions on the nation's healthcare. Dr. Kizer began with VHA's first and foremost mission: to provide medical care to veterans. Approximately 37 percent of the U. S. veteran population have service-connected disabilities and/or are poor. This represents approximately 9.4 million people.

The magnitude of VHA's contribution to national healthcare is increased when the impact of VHA's education and training missions is also considered. VHA is the largest single provider of health professions training in the world. In addition to providing training to half of all U. S. medical students and a third of postgraduate physicians (residents), VHA also affords education and training for more than 54,000 allied health practitioners including nurses, pharmacists, podiatrists, optometrists and about 40 other healthcare professions every year. While this academic medicine capability clearly benefits veterans, it also provides a foundation of excellence in medical training for the entire nation.

A similar contribution results from VHA's research program that benefits veterans. VHA is unquestionably one of the largest and most productive research organizations in the country. VHA research appears regularly in the nation's top medical journals. VHA's contribution to new medical knowledge is continual and substantive. Again, while directly benefiting the veteran population, the VHA research program also makes an enormous contribution to medicine and healthcare nationwide.

VHA's mission to provide contingency support to the Department of Defense (DoD) and the Public Health Service during times of disaster or national emergency has a national benefit. In fact, as DoD downsizes and the Public Health Service and Indian Health Service hospitals are eliminated, VHA is becoming the federal government's principal asset for responding with medical assistance for large-scale natural or technological disasters.

Finally, VHA's unwritten fifth mission – to provide medical services and other support for homeless veterans – provides a nationwide benefit. Today, VHA is the largest direct care provider for homeless persons in the country – a critically important, albeit largely unrecognized, element in the nation's public safety net.

Thus, VHA serves as a major national resource in many ways, first and foremost being the healthcare of the nation's veterans. The breadth of experience and the richness of expertise that these five missions provide have been enhanced and strengthened by the reorganization and reengineering that has accompanied the emergence of the "new VHA." VHA is now competing effectively in the managed care marketplace; and, as is evident from the preceding chapters, VHA is attaining or surpassing industry standards.

Additional achievements are provided in detail in the preceding chapters. In particular, VHA has made singular advances in quality management as part of the development of the "new VHA." With regard to private sector standards for quality of care measurement, VHA performance is superior across the board. VHA is setting the national benchmark by mandating the use of standardized instruments for alcohol abuse screening and assessment of the functional status of those with addictive disorders. VHA is also providing national leadership in defining and measuring care at the end of life. A comparison of VHA's mental health services with data from the Marketscan® Data Base indicates that VHA performance is comparable to or superior to the private sector on most measures of coverage, service delivery, efficiency and service satisfaction.

VHA will continue with its efforts to provide healthcare value. Three general directions for evolving in the future include getting better at what we currently do by:

- Managing care to improve quality and service;
- Ensuring consistency and predictability of care; and,
- Improving technology and information management.

U. S. healthcare will continue to undergo rapid and tumultuous change. During this change, VHA's future will be enhanced by forging relationships with others, by providing the broad array of services/resources that contribute critical infrastructure elements to the national healthcare system, and by assuming leadership positions in those areas of special expertise as the millennium approaches.

VHA AND THE WORLD OF TOMORROW

VHA today faces the issues and trends of the changing healthcare marketplace of tomorrow with a number of distinct advantages. VHA has:

- A strong, decentralized national network of healthcare providers;
- A full continuum of care;
- Clinical services grounded in clinical care guidelines;
- A 10 dimension quality management accountability program;
- A strong and well-qualified staff; and,
- A wealth of experience in education, research, chronic care and geriatric care.

These advantages position VHA well to participate fully in the national healthcare agenda as the millennium approaches.

VHA has identified the following eight key strategic objectives for meeting the challenges of the future.

- Demonstrate value
- Enhance and standardize quality
- Improve service satisfaction
- Improve access
- Improve information management
- Allocate resources equitably
- Increase collaborations
- Reduce operating costs

To achieve these objectives, VHA healthcare delivery will focus on continuing the consolidation of the gains from our recent reorganization and decentralization. As the mainstay of its forward-looking strategy, VHA will focus on five areas where it may assume a leadership role over the next several years:

- Technical quality
- Being an employer of choice
- Research
- Education
- Information technology

Technical Quality:

Increasing numbers of providers and patients have become associated with health maintenance organizations, group practices, and other modalities of managed care. Although cost management is part of care management, it is not an end in itself. Perhaps one of the greatest criticisms of managed care has been that it has focused too much on managing cost, without actually improving care. To be successfully managed, care must become more coordinated, more convenient, and more coherent.

To provide quality managed care, providers must use the most effective and appropriate prevention, diagnosis, treatment, and follow-up techniques for promoting health, in a well coordinated and user friendly environment. VHA has historically served and will continue serving as a laboratory to identify the most effective and appropriate techniques as well as the management processes most conducive to their effective delivery. VHA's Strategic Framework for Quality Management (Chapter 2) focuses on generating new knowledge that facilitates improved health outcomes.

VHA has already been paralleling the shift in private sector healthcare from an intensive focus on managing costs to an expanded focus on managing care through improving quality, customer service and integration of services. As the nation's largest fully integrated healthcare system, VHA has extensive experience in managing a large, decentralized system; in designing and implementing a full range of quality management programs, customer service programs, and information systems; and in treating an older (and sicker) population. Playing to these strengths, VHA expects to take a leadership position in setting the national standards in how to define, measure, and deliver healthcare value.

Congress and consumers are demanding more information on healthcare; information that is relevant, standardized, and easy to comprehend; and information essential to assessing healthcare value. Maintaining such comparative information is a critical component of VHA's Strategic Framework for Quality Management, as evidenced by the following strategies:

- Employing clinical care strategies that increase the likelihood of achieving desired health outcomes;
- Measuring and monitoring progress in achieving desired health outcomes;
- Engaging all levels of the organization in routine and event-triggered cycles of improvement;
- Implementing an impartial and independent review process; and,
- Optimizing patient and family involvement in the design and delivery of healthcare services.

VHA will also continue to emphasize its core business of providing for the special care needs of veterans, especially by providing services that are not readily found in the private sector. That is the fundamental reason for the system's existence. However, future expectations require VHA to deliver predictable healthcare value to an increasing number of veterans while reducing costs, demanding a concerted and coordinated effort on the part of all involved. During the coming five years, VHA plans to consolidate the gains from reorganization and decentralization.

VHA will use management-by-objective, total quality management, and implementation of the Government Performance and Results Act and Reinventing Government recommendations to accomplish these objectives - all part of a systematic and continuous quality improvement program. VHA will apply existing national standards and develop new ones, sharing progress widely with the private sector to facilitate rapid dissemination of pertinent timely consumer-oriented healthcare information. The VHA quality management program will strive to become the national standard for healthcare quality.

Leadership: It is VHA's goal to set the national standard for healthcare quality management.

Employer of Choice:

As our population continues to age, with the fastest growing segment being over age 85, the future will bring a demand for more care in general, and especially for the management of chronic conditions. This demand, coupled with new technical capabilities and advances in provider knowledge, create an environment in which accelerated change is the norm. This tumultuous, changing environment will require rapid adaptation by every person - clinicians, managers, support staff, et al., - involved directly or indirectly with maintaining and improving healthcare value.

In dealing with this rapidly changing environment, VHA's most important asset is its workforce. Beginning with its national program, "Putting Veterans First," VHA has built a workforce that is well regarded by customers and ranks highly when compared with national standards. Customer satisfaction is climbing and VHA is meeting national benchmarks for service.

Specific programs are already in place to harvest the collective insight, creativity and energy of the VHA workforce and use it to optimally achieve VHA objectives. Additionally, VHA will implement programs to prepare the current workforce to both deliver high quality healthcare and actively participate in improving care. Building on the VHA Values of Trust, Respect, Excellence, Compassion, and Commitment, VHA will continue to strive to be an employer of choice.

Leadership: It is VHA's goal to have a compassionate and high quality workforce that is nationally regarded as being in the vanguard of innovation, teamwork, quality and service.

Research:

VHA research includes basic medical research, clinical cooperative studies, a full spectrum of health services delivery research programs, and a long history of research in rehabilitation medicine. The size and scope of the VA healthcare system will continue to provide a rich national resource for clinical trials, basic medical research and health services delivery research. This resource will provide the full gamut of clinical facilities and programs. In addition, VHA will strive to develop collaborative ties with industry to expand the research base and to focus VHA research on the diseases of its patient population.

Leadership: It is VHA's goal to generate new knowledge at the forefront of national healthcare and that facilitates improved clinical outcomes.

Education:

VHA has a long and distinguished record of health professional education. Through its education programs, publications, the World Wide Web, and other means of information dissemination, VHA will continue to promote medical education, as well as the understanding and implementation of its formal and operational research findings.

In response to the shift to managed care and the need to contain costs through providing care in the most appropriate setting at a reasonable cost (e.g., decreasing inpatient utilization), VHA is shifting its major role in the education of health professionals, particularly the medical education of physicians, to primary care in an ambulatory setting. Concomitantly, VHA has decreased the number of specialty resident positions and increased positions for training primary care physicians. Training healthcare practitioners in rehabilitation medicine remains a VHA objective. VHA health education programs will build upon its experience base to be in the vanguard of integrating medical education and managed care.

Leadership: It is VHA's goal to build health education programs reflecting its experience base and to be in the vanguard of integrating medical education and service delivery in organized or managed care settings.

Information Technology:

Information technology is critical to both the application of existing knowledge and the development of new knowledge. Every aspect of delivery of care, whether it is at the narrowest level (the individual patient) or the broadest level (the population), can be captured, monitored, evaluated, etc., through a variety of electronic means. VHA will move forward in determining what is the most useful information to maintain and in developing cost-effective, user-friendly systems to do it.

VA databases have historically been at the forefront of the information technology field and have been used as examples when describing innovative development efforts. At the heart of "One VA" is the necessity for VHA, the Veterans Benefits Administration, and the National Cemetery System to share records and communicate seamlessly to provide the best possible services to veterans. VHA will continue to develop systems to facilitate network communication and sharing of data.

As the VHA healthcare system completes its decentralization process, the requirement for flexible and state-of-the-art information systems is growing. Eventually, VHA will be able to transmit patient information and clinical data across networks and among all the system facilities. This capability will also be an invaluable asset in collaborating with community health resources. To the veteran and to our employees who provide that veteran services, our efforts in information technology will continually move toward a seamless flow of information within the concept of "One VA."

Leadership: It is VHA's goal to be a national leader in providing exceptional information technology and services to support delivery of the best healthcare to veterans.

CONCLUSION

What we imagined a few years ago is reality today.

*Thomas L. Garthwaite, M. D.
Deputy Under Secretary for Health
VHA Strategic Management Planning
Conference, April 1998*

VHA will continue to be an integral and vital part of the national healthcare delivery system. The opportunities and challenges envisioned for the next five years have been anticipated and the reorganization, decentralization, and reengineering that VHA has accomplished over the past two years have provided a strong foundation for responding to future opportunities. VHA is ready, willing and able to meet the needs of veterans today and the challenges of tomorrow.

GLOSSARY OF ACRONYMS

A&MM:	Acquisition and Materiel Management
ACCESS:	Access and Continuity in Education of Specialists
ACG:	Ambulatory Care Group
ACPS-DP:	Federal Advisory Committee on Prosthetics & Special Disabilities Programs
ADP:	Automated Data Processing
ADG:	Ambulatory Diagnostic Group
AFMA:	Automated Fabrication of Mobility Aids
AIDS:	Acquired Immune Deficiency Syndrome
ALOS:	Average Length of Stay
AMIE:	Automated Medical Information Exchange
AMIS:	Automated Medical Information System
ASA:	American Society of Anesthesiologists
ASI:	Addiction Severity Index
ATM:	Asynchronous Transfer Mode
AY:	Academic Year
BDOC:	Bed Days of Care
C&P:	Compensation & Pension
CAIRO:	Computerized Information Repository
CARF:	Commission on Accreditation of Rehabilitation Facilities
CBOC:	Community Based Outpatient Clinic
CCSCMI:	Committee on Care of Severely Chronically Mentally Ill Veterans
CDR:	Cost Distribution Report
CDROM:	Compact Disk Read Only Memory
CHALENG:	Community Homelessness Assessment Local Education & Networking Groups
CHAMPUS:	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA:	Civilian Health and Medical Program of the VA
CIO:	Chief Information Officer
CIR:	Corporate Information Repository
CIRN:	Clinical Information Resource Network
CMR:	Consolidated Memorandum Receipt
CMI:	Chronically Mentally Ill
CMOP:	Consolidated Mail-Out Pharmacy
COIN:	Computer Output Identification Number
COPD:	Chronic Obstructive Pulmonary Disease
COPS:	Community Outreach Preventative Services
CPG:	Clinical Practice Guideline
CPRS:	Computerized Patient Record System
CQI:	Continuous Quality Improvement
CRC:	Confirmed Colorectal Cancer
CSS:	Customer Service Satisfaction

GLOSSARY OF ACRONYMS

CT (CAT):	Computerized (Axial) Tomography
DHCP:	Decentralized Hospital Computer Program
DOD:	Department of Defense
DRG:	Diagnosis Related Groups
DSM:	Diagnostic and Statistical Manual of Mental Disorders
DSS:	Decision Support System
DVHIP:	DOD and Veterans Head Injury Program
EES:	Employee Education System
ELC:	Executive Leadership Council
ENT:	Ears, Nose and Throat
EPRP:	External Peer Review Group
ESPC:	Energy Savings Performance Contract
Ex-POW:	Ex-Prisoner of War
FEMA:	Federal Emergency Management Administration
FIM:	Functional Independence Measures
FMS:	Financial Management System
FTE:	Full Time Employee
FTEE:	Full Time Employee Equivalent
FY:	Fiscal Year
GAF:	Global Assessment of Functioning
GAO:	General Accounting Office
G-CPR:	Government Computer-based Patient Record
GI:	Gastrointestinal
GME:	Graduate Medical Education
GPRA:	Government Performance and Results Act
GRECC:	Geriatric Research, Education and Clinical Center
GUI:	Graphical User Interface
GYN:	Gynecology
HBPC:	Home Based Primary Care
HCFA:	Health Care Financing Administration
HCS:	Health Care System
HEC:	Health Eligibility Center
HMO:	Health Maintenance Organization
HSR&D:	Health Systems Research & Development
HUD-VASH:	Housing and Urban Development-VA Stable Housing
IDCU:	Information Data Communications Utility
IPCC:	Intensive Psychiatric Community Care
IMPAC:	International Merchant Purchase Authorization Card
IOM:	Institute of Medicine
IRM:	Information Resources Management

GLOSSARY OF ACRONYMS

IT:	Information Technology
IVM:	Income Verification Match
JCAHO:	Joint Commission on Accreditation of Healthcare Organizations
KLF:	Kathy Lee Frisbee Menu
LAN:	Local Area Network
LOS:	Length of Stay
MAC:	Management Assistance Council
MCCF:	Medical Care Collections Fund
MCCR:	Medical Care Cost Recovery
MCCRF:	Medical Care Cost Recovery Fund
MD:	Medical Doctor
MIRECCS:	Mental Illness Research, Education and Clinical Centers
MRI:	Magnetic Resonance Imaging
NCFC:	National Customer Feedback Center
NCS:	National Cemetery Service
NDMS:	National Defense Monitoring System
NIH:	National Institutes of Health
NHCU:	Nursing Home Care Unit
NRM:	Non-Recurring Maintenance
NSC:	Non-service Connected
NT:	Network Termination
OCIO:	Office of the Chief Information Officer
ODS:	Operational Data Store
OEE:	Office of Employee Education
OEMP:	Office of Emergency Medical Preparedness
OMB:	Office of Management and Budget
OPC:	Outpatient Clinic
OSHA:	Occupational Safety and Health Administration
OWCP:	Office of Workers Compensation Program
PACT:	Preservation/Amputation Care and Treatment
PACS:	Picture Archiving and Communications System
PC:	Personal Computer
PCECT:	Primary Care Education and Consultation Team
PCHS:	Procurement of Computer Hardware and Software
PHS:	Public Health Service
PKI:	Public Key Infrastructure
POE:	Physician Order Entry
POW:	Prisoners of War
PTF:	Patient Treatment File
PI:	Prevention Index

GLOSSARY OF ACRONYMS

POW:	Prisoner of War
PsyPCE:	Psychiatry Primary Care Education
PTSD:	Post Traumatic Stress Disorder
PVA:	Paralyzed Veterans of America
QI/QA:	Quality Improvement/Quality Assurance
QM:	Quality Management
QMAP:	Quality Management Advisory Panel
QMIC:	Quality Management Integration Council
RAI/DMS:	Resident Assessment Instrument/Minimum Data Set
RN:	Registered Nurse
RRRC:	Residency Realignment Review Committee
SC:	Service Connected
SCI/D:	Spinal Cord Injury/Dysfunction
SCI & DSHG:	Spinal cord Injury & Disorder Strategic Healthcare Group
SDP:	Special Disability Program
SEAT:	Service Evaluation & Action Team
SEP:	Special Emphasis Program
SF-36:	Short Form with 36 questions yielding an 8-scale health profile
SISP:	Strategic Information Systems Plan
SMI:	Seriously Mentally Ill
SMS:	System Management Server
SSN:	Social Security Number
SOO:	Statement of Objectives
SOPC:	Satellite Outpatient Clinic
SSL:	Secure Socket Layer
TBI:	Traumatic Brain Injury
TIP:	Telecommunication Infrastructure Project
TQI:	Total Quality Improvement
UM:	Utilization Management
VACHCS:	VA Chicago Health Care System
VACIB:	VA Capital Investment Board
VACIP:	VA Capital Investment Panel
VAMC:	VA Medical Center
VAMROC:	VA Medical & Regional Office Center
VARO:	VA Regional Office
VARRAC:	VA Research Realignment Advisory Committee
VBA:	Veterans Benefits Administration
VCNV/ALB:	VA Conversion/Account Ledger Budget
VERA:	Veterans Equitable Resource Allocation

GLOSSARY OF ACRONYMS

VHA:	Veterans Health Administration
VISN:	Veterans Integrated Service Networks
VISTA:	Veterans Health Information Systems & Technology Architecture
VIST:	Visually Impaired Service Team
VSO:	Veterans Service Organization
WWI:	World War I

- EXCELLENCE IN HEALTHCARE VALUE
- EXCELLENCE IN SERVICE AS DEFINED BY CUSTOMERS
- EXCELLENCE IN EDUCATION AND RESEARCH

MISSION GOALS



- BE AN ORGANIZATION CHARACTERIZED BY EXCEPTIONAL ACCOUNTABILITY
- BE AN EMPLOYER OF CHOICE

- TECHNICAL QUALITY
- COST/PRICE
- SERVICE SATISFACTION
- ACCESS
- FUNCTIONAL STATUS

DOMAINS / THEMES



- CAPITALIZE ON NEEDS & OPPORTUNITIES IN VHA
- LINK EDUCATION & RESEARCH WITH PATIENT NEEDS
- INCREASE EXTERNAL AWARENESS & COLLABORATION
- LINK REWARD, RECOGNITION & PROMOTION TO PERFORMANCE MEASUREMENT
- CULTURE OF TEAM EFFORT & INDIVIDUAL ETHICS & ACCOUNTABILITY
- JOB SATISFACTION
- EQUAL OPPORTUNITY EMPLOYER
- SAFE WORK ENVIRONMENT
- PROMOTE LEARNING THROUGH QI

2002 STRATEGIC TARGETS

- DECREASE SYSTEM-WIDE COST/PATIENT BY 30%
- INCREASE HEALTHCARE USERS BY 20%
- INCREASE REVENUES FROM NON-APPROPRIATED SOURCES TO 10% OF TOTAL OPERATIONS
- EXCEED BY 10% PROPORTION OF PATIENTS OF OTHER PROVIDERS WHO ACHIEVE MAXIMAL FUNCTIONAL POTENTIAL
- 90% OF PATIENTS RATE VA AS VERY GOOD OR EXCELLENT

- 90% OF PATIENTS RATE VA BETTER THAN OTHERS
- 99% OF RESEARCH RELATES TO VA PATIENT CARE
- 95% OF TRAINEES RATE VA EXPERIENCE AS GOOD
- INCREASE EMPLOYEE EDUCATION FOR QI OR CUSTOMER SERVICE TO 40 HOURS/YEAR
- 100% OF EMPLOYEES CAN RELATE THEIR WORK TO THE "NEW VHA" MISSION



ANNUAL PERFORMANCE MEASURES

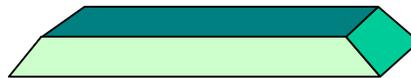
- BED DAYS OF CARE/1000 UNIQUE USERS
- TOTAL OPERATING BEDS
- AMBULATORY SURGERY
- CATEGORY A USERS
- TIMELINESS OF ACCESS
- PRIMARY CARE ENROLLMENT
- COMPENSATION AND PENSION REQUESTS
- CHRONIC DISEASE INDEX



- PREVENTION INDEX
- NETWORK-WIDE CLINICAL PRACTICE GUIDELINES
- END OF LIFE PLANNING
- CUSTOMER SERVICE STANDARDS
- SPINAL CORD INJURY PATIENT SATISFACTION
- ADDICTION SEVERITY INDEX
- TOTAL PEER-REVIEWED RESEARCH FUNDING
- UNDERSTAND MISSION AND ROLE IN MEETING MISSION

OPERATIONAL STRATEGIES

- RESOURCE MANAGEMENT
- MANAGED CARE
- SHIFT FROM INPATIENT TO OUTPATIENT CARE
- IMPROVE ACCESS



- IMPLEMENT ELIGIBILITY REFORM
- ENHANCE INFORMATION SYSTEMS
- LINK EDUCATION AND RESEARCH TO PATIENT CARE
- EMPOWER EMPLOYEES

VHA STRATEGIC MANAGEMENT FRAMEWORK

JOURNEY I

APPENDIX C

**1998 3RD QUARTER PROGRESS REPORT ON
SELECTED PERFORMANCE MEASURES**

Chart C-1

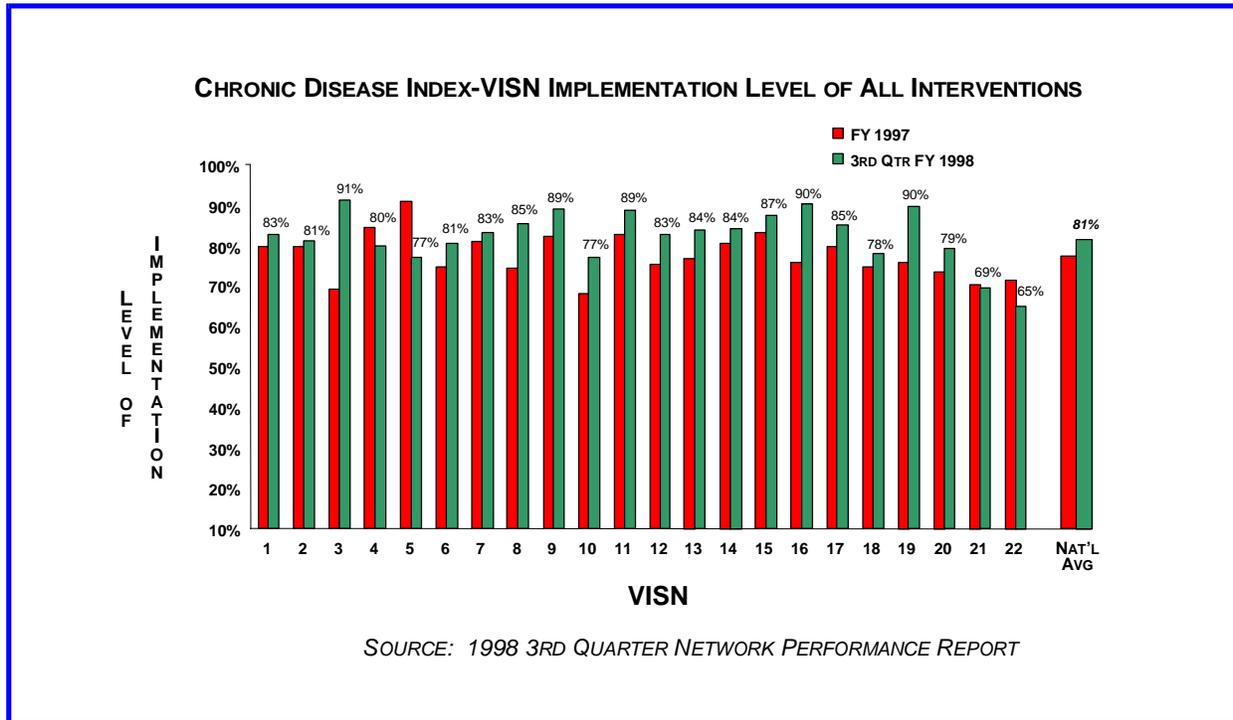


Chart C-2

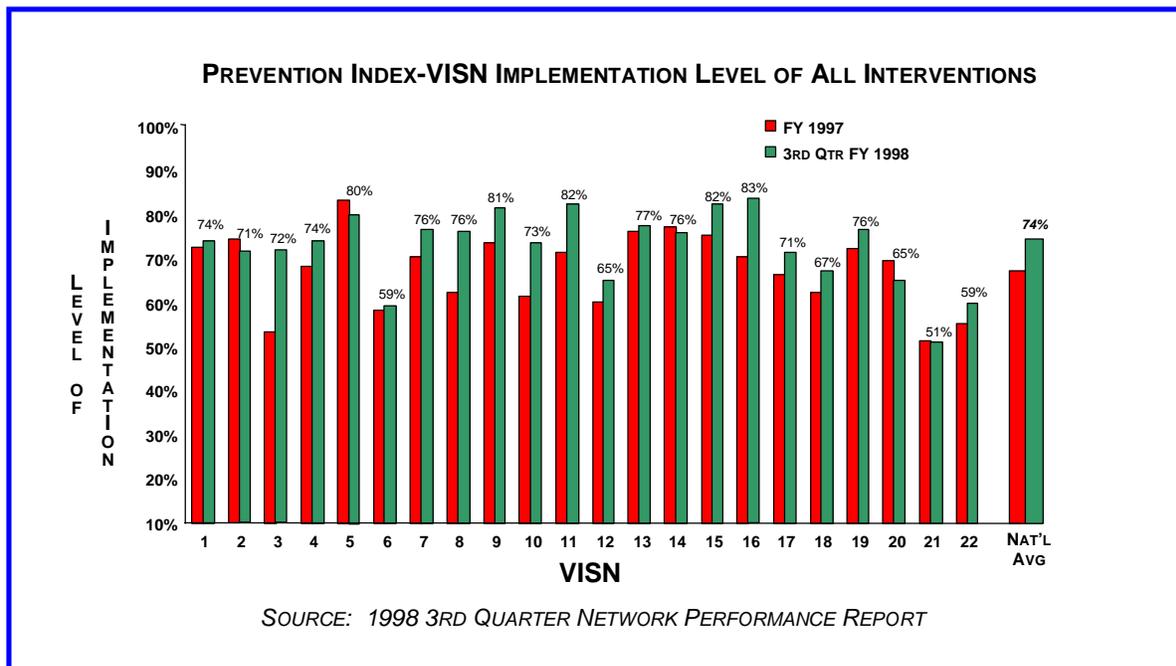


Chart C-3

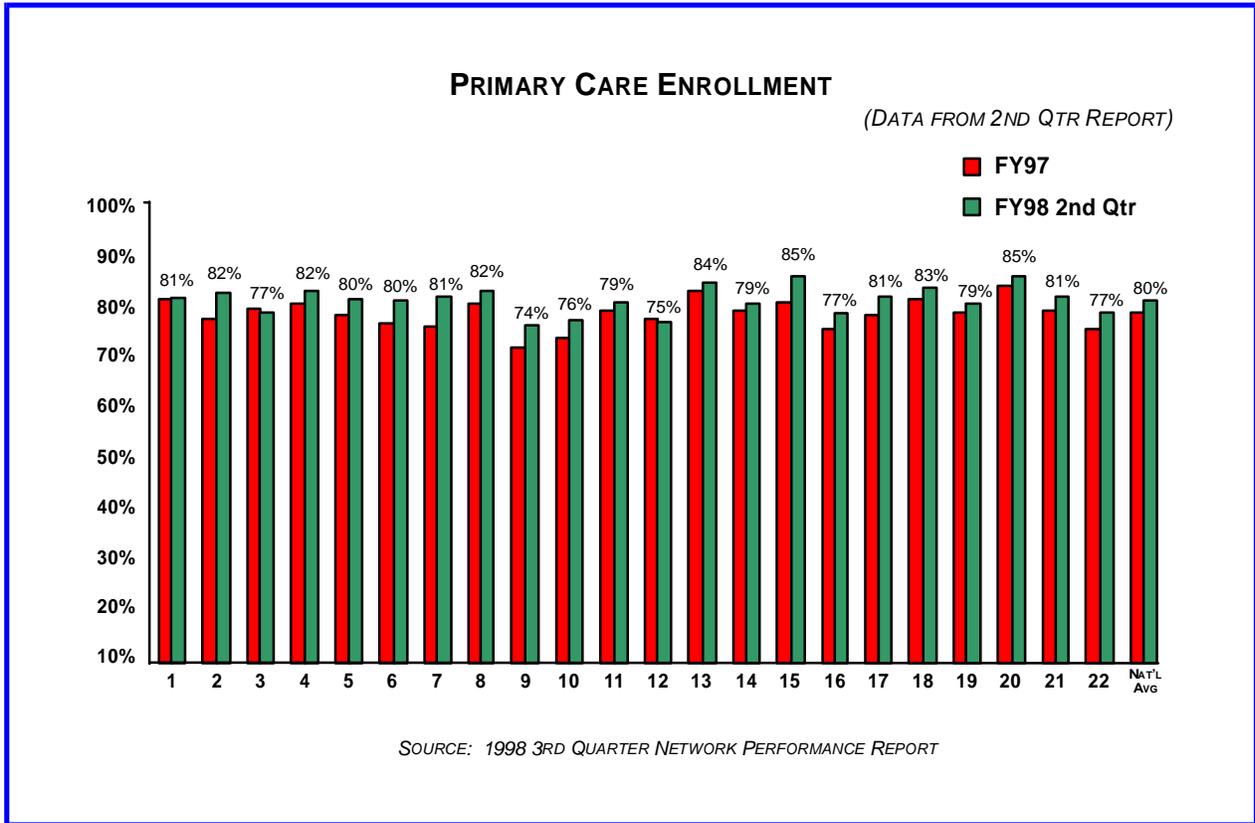


Chart C-4

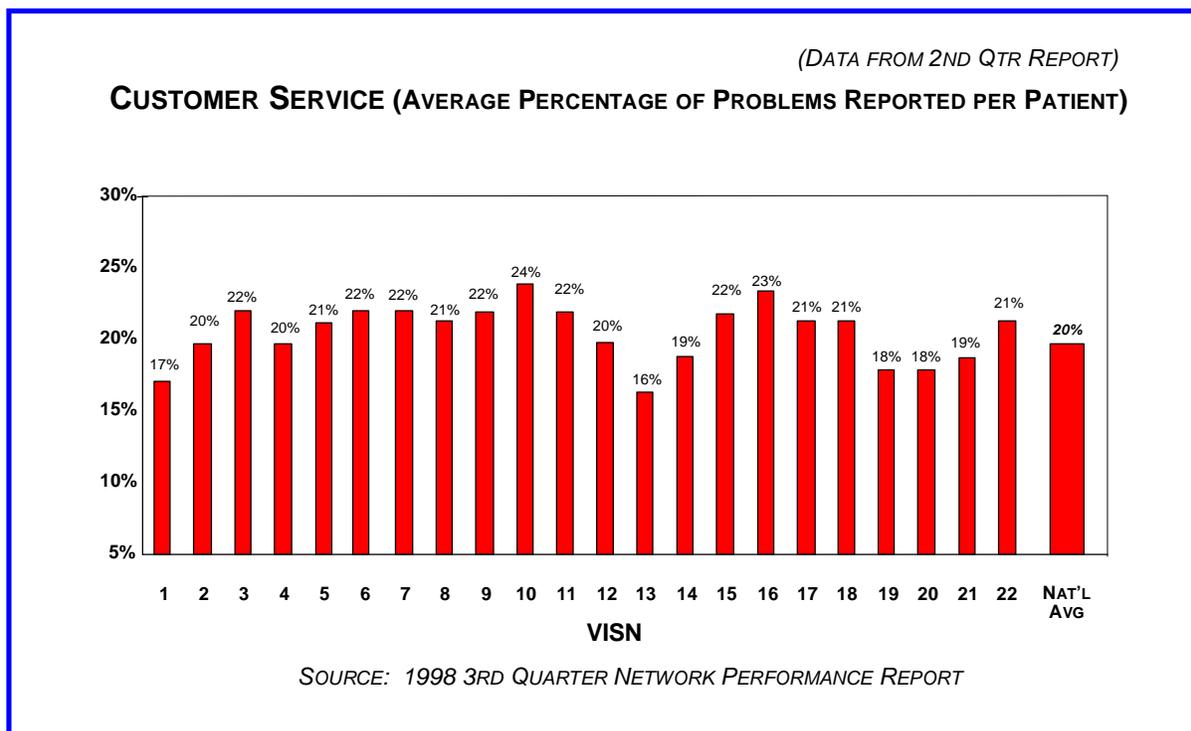


Table C-1

CUSTOMER SERVICE STANDARDS (CSS) SCORES

MID-YEAR 1998 VA CUSTOMER SURVEY RESULTS COMPARED WITH 1997 VA SURVEY		
CUSTOMER SERVICE STANDARD	1997 SURVEY	1998 Mid-Year Survey
ACCESS	.15	.14
EDUCATION	.33	.33
PREFERENCES	.25	.25
EMOTIONAL SUPPORT	.22	.22
COORDINATION (VISIT)	.19	.19
COURTESY	.09	.09
AVERAGE	.21	.20

SOURCE: 1998 3RD QUARTER NETWORK PERFORMANCE REPORT

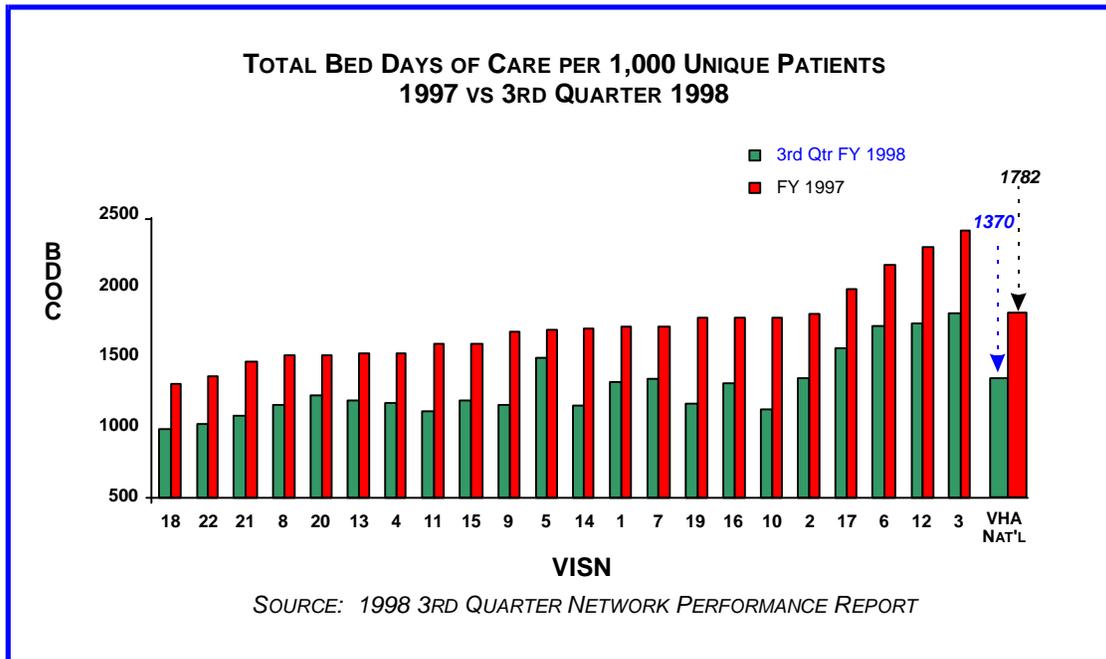
Table C-2

**TOTAL OPERATING BEDS
(INCLUDES HOSPITAL, DOMICILIARY AND NURSING HOME)**

VISN	1997 Actual Beds	3 rd Qtr 1998 Actual Beds	Actual Reductions from 1997 – Beds	Actual Reductions from 1997 - %
1	2,490	2,190	-300	(-12%)
2	1,961	1,829	-132	(-7%)
3	3,614	3,287	-327	(-9%)
4	3,904	3,178	-726	(-19%)
5	1,770	1,650	-120	(-7%)
6	3,028	2,674	-354	(-12%)
7	3,676	2,723	-953	(-26%)
8	3,297	2,832	-465	(-14%)
9	2,645	2,125	-520	(-20%)
10	2,019	1,885	-134	(-7%)
11	2,267	2,163	-104	(-5%)
12	3,066	2,858	-208	(-7%)
13	1,458	1,337	-121	(-8%)
14	962	922	-40	(-4%)
15	1,566	1,458	-108	(-7%)
16	3,194	2,786	-408	(-13%)
17	2,974	2,822	-152	(-5%)
18	1,419	1,312	-107	(-8%)
19	1,161	1,029	-132	(-11%)
20	2,228	2,202	-26	(-1%)
21	1,741	1,734	-7	(-1%)
22	2,266	1,987	-279	(-12%)
Nat'l	52,706	46,983	-5,723	(-11%)

SOURCE: 1998 3RD QUARTER NETWORK PERFORMANCE REPORT

Chart C-5



**VHA OFFICE OF POLICY AND PLANNING
INFORMATION**

***Journey of Change II* and other Policy and Planning
information is available on the Internet at:**

<http://www.va.gov/vhareorg/>

And on the VA Intranet at:

<http://vaww.va.gov/stratinit/index.htm>

For additional information

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