United States General Accounting Office

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Report to the Ranking Democratic Member, Committee on Veterans' Affairs, House of Representatives

April 2000

DISABLED VETERANS' CARE

Better Data and More Accountability Needed to Adequately Assess Care

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Abbreviations

BROS	blind rehabilitation outpatient specialist
CDR	cost distribution report
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
FTE	full-time-equivalent
PTSD	post-traumatic stress disorder
SCI	spinal cord injury
SCI&D	spinal cord injury and disorder
SMI	serious mental illness
TBI	traumatic brain injury
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-283462

April 21, 2000

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

In 1996, the Congress expressed concern that budgetary pressures and ongoing reorganization within the Department of Veterans Affairs (VA) health care system could make VA's specialized programs for disabled veterans vulnerable to inappropriate cost cutting. Section 104 of the Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262) requires the Secretary of VA to (1) ensure that VA's systemwide capacity to provide specialized treatment and rehabilitative services to veterans with spinal cord dysfunction, blindness, amputations, or mental illness is not reduced below October 1996 levels and (2) provide veterans with reasonable access to needed specialized care and services. VA is required to report to the House and Senate Committees on Veterans' Affairs annually from 1997 through 2001 about its systemwide capacity to provide this specialized care.

Although the legislation directed VA to preserve capacity and to ensure reasonable access for veterans with special disabilities, it did not define capacity or access or specify how each was to be measured. After consultation with stakeholders,[1] VA defined capacity as the number of individual veterans treated within specialized inpatient units and clinics and the dollars expended for their care. VA included number of beds and staffing levels as additional measures of capacity for spinal cord dysfunction and blind rehabilitation. Access was defined as timeliness in providing services to veterans for their specialized needs. In addition, VA planned to implement outcome measures within 2 to 3 years to evaluate program effectiveness, regardless of resources expended, by measuring treatment results.

[1]Stakeholders included members of the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on the Care of Severely Chronically Mentally Ill Veterans.

This report responds to your request that we review VA's compliance with the requirements to maintain capacity and access for veterans with special disabilities.[2] Specifically, we provide the results of our review of (1) the accuracy of the conclusions in VA's fiscal year 1998 annual capacity report and (2) challenges facing VA in managing its special disability programs. In addition, we assessed whether VA has complied with section 903 of the Veterans Programs Enhancement Act of 1998 (P.L. 105-368), which directed the Under Secretary for Health to prescribe, by January 1, 1999, job performance standards for employees responsible for allocating and managing special disability program resources.

To develop this information, we met with VA officials responsible for developing and analyzing information on the disability programs; VA officials responsible for managing the special disability programs at the national level; officials at Veterans Integrated Service Networks (VISN) in Durham, N.C., Atlanta, Ga., and San Francisco, Calif.; officials at facilities in Durham, N.C., Richmond, Va., Decatur and Augusta, Ga., and Palo Alto and San Francisco, Calif.; and representatives from veterans' service organizations and advisory committees with which VA is required to consult in responding to the 1996 legislation. We also reviewed relevant VA and advisory committee reports, policies, manuals, and publications. We performed our work between October 1998 and January 2000 in accordance with generally accepted government auditing standards.

Results in Brief

VA concluded in its annual report for fiscal year 1998 that it had maintained its capacity to treat veterans with special disabilities. However, VA's data are not sufficient to support that conclusion because of extensive data problems, such as the use of unreliable proxy measures to identify veterans with special disabilities. Moreover, VA based its conclusion on national statistics that indicated more special disability veterans were served with fewer resources expended in 1998 than in 1996. However, there is considerable variability among the VISNs, and, in fact, some VISNs reported serving fewer veterans. In addition, VA attributes reduced expenditures and the use of fewer resources to efficiency gains; however, because it lacks outcome measures, VA cannot tell whether it has maintained, enhanced, or diminished quality of care.

[2]We provided preliminary information on the results of our review in a briefing to your staff on May 24, 1999.

VA faces challenges in maintaining its capacity to serve special disability populations. In particular, the lack of a single VA headquarters unit accountable for ensuring compliance with the capacity legislation may have caused delays in (1) monitoring and investigating locations where capacity appears to have declined and (2) fully implementing congressionally mandated performance standards for VA employees responsible for allocating and managing special disability program resources. In order to ensure compliance with the capacity legislation, we are recommending that VA designate a single office to be accountable for fully implementing the mandate to maintain capacity in special disability programs.

Background

Since 1995, VA has taken significant steps to transform its health care system from a hospital- and specialist-based system to a prevention-oriented, community-based system with primary care as its foundation. To accomplish this transition, VA moved from a management structure based on 172 hospitals to one based on VISNs in 22 separate geographic areas. These VISNs have substantial operational autonomy and are responsible for making basic budgetary, planning, and operational decisions to meet the health care needs of veterans living within the 22 geographic areas. Each VISN oversees between 5 and 11 large hospital facilities, as well as clinics and other delivery locations.

The Veterans Health Care Eligibility Reform Act of 1996 authorized new eligibility rules for outpatient treatment that permit VA to provide medical care in the most appropriate settings. Eligibility reform was intended to reduce inappropriate admissions and denial of care to many veterans who were ineligible under the old rules for outpatient treatment. In addition, VA proposed a plan to operate within the same annual appropriation for VA health care through 2002.[3] As a result, VISN and facility managers had strong incentives to reengineer delivery systems to offset rising health care costs.

In this environment of shifting service delivery from inpatient to outpatient settings, system reorganization, and no-growth budgets, section 104 of the Veterans Health Care Eligibility Reform Act directed VA to protect services and resources committed to veterans with spinal cord dysfunction,

[3]Nevertheless, VA's fiscal year 2000 budget appropriation for health care was increased by $1.7 billion over the fiscal year 1999 budget appropriation.

blindness, amputations, or mental illness. After discussions with stakeholders, as required by the act, VA added two more special disabilities—traumatic brain injury and post-traumatic stress disorder (PTSD)—to this list. For the purpose of the capacity requirement, VA limited the definition of mental illness to refer to only those veterans with serious mental illness and created two subcategories: veterans disabled as a result of a disorder related to substance abuse and homeless veterans disabled as a result of serious mental illness.

House Report 104-690, which accompanied the 1996 legislation, noted that the special disability programs constitute a vital core of VA's mission, tend to be high-cost efforts, and are unmatched in scope and quality in the private sector. The six special disabilities were targeted because of their close association with service-related illnesses and the likelihood of progressively worsening disability in the absence of specialized treatment or rehabilitation. VA must carry out the requirements of the legislation in consultation with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on the Care of Severely Chronically Mentally Ill Veterans,[4] and VA has done so.

Although the legislation directed VA to preserve capacity and to ensure reasonable access for veterans with special disabilities, it did not specify how capacity and access were to be defined or measured. VA defined capacity as the number of individual veterans treated within specialized inpatient units and clinics and the dollars expended for the care of these veterans. VA intends to use outcome measures, when they become available, to measure the effectiveness of its specialized programs. At the insistence of veterans' service organizations, number of beds and staffing levels were included as additional measures of capacity for spinal cord dysfunction and blind rehabilitation. VA defined access as timeliness in providing services to veterans for their specialized needs. Although VA considered other measures of access, the data necessary to develop these measures, primarily the number and location of the universe of veterans with each disability, are not generally available.

[4]The members of the Advisory Committee on Prosthetics and Special Disabilities Programs are from veterans' service organizations, universities, and private sector health care providers. In accordance with the Veterans Health Care Eligibility Reform Act, members of the Committee on the Care of Severely Chronically Mentally Ill Veterans must be employees of the Veterans Health Administration with expertise in the care of the chronically mentally ill and must be appointed by VA's Under Secretary for Health.

VA Has Insufficient Evidence to Support Its Conclusion That Capacity Has Been Maintained

VA's fiscal year 1998 annual capacity report concluded that VA's capacity to treat special disability groups nationwide had been generally maintained. This conclusion was based on national statistics that indicated that more special disability veterans were served in 1998 than in 1996. However, measurement results varied among VISNs, with some showing a decrease in veterans served. In our view, the available data are insufficient to support any conclusions because VA's workload and resource data are inaccurate. In addition, reliable outcome measures are not available to assess whether the quality of care provided to special disability populations has changed or is satisfactory.

VA Has Claimed That Serving More at Less Cost Maintains Capacity

VA has asserted that capacity to treat veterans with special disabilities has been maintained because the number of veterans treated in special disability programs increased from fiscal year 1996 to fiscal year 1998 by 8 percent, or 28,141 individuals. However, during that same period, spending for these programs decreased by 8 percent, or approximately $184 million. Veterans with a serious mental illness accounted for 81 percent of the special disability veterans served and 84 percent of the dollars spent in the special disability categories. The number of veterans with special disabilities served during the period increased or remained relatively constant for all conditions except amputations. VA reported the decline in the number of veterans with amputations as a favorable outcome of successful efforts to prevent amputations in diabetic patients. VA expenditures decreased for amputations, serious mental illness, and PTSD. Analysis of expenditures for two subcategories of serious mental illness shows a decrease of 29 percent for veterans with a disorder related to substance abuse and an increase of 23 percent for veterans who were homeless. Expenditures also increased for spinal cord dysfunction, traumatic brain injury, and blind rehabilitation. (See table 1.)

Table 1: Change in Number of Special Disability Veterans Served and Dollars Spent Between Fiscal Years 1996 and 1998

	Veterans served			Dollars spent (in thousands)		
Disability	**FY 1996**	**FY 1998**	**Change (percentage)**	**FY 1996**	**FY 1998**	**Change (percentage)**
Spinal cord dysfunction	8,598	9,252	+654 (+8)	$199,848	$202,878	+$3,030 (+2)
Blindness	9,726	11,930	+2,204 (+23)	43,855	53,935	+10,080 (+23)
Traumatic brain injury	176	189	+13 (+7)	4,439	4,906	+467 (+11)
Amputations	4,765	4,549	-216 (-5)	5,953	5,286	-667 (-11)
Serious mental illness[a]	269,009	290,961	+21,952 (+8)	2,080,240	1,900,938	-179,302 (-9)
Substance abuse	107,074	106,599	-475 (-0.4)	575,902	407,334	-168,568 (-29)
Homeless	24,539	27,201	+2,662 (+11)	75,071	92,614	+17,543 (+23)
PTSD	39,653	43,187	+3,534 (+9)	101,882	84,112	-17,770 (-17)
Total	**331,927**	**360,068**	**+28,141(+8)**	**$2,436,217**	**$2,252,055**	**-$184,162 (-8)**

[a]The total for serious mental illness is more than the sum of the subcategories listed under it because the category includes, but is not limited to, veterans who are substance-abusing or homeless.

Source: VA's 1998 capacity report to the Congress: *Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans* (VA, June 1999).

VA's fiscal year 1998 capacity report was an improvement over its previous reports because it included for the first time a breakout of veterans served in both inpatient and outpatient settings. Between 1996 and 1998, the number of veterans served in inpatient settings increased for blindness, traumatic brain injury, the homeless subcategory of serious mental illness, and PTSD. The shift from inpatient to outpatient care was most evident in the broad category of serious mental illness and its subcategory of substance abuse. The number of seriously mentally ill veterans treated in an inpatient setting declined by approximately 19 percent, while the number of seriously mentally ill veterans with substance abuse disorders who received inpatient care declined by approximately 41 percent. The number of special disability veterans treated in outpatient settings increased for all conditions with the exception of amputations. (See table 2.)

Table 2: Change in Number of Special Disability Veterans Served in Inpatient and Outpatient Settings Between Fiscal Years 1996 and 1998

Disability/Setting	Veterans served FY 1996	Veterans served FY 1998	Percentage change
Spinal cord dysfunction			
Inpatient	5,185	5,117	-1
Outpatient	6,599	7,576	+15
Blindness			
Inpatient	1,607	1,976	+23
Outpatient	9,345	11,560	+24
Traumatic brain injury[a]			
Inpatient	176	189	+7
Amputations[a]			
Outpatient	4,765	4,549	-5
Serious mental illness			
Inpatient	117,088	95,068	-19
Outpatient	251,216	278,674	+11
Substance abuse			
Inpatient	50,628	30,021	-41
Outpatient	90,916	99,337	+9
Homeless			
Inpatient	5,273	7,072	+34
Outpatient	21,913	23,763	+8
PTSD			
Inpatient	4,312	4,694	+9
Outpatient	37,768	41,224	+9

[a]Data were not reported for both inpatient and outpatient settings.

Source: VA 1998 capacity report (VA, June 1999).

For veterans disabled by spinal cord dysfunction or blindness, capacity was also measured by staff resources—full-time-equivalent (FTE) employees—and the number of specialized beds dedicated to veterans with these disabilities. From 1996 to 1998, VA reported that staffing levels dropped by 12 percent (267 FTE employees) for spinal cord dysfunction and increased by 1 percent (3 FTE employees) for blind rehabilitation. Numbers of beds declined in both areas: 15 percent (180 beds) for spinal cord dysfunction and 7 percent (15 beds) for blind rehabilitation. (See table

3.) Veterans' service organizations have questioned the accuracy of these numbers on the basis of surveys they have conducted at VA facilities and have concluded that capacity reductions have been even greater: 18 percent fewer spinal cord care beds and 32 percent fewer spinal cord care staff resources. In addition, the Advisory Committee on Prosthetics and Special Disabilities Programs has questioned whether VA inappropriately included unstaffed spinal cord and blind rehabilitation beds in the capacity report. Two of the facilities we visited reported delays in transferring veterans with acute care needs to a specialized spinal cord injury unit. In addition, the national average waiting time for admission to an inpatient blind rehabilitation program increased slightly, from 31.8 weeks in fiscal year 1996 to 33.4 weeks in fiscal year 1998. Moreover, outreach efforts by the facility-based Visual Impairment Services Team, which provides coordinated services to legally blind veterans, continued to increase the already lengthy waiting lists for blind rehabilitation programs. The delays in admission to spinal cord care beds in some areas and the lengthy waiting times for blind rehabilitation indicate that the reduction in bed levels may be affecting access to these services.

Table 3: Change in FTE Employees and Beds for Spinal Cord Dysfunction and Blind Rehabilitation Between Fiscal Years 1996 and 1998

Disability/Measure	FY 1996	FY 1998	Percentage change
Spinal cord dysfunction			
FTE employees	2,175.8	1,909.3	-12
Beds	1,209	1,029	-15
Blindness			
FTE employees	414.5	417.3	+1
Beds	228	213	-7

Source: VA 1998 capacity report (VA, June 1999).

Some VISNs Reported Fewer Special Disability Veterans Served

While VA stated that it had maintained capacity nationally, some VISNs appeared to be maintaining workloads and expenditures for special disability populations, while others showed declines in veterans served and expenditures. For example, only two VISNs maintained or increased their workloads for all six disabilities. Another two VISNs served fewer veterans in at least four of the six special disability groups. VA's Committee on the

Care of Severely Chronically Mentally Ill Veterans stated in its response to the capacity report that because the measure of maintenance of clinical effort (dollars expended) had actually decreased, VA should scrutinize those VISNs with the largest reductions in capacity. The committee further stated that many VISNs showed substantial increases in the numbers of veterans treated (up to 17 percent) with relatively constant expenditures, while other networks showed decreases in veterans treated and decreases in funds expended. VA provided no data to show that decreased demand for services accounted for the decrease in veterans treated.

VA's Data Are Inadequate for Capacity Analysis

The information management systems currently used by VA are not precise enough to capture the information necessary to accurately calculate workload and expenditure statistics for the special disability populations. As a result, VA developed a complex process using eight different databases to compile VISN and national workload and resource data for the six disabling conditions. This process used inpatient diagnostic information, when available, and a set of proxy measures to infer a likely condition when diagnostic information was not available. For example, because VA's outpatient care database does not currently include diagnostic information,[5] VA identified additional patients as belonging to a special disability group on the basis of information regarding the number of visits to specific clinics. Thus, veterans who visited certain psychiatric/mental health clinics at least six times were counted as disabled by serious mental illness. Because of the lack of diagnostic information and the sometimes inappropriate proxies used, we are not confident that the workload figures and subsequent expenditure amounts are accurate. Stakeholders have voiced similar concerns. For example, the cochair of the Committee on the Care of Severely Chronically Mentally Ill Veterans stated during testimony in 1998 that "the currently available data is inadequate to comprehensively and reliably monitor the Veterans Health Administration's efforts to maintain capacity for these disabling conditions."

[5]VA has begun implementation of a Decision Support System that will capture diagnostic information for outpatient clinic visits and will provide cost accounting information.

Our visits to selected field locations helped confirm the validity of our concerns about the accuracy of VA's workload and resource data. We were unable to validate workload and resource data contained in the capacity report using information maintained at VA facilities because data were not routinely available under the definitions developed for the disabling conditions (see app. I).[6] Several clinicians told us that the definitions used in the capacity report had no clinical basis when it came to treating patients. For example, as defined by VA's capacity report, seriously mentally ill veterans represented about 81 percent of the universe of veterans with special disabilities in fiscal year 1998. Yet the seriously mentally ill category would not be tracked at the facility level because it does not represent a meaningful grouping of patients who would receive similar medical care.

Our site visits also found that despite 3 years of requirements to report on capacity, management staff at VA facilities generally did not know the definitions used by VA headquarters to identify veterans with special disabilities or the methodology used to develop workload data for their facilities. For example, one facility offered substance abuse treatment in a day treatment program instead of a traditional substance abuse clinic. The capacity report indicated that this facility experienced a 17-percent decline in the treatment of seriously mentally ill patients with substance abuse disorders and a 9-percent decline in expenditures for this population. Facility officials believed that the capacity report understated workload for seriously mentally ill patients with substance-related disorders because VA's methodology did not include the day treatment clinic as a program serving this special disability population.

[6]Other groups, such as the minority staff of the Senate Committee on Veterans' Affairs, were also unable to verify workload and resource data because of problems in obtaining reliable or comparable data across facilities. See *Minority Staff Review of VA Programs for Veterans With Special Needs*, prepared for Senator John D. Rockefeller IV, July 27, 1999.

We also identified deficiencies in the accuracy of VA's resource measures (that is, expenditures for all programs and staffing levels and beds for spinal cord care and blind rehabilitation). Moreover, veterans' service organizations have reported discrepancies between the cost distribution report (CDR), which is the data system used by VA to allocate costs, and information reported by special disability program officials. The information in the CDR is suspect because it relies on subjective judgments to allocate the distribution of staff time and dollars spent in each inpatient unit and outpatient care area. VA's Inspector General found that service-level managers have broad discretion in selecting and applying cost allocation techniques, leading to inconsistency, infrequent updates, and disparate treatment of similar cost accounting issues.[7] Clinical staff told us that vacancies were at times deliberately hidden through the reallocation of staff to special disability programs in the CDR or filled with individuals possessing less skill and ability. Thus, these staff believe that the CDR can be easily manipulated to create the appearance that staffing and expenditure levels in the special disability program have been maintained.

VA acknowledged that its data systems need improvement, and in December 1998 the Veterans Health Administration (VHA) held a Data Quality Summit to identify issues related to the collection and use of data in VHA. Multiple data quality issues were identified, including the completeness, reliability, validity, and timeliness of ambulatory care data. Recognizing problems with the data used to prepare the annual capacity report, VA used a verification and data correction process to improve the accuracy and reliability of data for the fiscal year 1998 report to the Congress. VA headquarters shared preliminary data with medical centers, VISNs, and program offices to identify problems. In addition, the most recent capacity report reflects a closer working relationship among VA, its advisory committees, and interested veterans' service organizations. According to VA, this collaboration has resulted in data improvements. While the steps taken by VA to improve its data quality are commendable, we believe that these efforts will not bear fruit in the short term because of the myriad people and processes at the facility, VISN, and national levels that make data collection at VA so cumbersome.

[7]VA Office of Inspector General, *Evaluation of Medical Center Investment in Ambulatory Care Infrastructure*, Report Number 9AY-A19-078 (Washington, D.C.: VA, Mar. 31, 1999).

Limited Outcome Measures Further Impede Capacity Measurement

The primary basis for VA's conclusion that it has maintained capacity is the increased number of veterans served by the special disability programs. However, of the five special disability programs that reported serving more veterans, two experienced a decrease in expenditures and two a reduction in dedicated beds. Without outcome measures, the effect of these changes on the appropriateness and effectiveness of treatment is unclear. For example, although the number of veterans treated for serious mental illness increased by 8 percent from 1996 to 1998, expenditures decreased by 9 percent. Similarly, the number of veterans treated for PTSD increased by 9 percent, while expenditures declined by 17 percent. VA generally attributed expenditure reductions to increases in efficiency as outpatient or domiciliary care replaced more costly hospital inpatient treatment. Other stakeholders review the same data and conclude that reduced expenditures have eroded comprehensiveness and quality of care.

Facility managers we contacted were primarily concerned with maintaining operations given the constraints of constant budgets, staff reductions, and increasing workloads. These managers implemented various strategies to improve efficiency while maintaining services to all veterans, including those served in the special disability programs. These strategies included the use of service lines,[8] "hoptel" beds,[9] making referrals to community-based service providers, and shifting care to outpatient settings. Facility officials generally believed that newly developed alternative care settings were appropriate for special disability populations, although no clear evidence exists to support this position.

While facility officials believed that they were meeting the demand for special disability services, they expressed concern that additional cost reductions might adversely affect quality of care. One facility was able to reduce the number of inpatient psychiatric beds from over 400 to fewer than 100. Officials at this location were confident that the community infrastructure was adequate for most veterans. VA case managers were assigned to patients, and staff members were working with the community to develop additional capacity as needed. In contrast, officials from another facility stated that their community had few suitable alternatives, a situation that led the facility's chief of staff to question the strategy of deinstitutionalizing patients with mental illness.

Assessment of patient care outcomes for VA's special disability populations would be a major asset in interpreting VA data and trends that showed more veterans served with fewer resources. Although outcome measures are difficult to develop and are not generally available in private sector health care systems either, VA made a commitment in 1997 to develop within 2 years comprehensive and reliable measures of treatment outcome for the six disability groups.

The fiscal year 1998 capacity report contains performance "monitors" that are a mixture of outcome and process measures related to the care

[8]A service-line model is a health care organizational model based upon providing a comprehensive set of clinical and administrative services to meet the needs of a particular segment of the market (for example, veterans with mental illness or spinal cord dysfunction). Budgetary, personnel, and reporting authorities vary in the different service-line models.

[9]Hoptels are temporary lodging, usually within facilities, that provide a cost-effective alternative to inpatient admissions.

provided to the six disability groups. The 18 performance monitors VA identified are designed to assess quality, functional status, and patient satisfaction. According to VA, these measures will be revised as more appropriate ones are identified.

Data were unavailable for 7 of the 18 performance monitors identified in the fiscal year 1998 capacity report, and information was unavailable for the 3 years from 1996 through 1998 for 15 monitors (see app. II). Some performance monitors, such as continuity of care for previously hospitalized patients and changes in functional status, appear to be useful indicators of quality. However, others are more process-oriented and do not support an assessment of possible improvements resulting from the care provided. For example, the performance monitor for the care of veterans with serious mental illness is a process measure of the percentage of patients who are assessed on a one-time basis for their level of functioning, not an outcome measure of their improvement. Furthermore, some monitors are limited to a small segment of the population or address populations broader than the special disability populations. For example, performance monitors for the spinal cord dysfunction population include only those patients discharged after inpatient treatment (about 55 percent of all spinal cord dysfunction patients served), and measures for the serious mental illness category include all psychiatric patients, and not just those with serious mental illnesses.

Both advisory committees questioned the validity of VA's performance monitors and expressed concern that insufficient progress has been made in the development of comprehensive and valid measures of treatment outcome as VA transitions to greater reliance on outpatient delivery systems. While VA's development of performance monitors is a step in the right direction, more research is needed to determine whether these measures are adequate to assess whether the care provided to veterans in the special disability programs is as comprehensive as, and equal in quality to, the care provided in 1996.

VA Managers Are Not Specifically Accountable for Special Disability Programs

Special disability services are delivered at the facility level, where VISN and facility officials face the need to become more efficient to meet the needs of more veterans with fewer resources. The alternative to increased efficiency is decreased services. Accountability for maintaining capacity in the special disability programs is currently fragmented among several organizational units in VA, and performance standards mandated by statute have not been fully implemented for those managing resources or

allocating them to special disability programs. VA indicated in its fiscal year 1998 capacity report that it was monitoring situations in which capacity appeared to have declined, but VA did not respond to our repeated requests that it identify who was responsible for this monitoring.

Responsibility for Maintaining Capacity Is Fragmented Among Organizational Units

Responsibility for implementing the mandate to maintain capacity in special disability programs is divided among several headquarters units, including the Office of Policy and Planning, the Chief Network Office, and the Office of Patient Care Services. The Office of Policy and Planning is responsible for developing the annual capacity report. This office coordinates the development of capacity statistics and program definitions, oversees the verification and validation process,[10] and consults with internal and external stakeholders in finalizing the capacity report. The Chief Network Officer is the primary point of contact for the VISNs and provides operational direction and supervision to the field through the 22 VISN directors. The Office of Patient Care Services houses the clinically related headquarters programs that support the delivery of patient care services in the field. This office develops patient care policies and guidelines, acts as program consultant to the special disability programs, and provides advice and consultation to VISN and facility directors.

After contacting these three headquarters units, we concluded that none of them was responsible for monitoring field locations whose capacity to serve special disability populations appears to have declined. Each of the units denied responsibility for monitoring and referred us to one of the other offices as the potentially responsible unit. Despite VA's data problems, enhanced monitoring and follow-up could be useful in mitigating the limitations of VA's current capacity measures and performance monitors. In addition to helping identify data reliability issues, such monitoring efforts could bring to light legitimate concerns about the provision of services to special disability populations in alternative care settings.

[10]VA refers to this as the error detection and correction process in its fiscal year 1998 capacity report.

Mandatory Job Performance Standards Have Not Been Fully Implemented

To improve accountability for maintaining capacity in the special disability programs, the Congress, through the Veterans Programs Enhancement Act, required VA to develop job performance standards for employees responsible for allocating and managing resources for serving veterans with special disabilities. The law also required that the standards include measures of workload, allocation of resources, and quality of care indicators, and that the standards be implemented by January 1, 1999.

As of January 2000, VA had implemented at least one quality of care performance standard, or monitor, in each of the six special disability programs. The 2000 VISN directors' performance agreement states that part of the performance evaluation will be based on the results of the monitors of capacity for special populations. The agreement includes 12 monitors related to the disability populations. Achievement goals for VISN directors have been established for the 2 spinal cord care monitors, but not for the remaining 10 monitors. Without stated goals, it is unclear what would be considered acceptable performance.

Also, the performance agreement is silent on the measurement of workload and allocation of resources, which is required by the law. The mandatory job performance standards cannot be considered fully implemented without measures of workload and allocation of resources.

VA has demonstrated that measurable performance standards for key management officials can promote change. For example, by including in the VISN directors' performance agreements a requirement to decrease the number of days inpatients spent in acute care in fiscal year 1998, VA reduced these acute-bed-days from 3,430 per 1,000 veterans served in fiscal year 1994 to 1,333 per 1,000 veterans served in fiscal year 1998, a 61-percent decrease.

Conclusions

While questions remain about the accuracy of VA's workload and resource data, VA has committed to work with stakeholders and veterans' service organizations to improve the accuracy and reliability of the data. VA has also committed itself to developing measures of quality of care in special disability programs in order to ensure that quality is maintained or improved. However, in view of the difficulty of developing and validating outcome measures, it is unlikely that VA will be able to develop measures across all special disability programs in the near future. In the meantime, the annual capacity report can be a valuable tool for identifying specific

locations with potential problems in service delivery to special disability populations. Enhanced monitoring of such locations could be used to augment VA's current limited capacity measures and performance monitors.

Responsibility for managing VA's response to the capacity requirement is dispersed among several of VA's organizational components, and none of them has taken responsibility for investigating apparent declines in capacity or quality of services for veterans with special disabilities. Designating a single organization as responsible for these functions would help focus accountability for maintaining capacity. In addition, the accountable office could be charged with fully implementing the congressional requirement to develop job performance standards for employees responsible for allocating and managing resources used to serve veterans with special disabilities.

Recommendation to the Secretary of Veterans Affairs

To help ensure compliance with the law, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to assign lead responsibility to a headquarters unit for

- initiating efforts to monitor and determine the causes for apparent declines in capacity and
- developing job performance standards for employees who are responsible for allocating and managing the resources used to serve veterans with special disabilities.

Agency Comments and Our Response

In commenting on the draft report, VA generally agreed with our findings and recommendations. VA intends to take an approach to ensuring compliance with the law that is different from assigning lead responsibility to a headquarters unit. VA said it would renew its commitment to using existing coordination and issue resolution mechanisms to address compliance with the law. We continue to believe that assigning responsibility to one office would better ensure that capacity is accurately measured and appropriately maintained. The coordination mechanisms have not accomplished this in the past, and focusing one office's attention on the issue is, in our opinion, more likely to ensure accountability in the future. VA said that a new management structure would have to be created if it designated a single office as responsible for ensuring compliance with the law. We believe that a new management structure is not required and

that designating an office as accountable for compliance with the law would be sufficient. VA has tasked a working group, the 3-year-old Performance Management Work Group, with the development of job performance standards. This action should emphasize and delineate responsibility for the timely completion of the job performance standards.

VA also commented that it believes that measuring the full continuum of care, not just the numbers of beds and FTE staff, is the most appropriate measure of access to care. We agree with VA, but, as we have discussed in the report, VA does not have the data or processes available to consider the full continuum of care. In this regard, we support VA's efforts to develop outcome measures.

VA expressed concern that the draft report placed emphasis on the maintenance of capacity at the VISN level, noting that the law states that capacity should be maintained at the national level. As discussed in the report, we included information by VISN because the nationwide data hid the variability across the VISNs. Moreover, VA stated in its 1998 capacity report that it was monitoring situations in which capacity appeared to have declined in particular VISNs; however, we were unable to identify who was responsible for this monitoring. We support VA's initiative to monitor declines in capacity at the VISN level, knowing that such an effort exceeds the statutory requirement to maintain capacity nationally.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of the report. At that time, we will send copies of this report to the Honorable Togo D. West, Jr., Secretary of Veterans Affairs; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request.

Please contact me on (202) 512-7101 if you or your staff have questions about the report or need additional assistance. George Poindexter, Linda Diggs, Marcia Mann, and William Stanco made key contributions to this assignment.

Sincerely yours,

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

VA Definitions of Six Special Disabilities

Disability	VA capacity report definition
Spinal cord injury and disorders (SCI&D)	Veterans with neurological deficit lesions involving the spinal cord, including but not limited to traumatic spinal cord injuries; intraspinal neoplasms resulting in neurological deficit; vascular insults to the spinal cord; *cauda equina* syndrome; inflammatory disease of the spinal cord; and diseases such as multiple sclerosis, unstable traumatic lesions of the spinal cord, and degenerative spine diseases are considered to have SCI&D.
Blindness	Veterans are considered disabled by blindness when the best corrected central visual acuity with ordinary eyeglasses or contact lenses is 20/200 or less in the better eye, or when the best corrected visual acuity in the better eye is better than 20/200 but visual field defects exist that produce a useful visual field dimension of 20 degrees or less.
Traumatic brain injury (TBI)	Veterans who have sustained brain trauma, including from iatrogenic causes, and who have motor or cognitive impairments as a result of the brain injury for at least 3 months, are considered to have a TBI. These individuals either require rehabilitative services, such as acute intervention of speech pathology and cognitive rehabilitation, in the first several months or are so severely impaired that their rehabilitative potential is objectively so low that rehabilitative services are not appropriate. These patients may require chronic life support measures, such as mechanical ventilation.
Amputation	Amputation applies to veterans who have a full or partial amputation of a limb, including neurologic loss of a limb (except from stroke) and loss of the use of a limb from injuries to the brain, spinal cord, or peripheral nerves.
Serious mental illness (SMI)	Veterans who have within the past year had a diagnosed mental, behavioral, or emotional disorder of sufficient duration to result in a disability that meets the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),[a] criteria are considered to have an SMI. Disability is defined as a functional impairment that substantially interferes with or limits one or more major life activities, such as bathing, dressing, managing money, or taking prescribed medication. Two subcategories include veterans who have a diagnosed DSM-IV substance-related disorder and homeless veterans who have a disability as a result of mental illness.
Post-traumatic stress disorder (PTSD)	Veterans who meet the diagnostic criteria for PTSD include those who • have been exposed to a catastrophic or traumatic event involving actual or threatened death or injury, or a threat to the physical integrity of self or others, and who have a subjective response of intense fear, helplessness, or horror; • have intrusive recollections or reexperiences of the event; • persistently avoid stimuli associated with the trauma and have generally numbed responsiveness; • have persistent symptoms of increased arousal; • have symptoms that last 1 month or longer; and • experience clinically significant distress or impairment in social, occupational, or other important areas of functioning.

[a]DSM-IV is the standard handbook for psychodiagnosis employed by clinicians and researchers in the United States.

Performance and Access Monitors

Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
SCI&D	Access	Admission to a spinal cord injury (SCI) center within 1 day of request for patients needing acute, inpatient specialty care (average)	Process	Only SCI&D patients needing urgent admission to an SCI center are included in the measurement, which covers all newly injured veterans and a portion of the SCI&D population with older injuries. VA treats approximately 400 newly injured patients per year. The newly injured make up 8% of the SCI&D population treated as inpatients.	Survey of SCI centers by the SCI&D Strategic Health Group	FY 96—41% FY 97—91% FY 98—100%	Acute condition means care is required by newly injured veterans or by veterans with SCI who need urgent care because of medical complications or surgical needs. Results are reported as a percentage of SCI centers that met the requirements established by the indicator.
SCI&D	Access	SCI clinic appointment within 7 days of referral (average)	Process	Covers those patients seen in SCI clinics at facilities with an SCI center	Survey by the SCI&D Strategic Health Group	FY 96—87% FY 97—100% FY 98—100%	Results are reported as a percentage of SCI centers that met the requirements established by the indicator.
SCI&D	Performance	SCI inpatients rating VA care as “very good” to “excellent”	Outcome	Only veterans discharged from an SCI center can potentially be included in the denominator. Of the 5,117 patients discharged in FY 1998, only 550, or 10%, of the patients were included in the survey results.	Patient satisfaction survey results	FY 97—55% FY 98—55%	Of the 23 SCI centers, 16 had fewer than 30 respondents to the survey; according to VA, such small samples are regarded as unreliable and of questionable validity.

Continued

Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
SCI&D	Performance	Discharge from SCI bed unit to noninstitutional community living	Outcome	Includes veterans admitted for rehabilitation and other purposes, such as annual exams	National Patient Care Database on patients discharged from SCI bed unit	FY 97—95% FY 98—95%	VA states that discharge to noninstitutional community living "could be" viewed as positive. Outcome does not necessarily relate to quality of care received during inpatient treatment and may be the result of socioeconomic factors.
Blindness	Access	Average waiting time for admission to inpatient blind rehabilitation program	Process	Measures time only for patients actually admitted to program, not those on waiting list who decline admission	Self-reporting by blind rehabilitation centers	FY 96—31.8 weeks FY 97—32.2 weeks FY 98—33.4 weeks	Measures admissions during a 6-month period
Blindness	Access	Number and percentage change in the number of veterans served by blind rehabilitation outpatient specialists (BROS)	Process	There was a 36% increase in the number of veterans seen by a BROS, representing an increase from 7.4% in 1997 to 10% in 1998.	BROS semiannual reports	FY 97—873 FY 98—1,191 % change: +36	The number of veterans served is not the best measure of access. A numerator and a denominator are needed to determine accessibility of the program for veterans.
Blindness	Performance	Inpatients of blind rehabilitation program reporting being "satisfied" or "completely satisfied" with VA care	Outcome	Patients admitted to a VA blind rehabilitation program, which accounts for 17% of the blinded veteran population seeking care	Blind rehabilitation customer satisfaction survey	FY 97—98% FY 98—98%	The survey response rate in 1998 was 38%, which was an improvement over 1997. Two of the nine blind rehabilitation centers had less than 30 responses to the survey.

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
TBI	Access	Average waiting time for admission to a designated TBI bed	Process	Impossible to determine without numerators and denominators, which were not provided in the report	Survey of TBI centers	FY 96—3 days FY 97—2 days FY 98—2 days	There is no indication of the size of the survey sample.
TBI	Access	Average waiting time for first-time TBI outpatient appointment	Process	Impossible to determine without numerators and denominators, which were not provided in the report	Survey of TBI centers	FY 96—6 days FY 97—5 days FY 98—7 days	There is no indication of the size of the survey sample.
TBI	Performance	Discharge of "first-admission" TBI patients from TBI network medical rehabilitation beds to the community	Outcome	Measures only first-admission TBI patients	VA Functional Status Outcome Database	FY 98-—68%	Only percentages were provided, with a footnote stating that some were based on a very small number of discharges.
Amputation	Access	Delayed prosthetic orders (cumulative)	Process	Measures much more than patient population with amputations and was deleted from the list of access measures by VA for FY 1998	National delayed prosthetic order report	FY 96—1.3% FY 97—0.7%	
Amputation	Performance	Discharge of lower extremity amputees from inpatient rehabilitation units to community setting	Outcome	Unable to determine what percentage of amputees the data provided by VA represent	VA Functional Status and Outcome Database	FY 96—82% FY 97—77% FY 98—77%	The number of inpatient rehabilitation units has decreased and, as a result, the way care is delivered to veterans undergoing amputations has also changed, making comparisons by fiscal year difficult.

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
Amputation	Performance	Patients at risk for foot amputation who were referred to a foot care specialist	Process	Sample of diabetic patients	External peer review program—data collected by outside contractor.	Data not available.	Indicator included in Veterans Integrated Service Network (VISN) directors' performance measures under clinical practice guidelines
Amputation	Performance	Patient satisfaction with VA-issued lower extremity prosthetic limb	Outcome	Survey to be administered to lower extremity amputees	National survey of patients	Data not available.	
SMI	Access	Veterans seen in any psychiatric outpatient clinic within 30 days after discharge	Process	Indicator includes only those veterans discharged from a general psychiatry unit (approximately 33% of the veterans treated for SMI); unable to determine if this includes all discharges from psychiatry or just patients determined to have an SMI.	Patient Treatment File and outpatient files	FY 96—52% FY 97—53% FY 98—58%	The indicator for veterans with a psychiatric diagnosis who were seen within 30 days of discharge is part of the FY 2000 VISN directors' performance measures.

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
SMI	Access	Average time to first outpatient visit following discharge	Process	Indicator includes only those veterans discharged from a general psychiatry unit (approximately 33% of the veterans treated for SMI); unable to determine if this includes all discharges from psychiatry or just patients determined to have an SMI.	Patient Treatment File and outpatient files	FY 96—34 days FY 97—32 days FY 98—31 days	
SMI	Performance	Patients with at least one Global Assessment of Functioning score if seen in any Veterans Health Administration mental health inpatient or outpatient setting in FY 1998	Process	Includes all patients seen in a psychiatric inpatient or outpatient setting, not just those with SMI	Mental health package	Data not available.	Would need comparison of functional scores to measure outcome of treatment, which VA intends to accomplish in FY 1999.
SMI—substance abuse	Access	Veterans seen in any substance abuse outpatient clinic within 30 days after discharge	Process	The majority of substance abuse care is now delivered in an outpatient setting. This measure includes only the 28% of veterans treated for substance abuse in an inpatient setting and includes more than SMI patients.	Patient Treatment File and outpatient files	FY 96—38% FY 97—41% FY 98—41%	

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
SMI—substance abuse	Access	Average time to first outpatient visit for veterans discharged from substance abuse programs	Process	The majority of substance abuse care is now delivered in an outpatient setting. This measure includes only the 28% of veterans treated for substance abuse in an inpatient setting and includes more than SMI patients.	Patient Treatment File and outpatient files	FY 96—27 days FY 97—28 days FY 98—27 days	
SMI—substance abuse	Performance	Patients (percentage) that demonstrate improvement in the drug and alcohol use scores in the Addiction Severity Index	Outcome	Covers veterans receiving inpatient or outpatient care and would potentially include more than SMI patients in the sample	Mental health package	Data not available.	
SMI—homeless	Access	VA had not developed an access indicator for the homeless subcategory of SMI at the time the FY 1998 report was published.	Process	Not determined at the time the FY 1998 capacity report was published	Not determined at the time the FY 1998 capacity report was published	Data not available.	Because of the closure of substance abuse and general psychiatry beds, VA did not include access data for these patients and may not include them in the future because of small sample sizes.

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
SMI—homeless	Performance	Veterans who acquired living arrangements at discharge from a Domiciliary Care for Homeless Veterans program or Health Care for Homeless Veteran community-based contract residential care program	Outcome	May include veterans without SMI when looking at homeless population discharged from a Domiciliary Care for Homeless Veterans program or Health Care for Homeless Veteran community-based contract residential care program	Northeast Program Evaluation Center files	FY 96—51% FY 97—52% FY 98—52%	Sample size was not provided in report.
SMI—homeless	Performance	Veterans who obtained employment at discharge from a Domiciliary Care for Homeless Veterans program or community-based contract residential care program	Outcome	May include veterans without SMI if looking at homeless population discharged from a Domiciliary Care for Homeless Veterans program or community-based contract residential care program	Northeast Program Evaluation Center files	FY 96—49% FY 97—52% FY 98—54%	Sample size was not provided in report.

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
SMI—homeless	Performance	Veterans with mental illness (including substance abuse) who had a follow-up mental health outpatient visit within 30 days of discharge from a contract Domiciliary Care for Homeless Veterans program or community-based residential care program	Process	May include veterans without SMI if looking at homeless population discharged from a contract Domiciliary Care for Homeless Veterans program or community-based residential care program	1999 data to be collected and summarized by the Northeast Program Evaluation Center.	Data not available.	
PTSD	Access	Veterans with a primary diagnosis of PTSD seen in any psychiatric outpatient clinic within 30 days after discharge	Process	Covers PTSD population who received inpatient care, which accounts for approximately 11% of the population	Patient Treatment File and outpatient files	FY 96—64% FY 97—65% FY 98—68%	
PTSD	Access	Average time to first outpatient visit for veterans discharged with a primary PTSD diagnosis	Process	Covers PTSD population who received inpatient care, which accounts for approximately 11% of the population	Patient Treatment File and outpatient files	FY 96—30 days FY 97—28 days FY 98—26 days	

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
PTSD	Performance	Veterans (percentage) treated for PTSD in specialized PTSD programs with at least one Global Assessment of Functioning score	Process	Covers PTSD population treated in both inpatient and outpatient programs	Mental health package	Data not available.	VA is using functional scores to determine the number of veterans disabled by PTSD for FY 1998.
PTSD	Performance	Change in PTSD symptoms on the short form of the Mississippi Scale from admission to follow-up 4 months after discharge (national average for adjusted mean scores)	Outcome	Covers PTSD population admitted to a specialized intensive PTSD program	The Northeast Program Evaluation Center is using a self-reporting survey.	FY 96—39.05 FY 97—37.19 % change: -1.86	
PTSD	Performance	Change in alcohol abuse symptoms as measured by the Alcohol Abuse Composite of the Addiction Severity Index from admission to follow-up 4 months after discharge (national average for adjusted mean scores)	Outcome	Covers PTSD population admitted to a specialized intensive PTSD program	The Northeast Program Evaluation Center is using a self-reporting survey.	FY 96—0.169 FY 97—0.137 % change: -0.032	

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Disability	Access or performance monitor	Indicator	Indicator type (process[a] or outcome[b])	Portion of population covered	Method of data collection	Results reported	Comments
PTSD	Performance	Change in drug abuse symptoms as measured by the Drug Abuse Composite of the Addiction Severity Index from admission to follow-up 4 months after discharge (national average for adjusted mean scores)	Outcome	Covers PTSD population admitted to a specialized intensive PTSD program	The Northeast Program Evaluation Center is using a self-reporting survey.	FY 96—0.071 FY 97—0.059 % change: -0.012	
PTSD	Performance	Change in occupational functioning as measured by the number of days the veteran has been employed during the past 30 days at admission and follow-up 4 months after discharge (national average for adjusted mean scores)	Outcome	Covers PTSD population admitted to a specialized intensive PTSD program	The Northeast Program Evaluation Center is using a self-reporting survey.	Data not available.	
PTSD	Performance	Veterans successfully contacted for outcome assessment after discharge from an intensive PTSD program	Process (step to collect data for an outcome measure)	Covers PTSD population admitted to a specialized intensive PTSD program	The Northeast Program Evaluation Center's response rate for survey	FY 96—62.7% FY 97—66.6% % change: +3.9	

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[a]A measure that focuses on a process that leads to a certain outcome and that, when executed well, will increase the probability of achieving a desired outcome.

[b]A measure that indicates the result of the performance or nonperformance of a function(s) or process(es).

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

APR 4 2000

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military
Health Care Issues
Health Education and Human Services Division
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus,

We have reviewed your draft report, ***VA HEALTH CARE: Better Data and Accountability Needed for Care for Disabled Veterans*** (GAO/HEHS-00-57) and its recommendations. Although we generally agree with GAO's findings and recommendation, the Veterans Health Administration intends to take a slightly different approach to ensuring compliance with the law than establishing a single headquarters office to serve as the lead as GAO recommends.

GAO is correct in stating that no single office in headquarters has responsibility for VA's capacity report. There exist, however, avenues that allow coordination and resolution of issues that arise among the offices sharing responsibility. We believe it would be more effective and efficient to renew our commitment to these existing mechanisms and to their improvement rather than creating another management structure. We will be discussing this issue within VHA further and GAO's report should assist us in our deliberations. Regarding the second part of the recommendation, to develop job performance standards for employees responsible for allocating and managing resources used to serve veterans with special disabilities, VHA has an established work group that is developing these performance standards.

Concerning the report findings and conclusions, we would note that to focus only on beds and FTEE is not the best way to assess whether or not VA is maintaining capacity. To fully appreciate the care provided for special populations, it is essential that the overall continuum of care be considered as well as the full range of settings in which care is being provided rather than only those prescribed in the law. By looking at the complete spectrum of settings where care is being provided, one could conclude that overall care for veterans with special disabilities has increased. In addition, GAO makes a point of focusing on changes in levels of care experienced at the VISN level; however, the law states that capacity is to be maintained at the national level. While it is VA's intention to provide needed care to all veterans in the most appropriate

2. Mr. Stephen P. Backhus

setting that is as convenient as possible for the veteran, we believe that GAO should place its emphasis consistent with the law rather than at the VISN level.

GAO acknowledges that, historically, outcomes have been difficult to measure. The report states that VA is not measuring outcomes of care. GAO notes that this circumstance is also true in the private sector. Although outcomes are not currently measured, VHA program offices are actively developing mechanisms and systems to measure outcomes and to provide functional status information. Many program offices will be ready to implement these measures in the near future and will provide this information in subsequent years.

We also recognize that there are other data limitations that impede our ability to assess levels of capacity, but we are also actively working to improve those systems. Full implementation of the Decision Support System and the Ambulatory Care Reporting Project are two improvements that should provide information that will directly address the requirements included in the law.

We appreciate the opportunity to comment on your draft report.

Sincerely,

Dennis Duffy
Assistant Secretary for
Planning and Analysis

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