UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

DECEMBER 7, 1984

B-217110

The Honorable Harry N. Walters
Administrator of Veterans Affairs

Dear Mr. Walters:

Subject: VA Needs a Systematic Approach to Assess the Management of Its Outpatient Clinics (GAO/HRD-85-15)

The Veterans Administration's (VA's) July 1984 report on caring for older veterans stated that VA would need to expand its capacity to provide outpatient care services from a projected 19 million visits in 1985 to between 26 and 33 million visits by the year 2000. By increasing the efficiency of its outpatient clinics, VA could treat more patients with available resources without adversely affecting the quality of care.

We reviewed the management of 15 VA outpatient clinics to determine the extent to which Department of Medicine and Surgery (DM&S) officials had established performance standards, collected needed data, and provided the incentives necessary to assess the efficiency of individual clinics. The data we collected at the 15 clinics (as shown on p. 13 of enc. I) indicate wide variations in performance and large deviations from DM&S standards. For example, DM&S expects that its clinics should provide for 500 visits annually for each full-time equivalent staff member. Visits per full-time equivalent at the 15 clinics ranged from 315 to 1,060. Although these variations and deviations do not conclusively indicate a clinic's efficiency, they could enable DM&S managers to identify clinics needing more analysis.

We found that (1) although DM&S had standards by which the performance of its outpatient clinics was to be assessed, clinic managers viewed these standards as outdated, simplistic, and too lenient to use for measuring their clinics' efficiency; (2) although DM&S routinely gathered and reported data on clinic

performance, clinic managers experienced problems (many of which we verified) with the data's accuracy and were unwilling to rely on the data to assess their performance; (3) DM&S' budget process and its system for evaluating medical center director performance emphasized the volume of outpatients treated and did not provide incentives for the directors to assess their clinics' performance; and (4) although regional directors were responsible for monitoring clinic performance, they were not doing so effectively.

DM&S has begun several actions to correct these problems. Staffing standards for outpatient care activities are being established. Recommendations of a DM&S task force to improve data reliability are being implemented. Finally, DM&S expects its new resource allocation system, which will be initiated for inpatient resources in fiscal year 1985 and for outpatient resources later, to provide an incentive for managers to ensure that facilities are operating efficiently.

We believe that if the new resource allocation system creates more incentives to measure and improve the efficiency of outpatient clinics, DM&S managers at all levels will need more generally accepted standards by which to judge clinic performance. Regarding data problems, we believe that DM&S has taken reasonable steps to begin to improve accuracy and reliability. Finally, we believe that DM&S' regional directors should play a more active role in monitoring clinic performance.

We recommend that you direct the Chief Medical Director to

--identify, in consultation with central office, regional, and outpatient clinic officials, performance indicators needed to measure outpatient clinic efficiency;

--establish, and update as necessary, generally accepted standards for indicators that central office and regional management officials can use to identify clinics needing management attention; and

--require that regional directors substantiate, on a clinic-by-clinic basis, the reason(s) for substantial deviations from the revised performance standards and routinely report such information to the responsible central office officials.

We have discussed our findings and conclusions with DM&S officials, who agreed with the need for improved standards, data, and monitoring. Their comments have been incorporated in the report where appropriate.

As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Director, Office of Management and Budget, as well as the Chairmen and Ranking Minority Members of the various committees and subcommittees concerned with DM&S' management of its outpatient care program. Copies will also be made available to other interested parties who request them.

Sincerely yours,

Richard L. Fogel
Director

Enclosure

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ILLUSTRATION

ABBREVIATIONS

DM&S	Department of Medicine and Surgery
FTEE	full-time equivalent employment
OIG	Office of Inspector General
VA	Veterans Administration

ENCLOSURE I

VA NEEDS A SYSTEMATIC APPROACH TO ASSESS THE MANAGEMENT OF ITS OUTPATIENT CLINICS

Our review of the management of 15 Veterans Administration (VA) outpatient clinics showed that the Department of Medicine and Surgery (DM&S) did not have performance standards that were accepted by clinic officials, accurate workload and cost data, and adequate incentives to assess the management of its clinics. Since we began our review, DM&S has announced plans to develop outpatient performance standards, improve the data, and create incentives. We believe additional steps can be taken to further improve DM&S' ability to assess the management of outpatient clinics.

ORGANIZATION OF VA'S HEALTH CARE SYSTEM

DM&S manages VA's health care system. The Chief Medical Director has jurisdiction over and is responsible for DM&S activities. The Associate Deputy Chief Medical Director is responsible for providing day-to-day operational direction to field managers. The Assistant Chief Medical Director for Professional Services recommends policies to provide a balanced array of professional services at field facilities. One of the Assistant Chief's specific responsibilities is to coordinate the efforts of all professional services in developing VA plans, policies, and professional standards for outpatient care. A deputy is responsible for providing program guidance for outpatient care.

As of July 1984 DM&S' health care system consisted of 172 medical centers--each of which operated an outpatient clinic; 53 satellite and independent clinics; 105 nursing homes; and 16 domiciliaries. The medical centers and clinics are grouped into 28 medical districts, each headed by a district director who is also a medical center director. Under DM&S' decentralized management philosophy, districts have assumed major planning responsibilities, but are not in the line of authority between the central office and the medical centers. Medical center directors are responsible for properly and efficiently managing the medical center, including controlling the use of funds and staff. They have the authority to organize and operate the medical center and to change internal procedures or workflows as dictated by local conditions or when such changes will produce improved service at the same cost or equal service at reduced cost.

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The 28 medical districts are grouped into 6 medical regions. Regional directors exercise direct-line supervision of directors of all field facilities. They are responsible for monitoring use of funds and staff and adjusting workloads and resources within their regions. They are also responsible for evaluating what VA's manual calls "operating effectiveness indicators" of field facilities, such as workloads and waiting lists, and taking corrective action as appropriate. Regional directors are responsible for ensuring that data validation procedures function effectively. They are also responsible for evaluating the performance of district directors and medical center directors.

INCREASING DEMAND FOR OUTPATIENT CARE HIGHLIGHTS NEED FOR EFFICIENT DELIVERY SYSTEMS

For fiscal year 1985, VA requested $1.7 billion for outpatient care--an increase of about $96 million, or 5.9 percent, over its estimated outpatient care expenditures in 1984. However, VA anticipates a future need for significant increases in funding resources to meet an unprecedented health care demand resulting from the aging of World War II and Korean conflict veterans.

In its July 1984 report, Caring for the Older Veteran, VA projects that between 1980 and 2000, the number of veterans who are 65 years of age or older will increase from 3 million to 9 million and that these veterans will need more of various health care services, including outpatient care. VA projects the number of outpatient visits to increase from an estimated 18.7 million in 1985 to between 25.7 and 32.7 million in 2000. Although the report does not project resource needs specifically for outpatient care, it estimates that total VA health care costs, including construction, would increase from $10.0 billion in 1985 to between $17.0 and $27.7 billion (in 1985 dollars) in 2000.

The Chairman of the House Committee on Veterans' Affairs concluded, based on a March 1983 survey of facility directors, that VA would need an extra $320 million in fiscal year 1984 to provide outpatient care to all currently eligible veterans seeking it from VA clinics. VA did not ask for any such supplemental funds. By increasing the efficiency of its outpatient clinics, VA could treat more patients with available resources without adversely affecting the quality of care.

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OBJECTIVE, SCOPE, AND METHODOLOGY

Our review objective was to determine to what extent DM&S officials at the central office, regional, and medical center levels had performance standards and reliable data to assess the efficiency of individual outpatient clinics. Specifically, we sought to determine whether

--the central office, regions, or medical centers had established productivity indicators or standards to assess clinic efficiency or the productivity of clinic physicians and other staff and

--data on clinic workload and resources were available in the system to allow DM&S to measure clinic productivity and identify possible areas for improving clinic efficiency.

During our fieldwork we interviewed central office, regional, and medical center officials and reviewed pertinent policies, guidelines, management reports (including funding and staffing requests), research projects, and other DM&S data on the outpatient care program. Our review was performed in Washington, D.C.; 4 medical districts; 3 regional offices; and the following 15 outpatient clinics:

Clinics at affiliated medical centers[1]

Atlanta, Georgia
Portland, Oregon
Tampa, Florida
West Roxbury, Massachusetts
White River Junction, Vermont

Clinics at unaffiliated medical centers

Bay Pines, Florida
Mountain Home, Tennessee
Togus, Maine
Walla Walla, Washington

[1]A VA medical center affiliated with a medical school.

Satellite clinics[2]

Ft. Myers, Florida
Orlando, Florida
Portland, Oregon
St. Petersburg, Florida
Worcester, Massachusetts

Independent clinics[3]

Boston, Massachusetts

These clinics were selected to provide a mix of facilities, considering such factors as size, affiliation status, urban or rural location, and type of clinic (medical center based, satellite, or independent). Our review at the clinics was performed between March and August 1983.

To evaluate the standards or productivity indicators by which managers assess clinic efficiency, we spoke to central office officials responsible for the management and operation of the field facilities, including officials in DM&S' Offices of Professional Services and Medical Administration Service. We also interviewed regional office officials responsible for the 15 clinics we reviewed. At each facility, we discussed these indicators with medical center and clinic managers and other officials.

To evaluate the data that managers use to assess clinic efficiency, we used fiscal year 1982 data provided by DM&S' automated management information system to analyze clinic activities. These data were the latest available at the time of our fieldwork.

One of the automated reports, Report of Medical Care Distribution Accounts--RCS: 14-4, showed total full-time equivalent employment (FTEE)[4] and costs for center outpatient programs. Because that report provided data only by medical

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[2]Clinics that are geographically separate from the medical center but administratively part of it.

[3]Clinics that are administratively independent of any medical center and report directly to a regional director.

[4]One FTEE is the equivalent of one person working 8 hours a day every workday for the fiscal year.

center or independent clinic, we asked medical center staffs, where appropriate, to allocate the data between on-site and satellite clinics. Other reports showed clinic visits,[5] prescriptions dispensed, and related workload data for on-site and satellite clinics. As discussed below, certain automated data we requested were found to be incomplete or incorrectly accumulated and had to be reconstructed for our use by medical center or clinic staff.

We also reviewed reports by VA's Office of Inspector General (OIG) to determine whether that office was using available data and standards to assess outpatient clinic performance.

Our review was conducted in accordance with generally accepted government auditing standards.

DM&S OUTPATIENT PERFORMANCE STANDARDS NOT ACCEPTED BY CLINIC OFFICIALS

DM&S has, over the years, developed performance standards for outpatient clinics. For example:

--DM&S initially staffs new clinics on the assumption that 1 FTEE will be needed for each 500 visits expected. DM&S also expects each existing clinic to incur 500 outpatient visits for each FTEE assigned.

--DM&S expects a physician using two treatment rooms to treat 5,280 patients annually and a physician using only one room to treat 4,400.

--An unpublished "rule of thumb" calls for 1 medical administration service FTEE for every 3,000 annual visits to an outpatient clinic.

Officials at the clinics we visited cited problems with the performance standards that make them unsuitable for DM&S' management system. DM&S is developing new staffing standards for its medical centers which should be more helpful in assessing clinic performance.

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[5]VA defines an outpatient visit as the presence of a patient at the clinic during a 24-hour period. A clinic stop is the presence of the patient at any specialty clinic. For example, a veteran who is treated at both the cardiology and dermatology clinics on the same day would be counted as one visit but two clinic stops.

Problems with standards

Clinic officials we talked with did not routinely use the standards that DM&S has identified as appropriate for measuring outpatient clinic efficiency because the officials generally considered the standards to be:

--Outdated. Most of the standards are over 10 years old and are considered to be unrealistic because of changing technologies and patterns of providing care. For example, radiology examinations are more sophisticated and time consuming than in the past.

--Simplistic. The standards do not take into account facility differences, such as patient mix, affiliation, location, condition and layout, and specialties offered. For example, the overall program staffing standard for outpatient care of 1 FTEE per 500 annual medical staff visits makes no distinction between affiliated and unaffiliated facilities. Also, the standard of 12,550 diagnostic X-ray examinations a year per radiologist FTEE applies to both medical center-based clinics, which conduct sophisticated X-ray procedures, and satellite clinics, which perform primarily simple X-ray procedures.

--Too lenient. Several clinic chiefs told us that the standards do not reflect efficient management. For example, one clinic chief said that the staffing standard for outpatient clinics of 1 FTEE per 500 annual medical staff visits may result in clinic overstaffing and that a ratio of 1 FTEE per 700 visits would probably be more appropriate.

Clinic officials also commented that VA's central office has no stated policy concerning the use of established standards to measure clinic efficiency. Officials cautioned that clinic performance output data cannot be used without considering the effect on quality of care. They stated also that medical centers had insufficient staff to perform analytical studies.

Our review showed that many of the clinic productivity standards are based on the judgment and experience of DM&S officials rather than work measurement studies. Central office officials consider standards for physicians and other personnel as "rules of thumb," not official standards by which clinics' performance should be measured. On the other hand, standards for radiology and laboratory services are based on data developed through studies published by professional societies.

A few clinic officials said that they compared their clinics' total visits per FTEE to the overall clinic staffing standard of 500 annual visits per FTEE in order to justify additional staffing. However, this standard may not present a valid picture of a clinic's efficiency. For example, DM&S does not distinguish between outpatient visits that routinely use substantial resources, such as care provided to cardiology patients, and those requiring few resources, such as mental health group treatment sessions. Thus, clinics with extensive mental health programs may appear more efficient than those that provide more individualized medical treatment.

Also, a clinic with more than 500 annual visits per FTEE may not necessarily be operating efficiently. For instance, one facility may schedule a patient for a number of diagnostic and therapeutic services in 1 day and receive credit for only one visit and several clinic stops. A second facility might spread the same services over several days and receive credit for several visits and the same number of clinic stops. If a clinic's efficiency were based on the number of visits, the first facility would appear less efficient than the second.

New staffing standards not yet developed for outpatient care

DM&S has been developing staffing standards[6] for most medical center activities. They are based on the current staffing and workload at the facilities, not on optimal types and numbers of personnel required to perform the tasks. These standards will be used initially as measurements of which facilities are above or below staffing requirements. They will not initially be used to determine staffing needs, but will serve as guides to show the facilities how their program or services compare with others. Areas for which new staffing guidelines are being developed include laboratory, pharmacy, radiology, dietetics, audiology and speech pathology, and nuclear medicine.

DM&S expects to develop and implement the staffing standards, which will cover about 85 percent of DM&S' payroll, by the end of fiscal year 1985. Because developing productivity guidelines for physicians is a sensitive area, DM&S has contracted for their development. These standards will not be available until some time after fiscal year 1985.

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[6]In late 1982 the term "standards" was changed to "guidelines" to show that they are subject to change.

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The staffing standards being developed apply only to inpatient activities. The Executive Assistant to the Assistant Chief Medical Director for Administration told us that most of DM&S' efforts in standards development are directed toward the inpatient area because it is labor intensive and accounts for most of DM&S' health care budget. According to him, new staffing standards for outpatient care are in the planning stage and will not be available until some time after the standards for inpatient care have been established. He added that any standards developed for inpatient or outpatient care will be guides for center directors to consider in staffing centers and clinics.

OUTPATIENT PERFORMANCE DATA ARE NOT ACCURATE

Managers at the central office, medical centers, and outpatient clinics were generally unwilling to rely on data from DM&S' automated system to assess the clinics' performance. Problems cited by these officials, many of which we verified, ranged from improper allocation of staff time between inpatient and outpatient activities to misinterpretation of data reporting instructions. DM&S is aware of these shortcomings (the OIG has identified problems with the automated system) and has several actions underway to improve the data's reliability.

DM&S does not have a system that accurately records all data relating to outpatient services. Data can be readily identified with outpatient services when physicians and staff are assigned full time to an outpatient clinic. More commonly, however, physicians and staff treat both inpatients and outpatients. In these instances, staff members estimate how much of their time is spent on each activity. Officials at some of the facilities we visited said that physicians were not concerned about administrative matters and did not attempt to allocate their time accurately between inpatient and outpatient activities.

Data reliability problems are illustrated in the following examples.

--The West Roxbury VA medical center reported 40.4 outpatient medical staff FTEE for fiscal year 1982. When we asked the West Roxbury fiscal officer to allocate this FTEE between the West Roxbury on-site and Worcester satellite clinics, he found that the reported FTEE was understated by 5.8 FTEE (12.6 percent).

--Fiscal officials at the Portland VA medical center told us that there had been a misunderstanding among clinicians in allocating FTEE and costs between inpatient and outpatient programs and that they did not believe that their cost distribution report for fiscal year 1982 accurately distributed costs between the two programs. They reconstructed the center's total FTEE and cost for outpatient care but did not have records showing how the costs should be allocated among the center's on-site clinic and two satellites (Portland and Vancouver). The allocations were later made based on input from the service chiefs.

--The Orlando satellite clinic's automated report showed 222 dermatology and 65 cardiology clinic stops during fiscal year 1982. However, medical administration service data showed the numbers of stops at these clinics were 1,500 and 2,625, respectively. The clinic chief said that he believed the automated data were erroneous due to incorrect coding entries on the patient routing sheets.

--Walla Walla's laboratory chief said that the center's automated laboratory workload summary apparently did not accurately distribute tests between inpatient and outpatient programs and the outpatient workload was understated. The reported data indicated an unrealistically wide difference in productivity between inpatient and outpatient activity, according to the chief.

--Some clinics' reports included visits to their dental units while others did not. Although data were not available to determine the number of dental visits included with outpatient visits, we believe the number could be significant. For example, we were advised that about 6 to 8 percent of the visits reported by the Tampa VA medical center on-site and Orlando satellite clinics were dental visits. Because outpatient medical FTEE and costs as reported in the cost distribution report exclude dental FTEE and cost, including dental visits with medical visits overstates visits per FTEE and understates the cost per visit.

Central office and medical center actions to improve data reliability

In February 1983, DM&S' central office established a task force to address the problems with the cost distribution report.

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Task force recommendations accepted by DM&S for implementation in fiscal years 1984 and 1985 were to

--shift data input responsibility from the fiscal units to the respective services (medical, laboratory, etc.),

--give the services responsibility for verifying the accuracy of cost allocations,

--standardize cost allocation instructions,

--have the services prepare primary data support for making cost allocations, and

--make local program managers and service chiefs more accountable for the accuracy of the reported data.

Four of the facilities we visited had started programs to improve the accuracy and reliability of their data. For example, Walla Walla's fiscal unit started a training program for service chiefs to encourage them to submit better data, make them more responsible for their data, educate them on the importance of accurate data, and improve the reliability of the cost distribution report. The fiscal unit chief said that his staff are updating the percentages used to allocate costs between the inpatient and outpatient programs. He added that the central office has had problems for years with some facilities not updating these percentages.

In addition, other facilities had implemented procedures to comply with the DM&S operating manual, which provides for a system to validate the data used in the cost distribution report and other automated reports. Officials at the Bay Pines, Tampa, and Atlanta medical centers said that they have implemented procedures to improve the accuracy of data entered into the cost distribution report and workload activity reports. Tampa is also requiring that printouts of FTEE, cost, and workload data be reconciled with source documents. DM&S has reinforced its manual through an October 26, 1983, circular which requires that field facilities establish a data validation process to review all data entered in several automated management systems.

In addition, DM&S' director of its Medical Administration Service told us that improved automated data processing capabilities at each VA medical center should increase the quantity and quality of data available to managers.

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INADEQUATE INCENTIVES FOR MEDICAL CENTER DIRECTORS TO ASSESS CLINIC EFFICIENCY

At the time of our review, DM&S' budget process and its system for establishing performance objectives for medical center directors did not contain adequate incentives for the directors or other clinic officials to assess the clinic's performance.

At that time, DM&S allocated its medical care funds among the 172 medical centers based on each center's prior year funding, adjusted for inflation and program changes. Several clinic officials told us that DM&S' budgeting process not only had no incentives for them to assess efficiency but also had disincentives for improving efficiency. One said that if a facility implemented efficiency improvements that reduced costs, its budget for the following year would probably be reduced accordingly. Another pointed out that if a clinic were able to schedule a veteran into several subspecialty clinics on one day--avoiding the travel costs associated with return visits--the clinic received credit for fewer outpatient visits.

One medical center director told us that he did not analyze visits per FTEE, cost per visit, or other common productivity indicators to assess the efficiency of the outpatient clinic. Rather, he checked how his facility's actual inpatient and outpatient workloads compared to budgeted or projected workloads. The director stated that he had not been directed and was not obligated to make outpatient care more efficient. His primary goal was to ensure that the budgeted workload was met and that costs did not exceed the facility's budget.

The specific annual performance objectives established by regional directors for medical center directors also did not create incentives to assess the clinics' efficiency. Most performance objectives for directors of facilities we visited concerned the management of resources for the facility as a whole; only a few related specifically to outpatient operations. The regional directors indicated they did not view performance objectives as particularly effective motivators to improve clinic efficiency.

Director performance objectives have been generally restated as staff performance objectives. The clinics we visited, however, had no specifically stated incentives for physicians and staff members to improve outpatient clinic efficiency.

Regarding physicians, clinic officials believe the only motivator has been "pride of service." For staff members, clinic officials believed the prospects for promotions or employee awards provided some motivation; however, the criteria for promotion and awards did not specifically include efficiency-related factors.

DM&S expects that its new resource allocation system will give facility managers incentives to become more concerned about efficiency. The system will be similar to the prospective payment system being used to reimburse nonfederal hospitals participating in the Medicare program. Beginning in fiscal year 1985, funds appropriated to VA for inpatient care will be allocated to each medical center on the basis of diagnoses associated with the facility's inpatient mix. As of September 1984 DM&S was developing a similar system for allocating resources for outpatient care.

REGIONAL DIRECTORS HAVE NOT BEEN EFFECTIVELY MONITORING OUTPATIENT CLINIC PERFORMANCE

Since at least 1968, VA regulations have directed DM&S to develop and use performance standards and measurement systems. These systems were intended to provide managers data with which to evaluate the effectiveness and economy of operations and thereby assure that personnel and other resources were effectively balanced with workload. However, regional officials responsible for the outpatient clinics we reviewed had not been routinely comparing data on the costs of outpatient services provided and the workload performance for their clinics with comparable data from other clinics or DM&S standards. As a result, DM&S has lacked a systematic means to accurately identify significant performance deviations among clinics, ascertain the reasons for deviations, and if appropriate, implement corrective action. Instead, it has relied on OIG reports to inform managers about the operations of its outpatient clinics.

Clinic costs and workloads not compared to standards or performance of similar clinics

VA's operating manual provides that internal management review programs should include analytical and appraisal techniques that measure workload performance data against standards. To assist in the analyses and appraisals, VA routinely collects and distributes data which regional directors could, but often do not, use to assess the performance against the standards established by DM&S for its outpatient clinics.

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As shown in the following chart, data we collected at the 15 clinics indicate wide variations in performance and large deviations from the DM&S standards. Although these variations and deviations do not conclusively indicate how efficiently a clinic is operating, they could enable regional directors to identify clinics where additional analysis of efficiency should be performed.

Variations From DM&S Performance Standards at 15 VA Clinics Visited

Performance indicator	VA standard	Average for 15 clinics	Range for 15 clinics
Visits per FTEE	500	495	315-1,060
Clinic stops per physician FTEE	4,000-5,000	3,084	1,213-6,928
Stops per treatment room	4,400-5,280	2,805	1,111-6,051
Outpatient prescriptions dispensed per pharmacist FTEE	(affiliated, 12,000) (unaffiliated, 19,000)	45,427	21,366-119,583
Outpatient radiology diagnostic exams per radiology FTEE	(affiliated, 7,530) (unaffiliated, 12,550)	10,310[a]	7,650-18,806
Outpatient laboratory tests per laboratory FTEE	94,000	93,600	21,521-173,026
Visits per medical administration service FTEE	3,000	2,324	1,201-4,073

[a]Includes data for only 14 clinics.

DM&S has divided 164 of its 172 medical centers into 13 groups, based on 20 characteristics, including veteran population served, workload, and degree of affiliation. DM&S produces a special cost distribution report for each group; therefore, regional directors could also compare some indicators of the clinics' performance to other clinics in each group. We found, however, that none of the regional directors and only one clinic we visited had used this special cost distribution report to compare clinics' performance and identify potential efficiency problems.

OIG reports have led to improved clinic efficiency

Several OIG reports issued during the period covered by our review identified outpatient clinics where the patient workload did not justify the staffing, based on VA staffing standards. Implementing the reports' recommendations resulted in improved clinic efficiency.

Examples of clinic overstaffing and other problems cited in the reports are as follows.

--In an August 1982 report on the Cleveland, Ohio, medical center and the Canton satellite clinic, the OIG reported that, based on central office guidelines, the satellite clinic was overstaffed by 15 FTEE. The OIG recommended that the clinic's FTEE be reduced, for an estimated annual cost avoidance of $520,000. The medical center director concurred and, according to the OIG, the clinic's FTEE was reduced by 14.0; 1.0 FTEE was justified.

--In a November 1982 report on the East Orange, New Jersey, medical center and the Newark outpatient clinic, the OIG found that clinic examination rooms were used an average of 49 percent of the time available. The OIG noted that by consolidating the on-site and Newark satellite clinics and making some renovations, the average utilization rate of the medical center's clinic examination rooms would increase to 66 percent with peaks of 79 percent on 2 workdays each month. The medical center director agreed that the consolidation of medical center operations would be beneficial, but did not agree with the OIG's suggested consolidation plan. According to the OIG, DM&S officials visited the East Orange VA medical center and also recommended that the clinics be consolidated. The center has submitted a proposed construction project with a fiscal year 1987 funding target to implement the recommendation.

--In a July 1982 report on the Santa Barbara clinic--a satellite clinic of the West Los Angeles, California, medical center--the OIG found actual workload much lower than reported. The auditors found that the 21,895 clinic visits reported by VA's automated system for fiscal year 1981 were overstated by 10,429, or about 48 percent. The reporting error occurred because many clinic visits were counted twice--both as initial visits and as visits for service-connected or non-service-connected conditions.

The OIG noted that clinic workload could increase and recommended that DM&S closely monitor the clinic's activities and workload and that if the projected workload did not increase, the clinic be closed. The OIG said that in June 1984 DM&S reported that the clinic's annual workload was about 28,000 annual visits; DM&S expects it to be about 30,000 annual visits by June 1985.

CONCLUSIONS

VA has indicated that it will need much greater resources to meet veterans' expected health demands. Before the Congress provides funds for additional outpatient resources to meet increasing demand, we believe that DM&S should demonstrate that it is efficiently using its resources. Currently, because DM&S lacks a systematic approach to assess the management of its outpatient clinics, it cannot, in our opinion, determine whether its clinics are operating at an acceptable degree of efficiency.

The problems we identified with DM&S' performance standards and data, in addition to the lack of incentives, have inhibited managers' ability to monitor and assess clinic efficiency. We believe that DM&S' plans to implement revised outpatient standards, increase emphasis on data reliability, and institute a new resource allocation system should improve medical center directors' ability to assess their clinics' efficiency. However, we believe that DM&S should take additional steps to ensure that its clinics are operating efficiently.

First, DM&S should ensure that the performance indicators by which clinic performance should be judged are acceptable to the managers responsible for the clinics' efficiency--the clinic officials, medical center directors, and regional directors--so that they are more likely to be used at the clinics to measure efficiency. Second, DM&S should ensure that the standards applied to these indicators are reasonable and are updated as necessary. In this regard, DM&S may wish to either use standards developed for military or nonfederal clinics or develop them in house. Finally, DM&S should recognize that regional directors are in the best position to ensure that medical center directors are assessing their clinics' performance. DM&S should hold regional directors responsible for ensuring that any substantial variation from a performance standard is identified, the reasons for the variation are determined, and action is taken to correct problems.

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On October 16, 1984, we discussed a draft of this report with DM&S' Deputy Assistant Chief Medical Director for Professional Services, Director of Medical Administration, Director of Resource Management, and other VA officials. They generally agreed with our findings and recommendations.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator direct the Chief Medical Director to

- --identify, in consultation with central office, regional, and outpatient clinic officials, performance indicators needed to measure outpatient clinic efficiency;
- --establish, and update as necessary, generally accepted standards for indicators that central office and regional management officials can use to identify clinics needing management attention; and
- --require that regional directors substantiate, on a clinic-by-clinic basis, the reason(s) for substantial deviations from the revised performance standards and routinely report such information to the responsible central office officials.