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VA HEALTH CARE

VA's Efforts to Maintain Services for Veterans With Special Disabilities

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VA Health Care: VA's Efforts to Maintain Services for Veterans With Special Disabilities

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to be with you today to discuss our ongoing work on the Department of Veterans Affairs' (VA) efforts to comply with section 104 of the Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262, Oct. 9, 1996). This provision reflects concerns that budgetary pressures and ongoing reorganization within VA might make VA's specialized programs and services for disabled veterans vulnerable to cost cutting. The provision requires the Secretary of VA to (1) ensure that the systemwide capacity of the department to provide specialized treatment and rehabilitative services is not reduced below its October 1996 capacity and (2) provide veterans with reasonable access to such needed care and services. The provision identified four disabling conditions; VA, after consulting with stakeholders, identified two additional conditions.[1] Further, VA is required to report to the House and Senate Committees on Veterans' Affairs annually on its compliance with section 104 from fiscal years 1997 through 1999.

You asked that I focus my remarks on whether VA (1) is maintaining capacity with reasonable access to specialized care and (2) has data that are sufficiently reliable to monitor and report on compliance. My comments are based on meetings we have held with VA officials responsible for administering the special disability programs, officials of veteran service organizations (VSO) that represent the veterans receiving specialized care, and representatives of two advisory committees with which VA is required to consult in responding to this legislation.[2] We are also reviewing VA and advisory committee reports, relevant policies and manuals, and other data and documentation. We will be continuing our work over the next several months and expect to issue a report next spring.

In summary, our work to date suggests that much more information and analyses are needed to support VA's conclusion that it is maintaining its national capacity to treat special disability groups. For example, while VA's data indicate that from fiscal year 1996 to fiscal year 1997, the number of veterans served increased by 6,000 (or 2 percent), the data also show that spending for specialized disability programs decreased by $52 million (or 2

[1]The four conditions identified in the statute are spinal cord dysfunction, blindness, amputations, and mental illness. VA limited its program for mental illness to veterans with serious mental illness and added two other conditions—traumatic brain injury and post-traumatic stress disorder (PTSD).

[2]The two committees are the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

percent). VA attributes the decreased spending to reducing unnecessary duplicative services and replacing more expensive hospital inpatient treatment with outpatient care. Such aggregate data and assertions may, however, mask potential adverse effects on specific programs and locations. For example, VA data also show that the number of veterans treated systemwide in fiscal year 1997 decreased for amputees, and expenditures were reduced for veterans with amputations, serious mental illness, and PTSD. In addition, for substance abuse patients with serious mental illness, VA data show that about 3,000 fewer veterans were served and $112 million less was spent.

Consistent with the Government Performance and Results Act (GPRA) of 1993,[3] VA plans to develop outcome measures over the next 2 to 3 years to track whether, among other things, the care provided to disabled veterans is effective as a result of its shift from inpatient to outpatient care. VA intends to replace expenditure data with outcome measures when they become available. While outcome measures are a valuable tool to evaluate program effectiveness and to help monitor physical, psychological, and social services, retaining current measures, such as dollars spent serving VA's special needs population, is also important to measure legislative compliance.

Beyond the issue of how VA chooses to measure its capacity to serve veterans with special disabilities, there are also questions regarding the reliability of VA's data. For example, in 1998, VA reduced its reported 1996 baseline expenditure data in all six specialized programs and services by as much as 50 percent without explaining in its report the basis for such changes. VA's two advisory committees have also raised questions about anomalies in the capacity data. VA has acknowledged the need to improve its data systems and has several efforts under way to do so. We will be examining data reliability issues in more detail as we complete our study.

Background

VA has taken steps to fundamentally change the way it delivers health care to the nation's veterans. In recent years—and consistent with major changes in the national health care industry—VA has moved toward providing more services to veterans on an outpatient basis. Also, VA's Veterans Integrated Service Networks (VISN) have greater discretion for determining the mix of services to be provided. In House Report 104-690, which accompanied the Veterans Health Care Eligibility Reform Act of

[3]GPRA requires agencies to prepare annual performance plans covering program activities set out in their budgets beginning in fiscal year 1999.

1996, considerable discretion is given to the Secretary of VA in managing the provision of health care services to veterans. However, the report pointed out that the uniqueness of VA's specialized treatment programs requires a far more prescriptive response in the legislation. The report noted that providing specialized treatment and rehabilitative services is vital to VA's health care mission. Due to the recognized high cost of these programs, budgetary pressures, and restructuring within the Veterans Health Administration (VHA),[4] the House Committee on Veterans' Affairs was concerned that "VA's costly specialized programs may be particularly vulnerable and disproportionately subject to budget cutting."

To address these concerns, a provision of the act directed the Secretary to ensure that VA maintain its capacity to serve veterans with special disabilities. This provision also requires VA to consult with the Advisory Committee on Prosthetics and Special Disabilities Programs (ACPSDP) and the Committee on the Care of Severely Chronically Mentally Ill (CCSCMI) Veterans in fulfilling the requirements of the act.[5] Primarily, ACPSDP advises the Secretary on issues affecting the delivery of prosthetic services to amputees and other special disability groups. The mission of CCSCMI Veterans is to assess VA's efforts to meet the treatment and rehabilitation needs of severely and chronically mentally ill veterans. VA coordinated with the committee and incorporated its input on the care of seriously mentally ill veterans. In addition, both committees worked with VA to identify the six special disability groups and to define measures of capacity and access. VA also established a Special Disability Programs Work Group to work with a number of stakeholders—including national and state VSOs, VHA networks and facilities, and special disability program managers—on issues such as identification of the six special disability groups, their definitions, and definitions of capacity and access.

While consensus was not reached among stakeholders, VA established an initial set of 1996 baseline capacity measures consisting of the number of veterans served and dollars spent on veterans with these specialized needs. For veterans disabled by blindness and spinal cord dysfunction, capacity is also measured by the number of specialized beds and staff resources dedicated to these disabilities. VA defines access as timeliness in

[4]VHA has decentralized its management structure to coordinate the organization of its medical facilities into 22 networks. This was done in an effort to improve efficiency by reducing unnecessarily duplicative services and shifting services from inpatient care to less costly outpatient care.

[5]ACPSDP members are from veteran service organizations, universities, and private sector health care providers. In accordance with P.L. 104-262, members of CCSCMI Veterans must be VHA employees with expertise in the care of the chronically mentally ill and be appointed by VA's Under Secretary for Health.

providing services to veterans for their specialized needs. VA is currently developing outcome measures to reflect the overall effectiveness of its programs.

Unclear If VA Has Maintained Capacity and Access to Specialized Services

VA's data show that from fiscal year 1996 to fiscal year 1997, there was an increase in the number of disabled veterans served—despite an overall decrease in dollars expended for the six programs and conditions. Overall, 2 percent—or about 6,000—additional veterans were served with 2 percent—or $52 million—less spending. VA's data also indicate that access improved nationally for most programs.

For five of the six programs and conditions, VA served more disabled veterans in fiscal year 1997 than it did in 1996 for a total increase of about 6,000 more disabled veterans served. Only in the amputee program was there a reduction in the number of veterans served—approximately 2 percent. Three of the six programs had higher expenditures during the same time period. The traumatic brain injury, blindness, and spinal cord injury programs experienced 68, 24, and 3 percent increases, respectively, in expenditures, although they served many fewer veterans than programs for mental conditions. (See table 1.)

Table 1: Percent Change in Number of Veterans Served and Dollars Spent From Fiscal Years 1996 to 1997

	Individuals served			Dollars expended (thousands)		
Program/condition	**FY 1996**	**FY 1997**	**Percent change**	**FY 1996**	**FY 1997**	**Percent change**
Spinal cord injury	8,598	8,922	4	$199,848	$206,228	3
Blindness	9,726	11,726	21	43,855	54,426	24
Traumatic brain injury	175	251	43	3,735	6,271	68
Amputations	4,765	4,684	–2	5,953	5,856	–2
Serious mental illness	269,009	272,229	1	2,080,240	2,015,642	–3
PTSD	39,653	40,027	1	101,882	95,223	–7
Total	**331,926**	**337,839**	**2**	**$2,435,513**	**$2,383,646**	**–2**

Note: We did not independently verify these numbers.

Source: VA Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans (Department of Veterans Affairs, May 1998).

Much of the change in expenditures involved veterans with serious mental illness, who in fiscal year 1997 accounted for 81 percent of the veterans served and 85 percent of expenditures for the six specialized programs

and conditions. VA data indicate that it provided services to an additional 3,000 seriously mentally ill veterans, while it reduced spending by about $65 million. VA attributes these changes to efficiencies gained from shifting the treatment emphasis from inpatient to outpatient care. It is unclear, however, whether VA's data are comprehensive enough to quantify the effect on capacity of changes in service delivery methods. Moreover, other data not used by VA, such as numbers and types of specialist providers and beds, may also be useful indicators of capacity.

Substance abuse services for veterans with serious mental illness illustrate the need for more comprehensive information to assess whether capacity is being maintained. For example, from fiscal years 1996 to 1997, substance abuse expenditures declined by 20 percent, or over $112 million, and VA treated about 3,000 fewer veterans with this condition. (See table 2.) Some VA networks believe that such numbers give an incomplete picture of actual services rendered because patients who are "mainstreamed" into general care programs may be receiving care outside the special programs. While improved efficiencies can account for some expenditure reductions, they do not appear to explain the large regional drops and variations in the number of patients served. In fact, it seems reasonable to expect that a shift to less costly outpatient delivery modes should result in significant increases in the number of patients treated for the same expenditures.

Table 2: Percent Change in Number of Veterans Served and Dollars Spent for Seriously Mentally Ill Programs From Fiscal Years 1996 to 1997

Program for seriously mentally ill	FY 1996	FY 1997	Actual change (percent change)	FY 1996	FY 1997	Actual change (percent change)
Substance abuse	107,074	104,441	–2,633 (–2)	$575,902	$463,372	$-112,530 (–20)
Homeless	24,539	24,613	74 (0)	75,071	72,765	–2,306 (–3)
PTSD	32,142	32,575	433 (1)	99,705	92,667	–7,038 (–7)
Other[a]	105,254	115,600	10,346 (10)	1,329,562	1,386,838	57,276 (4)
Total	**269,009**	**272,229**	**3,220 (1)**	**$2,080,240**	**$2,015,642**	**$-64,598 (–3)**

Note: We did not independently verify these numbers.

[a]These are veterans who currently have or at any time during the past year had a diagnosed mental, behavioral, or emotional disorder of sufficient duration to result in a disability, excluding those who have PTSD or substance abuse problems or are homeless.

Source: VA Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans.

With regard to reasonable access to care and services, VA's data indicate that access has improved for five of the six special disability programs. (See app. I.) For example, VA's data indicates that the proportion of veterans receiving psychiatric outpatient care within 30 days of hospital discharge increased by 0.6 percent in fiscal year 1997. This increase was accompanied by a 2-day average decrease in the number of days from discharge to the first outpatient visit. In contrast, monthly waiting times for admission to the inpatient blind rehabilitation program increased by 1 to 8 weeks for 11 months of the year. VA attributes increased waiting times, in part, to delays in filling vacant positions and increased demand for services.

VA is currently developing outcome measures to track the quality and effectiveness of care provided to disabled veterans. Outcome measures, such as functional status, provide an opportunity to examine the effectiveness of innovations in service delivery, which could lead to a higher degree of patient satisfaction. Outcome assessments also provide benchmarks for goal setting and facilitate comparisons among programs and facilities from year to year. Although VA has identified preliminary outcome measures for each special disability program, it estimates that 2

to 3 years will be required to fully develop and collect data to include outcome measures in its monitoring system. (See app. II.)

As it did in its first two reports to the Congress, VA plans to use individuals served and the dollars expended for their care as its measure of capacity in its final report in 1999. However, when outcome measures are developed, VA plans to measure capacity using them and only the number of individuals treated in specialized units. While VA will continue to collect information on costs and expenditures for special disability programs, this information will not be used to measure capacity.

More Reliable Information Needed

VA is working to develop more reliable information on its special disability programs.[6] However, we and others are concerned about the reliability of VA's data and VA efforts to improve it. For example, VA used different 1996 baseline capacity data in its 1997 and 1998 reports to the Congress. (See app. III.) VA reduced all baseline program expenditure figures in its 1998 report, with changes ranging from a high of $56.5 million to a low of $300,000. While VA attributed these changes to data refinement, it did not provide any specifics in its reports as to what prompted such refinements.

Baseline expenditures for the amputee program—which VA reduced about 50 percent ($5.8 million) in the 1998 capacity report—illustrate potential problems with VA's data. According to VA officials, the reduction occurred because the 1997 report inadvertently included in the amputations workload the amputations of toes other than the great toe, which is considered more likely to lead to a disabling condition than other toe amputations. It seems questionable, however, that this would result in baseline expenditure reductions of 50 percent in each VISN and all facilities, as VA reported.

VA's two advisory committees have also questioned the accuracy of VA's data. CCSCMI Veterans (comprised of VA employees) indicated that data problems hampered its ability to evaluate VA's capacity to treat seriously mentally ill veterans and that it is using other sources of data to aid in its assessment of capacity. ACPSDP did not endorse VA's 1998 report to the Congress because it believed the costs were questionable and raised concerns as to the overall accuracy of the report. They noted that one facility showed more than a 100-percent increase in (or 156) individuals

[6]Specifically, VA developed a methodology for identifying special disability program patients from existing registries and in some instances, created new registries. Additionally, workloads were defined using diagnostic and clinical procedure codes. Program costs for specialized inpatient and outpatient care are identified using VA's cost distribution report.

treated for blindness from fiscal years 1996 to 1997, with an increase of over $2.3 million in expenditures—from $66,000 to $2.4 million—or 3,500 percent. VA has been unable to explain the increase in expenditures.

As VA strives to measure compliance with the requirements of section 104 of the Veterans Health Care Eligibility Reform Act, it needs to develop more comprehensive data and improve the reliability of existing information. VA acknowledges the need to improve its information systems and has several initiatives under way. We will continue to assess these efforts as we complete our study.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you or other members of the Subcommittee may have.

VA's Access Measures for Special Disability Programs

Spinal Cord Injury—Acute Care

Measure	Waiting time for transfer of patients to spinal cord injury center.
Goal	All patients requiring acute care receive same-day transfers to a spinal cord injury center.
Performance	In fiscal year 1996, 41 percent of VISNs met the goal; in fiscal year 1997, 91 percent met the goal.

Spinal Cord Injury—Semiurgent Care

Measure	Waiting time for transfer of patients requiring semiurgent care to spinal cord injury center.
Goal	All patients requiring semiurgent care receive transfer within 2 weeks of referral.
Performance	In July 1997—the period for which data were available—89 percent of transfers occurred within 2 weeks.

Spinal Cord Injury—Outpatient Care

Measure	Waiting time for an appointment for outpatient care.

Goal	All patients requiring outpatient care receive an appointment within 7 days of referral to a spinal cord injury center.
Performance	In fiscal year 1996, 87 percent of VISNs met the goal; in fiscal year 1997, all met the goal.

Blindness

Measure	Waiting time for admission to VA inpatient blind rehabilitation program.
Goal	None specified.
Performance	In fiscal year 1997, monthly waiting times (1) averaged 27 to 34 weeks and (2) increased in 11 of 12 months over fiscal year 1996 waiting times.

Traumatic Brain Injury—Inpatient Care

Measure	Waiting time for admission to a designated traumatic brain injury bed.
Goal	None specified.
Performance	In fiscal year 1997, waiting times for inpatient care (1) ranged from 1 to 5 days and (2) improved over fiscal year 1996 performance in 12 of 14 VISNs with traumatic brain injury programs.

Traumatic Brain Injury—Outpatient Care

Measure	The number of days to obtain first appointment after discharge with a rehabilitation professional team member in the rehabilitation clinic.

Goal	None specified.
Performance	In fiscal year 1997, waiting times for outpatient care (1) ranged from 1 to 14 days and (2) improved over fiscal year 1996 performance in eight VISNs that had outpatient programs in 1997.

Amputations (Prosthetics)

Measure	Percentage of prosthetic orders that are delayed—that is, not processed within 5 work days because of incomplete management or administrative action.
Goal	Delays should not be in excess of 2 percent of total orders (workload).
Performance	In fiscal year 1996, 1.3 percent of all orders were delayed; in 1997, delays were 0.7 percent of orders.

Seriously Mentally Ill

Measures	(1) Percentage of patients receiving outpatient visits for primary disorder within 30 days after discharge. (2) The days elapsed between discharge and the first outpatient visit in the 6 months after discharge.
Goal	None specified.
Performance	(1) The percentage of seriously mentally ill patients who received outpatient care within 30 days of discharge increased from 52.1 percent in 1996 to 52.7 percent in fiscal year 1997—an increase of 0.6 percent. (2) In fiscal year 1997, seriously mentally ill patients experienced a 2-day decrease in the number of days from discharge to the first outpatient visit.

Post-Traumatic Stress Disorder

Measures	(1) Percentage of patients receiving outpatient visits for the primary disorder within 30 days after discharge. (2) The days elapsed between discharge and the first outpatient visit in the 6 months after discharge.
Goal	None specified.
Performance	(1) The proportion of PTSD patients receiving outpatient care increased 1.6 percent in 1997. (2) Days elapsed from discharge to the first outpatient visit decreased about 2 days.

Selected Outcome Measures by Special Disability Program

Special disability program	Description of outcome measure[a]	Status
Spinal cord dysfunction	Patient satisfaction survey	Implemented
	Assessment of functional status	Under development
	Discharge to community living	Under development
Blindness	Patient satisfaction survey	Implemented
	Rehabilitation outcome survey	Testing instruments
Traumatic brain injury	Assessment of functional status[b] (percent of first-admission traumatic brain injury patients discharged from traumatic brain injury network, and acute medical rehabilitation beds to the community)	Testing instruments
Amputations	Assessment of functional status (such as percent of lower extremity amputee patients discharged from inpatient rehabilitation units to community setting)	Under development
Seriously mentally ill	Assessment of functional status (such as comparing early and late global assessment of functioning (GAF)[c] scores for each individual during the year or comparing FY 1997 and FY 1998 scores, if only one is available)	Some are implemented, others are under development; software to capture functional status data estimated to be completed by early FY 1999
PTSD	Assessment of functional status (GAF scores and data such as percent of veterans scoring equal or better in PTSD symptoms 4 months after discharge)	Some are implemented, others are under development; software to capture functional status data estimated to be completed by early FY 1999

[a]VA reports that outcome measures will also facilitate comparisons among programs and facilities from year to year to assess the progress of special disability programs in meeting goals of quality care. Two to 3 years will be required to fully develop and collect data for all outcome measures.

[b]The Uniform Data System for Medical Rehabilitation criteria separate placement outcomes into categories such as community, long-term care, return to acute facility, and other. These categories are determined through functional assessment—the percent of patients maintaining cognitive and physical functional gain at 3- and 12-month follow-up.

[c]GAF rates a client's overall functioning, including psychological, social, and occupational rating.

Sources: VA's Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans, and several of VA's preliminary program reports on outcome measures.

Reductions in Fiscal Year 1996 Baseline Expenditure Data for VA Specialized Services

Special disability program	Baseline used in May 1997 report (millions)	Baseline used in May 1998 report (millions)	Actual differences in baseline (percentage differences)
Spinal cord dysfunction	$211.2	$199.8	$11.4 (5)
Blindness	48.0	43.9	4.1 (9)
Traumatic brain injury	4.0	3.7	0.3 (8)
Amputation	11.8	6.0	5.8 (49)
Seriously mentally ill	2,136.7	2,080.2	56.5 (3)
Substance abuse	597.3	575.9	21.4 (4)
Homeless	79.1	75.0	4.1 (5)
PTSD (seriously mentally ill only)	100.8	99.7	1.1 (1)
PTSD	103.0	101.9	1.1 (1)

Source: VA Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans.

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