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Report to the Chairman, Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, Committee on Government Reform, House of Representatives

December 2002

MANAGING FOR RESULTS

Efforts to Strengthen the Link Between Resources and Results at the Veterans Health Administration

GAO-03-10

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-03-10, a report to the Chairman, Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, Committee on Government Reform, U.S. House of Representatives

Why GAO Did This Study

Encouraging a clearer and closer link between budgeting and planning is essential to improving federal management and instilling a greater focus on results. Through work at various levels within the organization, this report on the Veterans Health Administration (VHA)—and its two companion studies on the Administration on Children and Families (GAO-03-09) and the Nuclear Regulatory Commission (GAO-03-258)—documents (1) what managers considered successful efforts at creating linkages between planning and performance information to influence resource choices and (2) the challenges managers face in creating these linkages.

What GAO Found

VHA's budget formulation and planning processes are centrally managed, but are not closely linked. Resource distribution to VHA's health care networks is mostly formulaic, determined primarily by the distribution of the veterans being served. VHA offices involved in budget formulation and strategic planning provide guidance to health care networks in developing their financial and strategic plans.

Integrating performance information into resource allocation decisions is apparent at the health care network level during budget execution. Health care network managers told us that they use an internal data system as a tool to decide how to allocate resources to their facilities and programs. They also use various communication methods to share information on performance measures, and are held responsible for meeting those measures.

Network managers provided specific examples where performance information influenced their resource allocation decisions. For example, one performance target specifies that all diabetic veterans are expected to receive retinal eye exams. An ophthalmologist must interpret the results of such an exam; however, most outpatient clinics do not have the resources to maintain an ophthalmologist on staff. One network invested in machines that record test results and transmit them to an ophthalmologist at another location, thereby increasing the network's capacity for meeting this performance target.

While budget and performance integration has improved, VHA managers still face additional challenges. VHA's budgeting and planning processes are not directly linked, but VHA officials noted that steps are being taken to better integrate them. Also, VHA does not use the most complete information available when making resource allocation decisions to its health care networks, so the link between resources and results could be improved.

www.gao.gov/cgi-bin/getrpt?GAO-03-10.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Paul Posner at (202) 512-9573 or PosnerP@gao.gov.

Contents

Abbreviations

CBOC	Community Based Outpatient Clinic
CEO	Chief Executive Officer
CFO	Chief Financial Officer
COO	Chief Operating Officer
DSS	Decision Support System
ELC	Executive Leadership Council
GPRA	Government Performance and Results Act of 1993
MCCF	Medical Care Collections Fund
NCA	National Cemetery Administration
OMB	Office of Management and Budget
OPP	Office of Policy and Planning
OQP	Office of Quality and Performance
PART	Program Assessment Rating Tool
PMWG	Performance Management Work Group
PSL	Patient Service Line
QMO	Quality Management Officer
TSPQ	Transforming Systems Performance & Quality Council
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VERA	Veterans Equitable Resource Allocation system
VHA	Veterans Health Administration

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Accountability * Integrity * Reliability

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

December 10, 2002

The Honorable Stephen Horn
Chairman, Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations
Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

During the past decade, the Congress and the executive branch have sought to improve federal management and instill a greater focus on results. Through enactment of a number of major management reforms, the Congress has created a statutory framework with the Government Performance and Results Act of 1993 (GPRA) as its centerpiece.[1] One of GPRA's major purposes is to encourage a closer and clearer linkage between planning, performance—i.e., results—and the budget process. Each administration takes a slightly different approach to implementing results management. Improving the integration of budget and performance is a high priority initiative included in the President's Management Agenda.[2] A central piece of that is the Office of Management and Budget's (OMB's) new diagnostic tool, the Program Assessment Rating Tool (PART). PART is designed to provide a consistent approach to reviewing program design, planning, and goals development as well as program management and results. OMB expects to use PART assessments in considering department and agency budget submissions for the fiscal year 2004 President's Budget request to the Congress.[3]

[1]Other significant legislation includes the Chief Financial Officers Act of 1990 (CFO Act) and related legislation, which created a structure for the management and reporting of the government's finances; and the Clinger-Cohen Act of 1996 and Paperwork Reduction Act of 1995, which required agencies to take an orderly, planned approach to their information technology needs.

[2]The President's Management Agenda, which by focusing on 14 targeted areas—5 governmentwide goals and 9 program initiatives—seeks to improve the management and performance of the federal government.

[3]Office of Management and Budget, *Program Performance Assessments for the FY 2004 Budget*, M-02-10 (Washington, D.C.: July 16, 2002).

In a number of different reports to the Congress, GAO has examined different aspects of the resources-to-results linkage. A series of three reports described agencies' progress over a 4-year period in linking performance plans, budgets, and, in the most recent report, financial statements.[4] We found that between fiscal years 1999 and 2002, agencies made significant progress in showing a direct link between expected performance and requested program activity funding levels through structural changes or cross-walks—the first step in defining the performance consequences of budgetary decisions. We concluded that additional effort was needed to more clearly describe the relationship between performance expectations, requested funding, and consumed resources. Furthermore, we said that the uneven extent and pace of developing these relationships were reflective of mission complexity and differences in operating environments across the government. Finally, we observed that describing the planned and actual use of resources in terms of measurable results was an essential long-term effort that would take time, and adaptation on the part of all agencies.

In another approach to defining performance and resource integration, we developed a framework of budget practices that we believe can contribute to an agency's capacity to manage for results.[5] We viewed these practices as desirable dimensions of budgeting that could be implemented in many different ways to reflect the characteristics and circumstances of a particular agency. Both our assessments of performance and budget account alignments and the framework of budget practices have led to the next phase of work and the subject of this report. This report—one of a group of three—looks at the resources-to-results link from the perspective of agency managers charged with making the linkage happen.

The objectives of this report on the Veterans Health Administration (VHA), and its two companion studies on the Administration for Children and Families and the Nuclear Regulatory Commission, are to document what

[4]U.S. General Accounting Office, *Performance Budgeting: Initial Experiences under the Results Act in Linking Plans with Budgets*, GAO-AIMD/GGD-99-67 (Washington, D.C.: Apr. 12, 1999); U.S. General Accounting Office, *Performance Budgeting: Fiscal Year 2000 Progress in Linking Plans with Budgets*, GAO-AIMD-99-239R (Washington, D.C.: July 30, 1999); and U.S. General Accounting Office, *Managing for Results: Agency Progress in Linking Performance Plans with Budgets and Financial Statements*, GAO-02-236 (Washington, D.C.: Jan. 4, 2002).

[5]U.S. General Accounting Office, *Results-Oriented Budget Practices in Federal Agencies*, GAO-01-1084SP (Washington, D.C.: August 2001).

managers in these three agencies considered successful efforts at creating linkages between planning and performance information to influence resource choices and the challenges they face in doing so. We neither evaluated their choices nor critiqued their processes. Instead, we asked managers to describe when and how planning and performance information was included in the budget cycle, to explain what strategies were used and why, and to provide evidence that there was a related programmatic effect. A third purpose was to show that there are multiple ways to get at these linkages, and that there can be successful applications even if progress in budget and performance integration is uneven.

Budgeting is and will remain an exercise in political choice, in which performance can be one, but not necessarily the only, factor underlying decisions. However, efforts to infuse performance information into resource allocation decisions can more explicitly inform budget discussions and focus them—both in the Congress and in agencies—on expected results, rather than on inputs. We believe that showcasing agencies' successes with and challenges in integrating budgeting and planning may prove useful to other agencies; congressional authorizing, appropriation, and oversight committees; and OMB in the shared goal of strengthening the link between program performance and resources.

Results in Brief

VHA's budget formulation and planning processes are centrally managed but are not closely linked. Through fiscal year 2003, VHA's budget was prepared centrally and reflected an incremental approach, primarily taking prior years' appropriations and making some adjustments for projected increases in workload, efficiency, and new policies. Resource distribution from central office to VHA's 21 health care networks is mostly formulaic, determined primarily by the distribution of the veterans being served. Planning documents, used in the development of performance measures, show relationships between agency goals, outcome measures, and performance targets. VHA offices involved in budget formulation and strategic planning provide guidance to health care networks in developing their financial and strategic plans. Budgeting and performance are more closely associated at health care networks during the budget execution phase, that is, after VHA receives its appropriation and the funds are allotted to the networks.

Integrating performance information into resource allocation decisions during budget execution is apparent at the two health care networks we visited. Managers at these networks told us that they use an internal data

system as a tool to make resource allocations to their health care facilities and programs. They also use various communication methods to share information on performance measures and are held responsible for meeting those measures. The managers provided specific examples where they used performance information to make resource allocation decisions.

Although budget and performance integration has improved, managers still face additional challenges. VHA's budgeting and planning processes are not directly linked, but VHA officials noted that steps are being taken to better integrate them. Also, VHA does not use the most complete information available to make its resource allocation decisions from central office to its networks.

In commenting on our draft report, the Department of Veterans Affairs (VA) agreed with our observations but stated that our report does not give the reader an adequate grasp of the depth and breadth of managing such a large health care system. Our review focused on VHA's efforts to create linkages between planning and performance information to influence resource choices, and was not intended to address all the complexities inherent in managing the entire VA health care system.

Background

VHA, an administration of VA,[6] is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through an integrated health care system. Headed by the Under Secretary for Health, VHA employed approximately 180,000 health care professionals to serve about 4.3 million veterans in fiscal year 2002. VHA's fiscal year 2002 budget included $21.3 billion in discretionary funds from the VA/HUD (Department of Housing and Urban Development) appropriations act and an additional $142 million from an emergency supplemental enacted in August 2002.

VHA developed its six strategic goals to support VA's GPRA goals. These strategic goals are as follows:

- put quality first until first in quality;
- provide easy access to medical knowledge, expertise, and care;

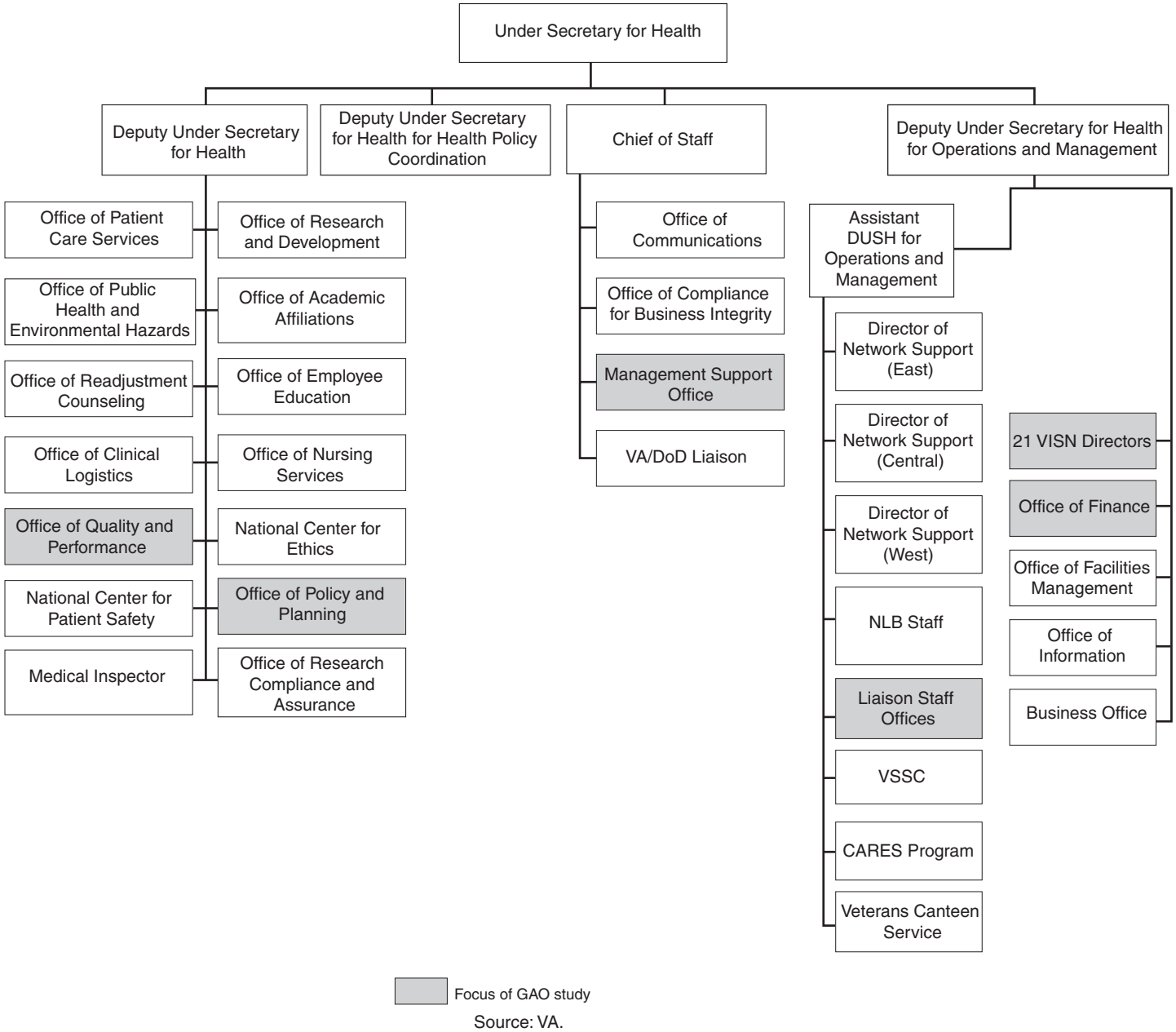
[6]VA includes three administrations: VHA, Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA).

- enhance, preserve, and restore patient function;
- exceed patients' expectations;
- maximize resource use to benefit veterans; and
- build healthy communities.

VHA's strategic planning document describes strategies to show how each goal will be met. The administration then develops performance measures to support the strategies identified.

VHA is headquartered in Washington, D.C. and has 21 Veteran Integrated Service Networks (networks) located throughout the country. The networks are the basic budgetary and decision-making units of VA's health care system. They have responsibility for making a wide range of decisions about health care delivery options, including contracting with private providers for health care services and generating revenue by selling excess services. A network director, who reports to the Deputy Under Secretary for Health for Operations and Management, heads each network. This organization is illustrated in figure 1, with offices we talked to regarding VHA's budget and planning processes shaded.

Figure 1: Veterans Health Administration Organizational Chart



Source: VA.

The VHA Office of Quality and Performance develops and recommends performance measures (mentioned above) to the Under Secretary for Health. A Performance Management Work Group, comprised of a variety of VHA staff with different subject matter expertise, provides overall guidance with regard to the measures and helps to prioritize them. VHA's Office of Policy and Planning prepares VHA's contribution to VA's 5-year Strategic Plan, as well as the Network Strategic Planning Guidance, which is used by networks to prepare their strategic planning documents. Among other responsibilities, VHA's Office of Finance is responsible for policy and operational issues relating to budget formulation and execution, financial management, and financial analyses.

As a consequence of VHA's field structure reorganization, decision making is currently more decentralized. In 1995, the 172 independent VA Medical Centers were reorganized into 22 networks, headed by network directors. Network directors are accountable for a variety of functions, such as contracting, budgeting, and planning for the medical facilities within their purview. Under this reorganization, VHA management anticipated that network directors could manage the distribution of the networks' resources to maximize the advantages to veterans within their service areas. Furthermore, the administration expected to perform less operational decision making and oversight at the central office level. Along with the decentralization, VHA shifted its service delivery focus from inpatient hospital care to outpatient care; between fiscal years 1995 and 2001, the average number of hospital inpatients declined from 31,137 per day to 13,452 per day. The number of annual outpatient visits increased from 26 million to 41 million during the same period.

Scope and Methodology

To address the report's objectives, we interviewed senior officials in VHA and VA to find out how they used performance information in the budget process. We reviewed several network managers' performance contracts and information on network performance measures to learn about the level of accountability VHA expects from its networks. We reviewed VA guidance on preparing budget requests, budget submissions, and other related documents for information on the budget process and the use of performance information. To learn about the planning process within VHA and assess its integration with the budget process, we read VA strategic plans and other planning documents. We attended congressional hearings and reviewed related documents to learn about VHA's budget requests, use of performance information, and VA/Department of Defense resource sharing. We did not assess the appropriateness of VHA's performance

measures or budget requests, or the accuracy of VHA's performance management information.

We conducted interviews in Washington, D.C. with senior officials from the VA Office of Budget, VHA Office of Finance, VHA Office of Policy and Planning, VHA Office of Quality and Performance, VHA Management Support Office, and the Liaison Staff Office to learn about VHA's budget process and performance measures.

Because we found the most evidence of a linkage between budget and performance during budget execution at the network level, we focused our work on that process at that level. We selected two networks—Network 2, in Albany, New York and Network 13, in Minneapolis, Minnesota—that VHA officials believed made the best use of performance information in managerial decision making. Networks 13 and 14 were combined and renamed Network 23 in January 2002, leaving 21 operational networks; there is a break in numerical sequence. We chose to focus on Network 13 rather than Network 23 since the structure of Network 23 had not yet been finalized at the time of our review, and we were interested in looking at processes that were already in place. Just as findings at individual federal agencies cannot be generalized across all agencies, the 2 networks selected for review are not representative of the other 19 networks. However, the observations of the network managers we interviewed are useful in understanding the different approaches taken to integrate budget and performance.

We reviewed network-specific budget and planning documents, such as strategic plans, annual performance plans, performance reports, and tactical plans for the two networks we visited. We interviewed over 20 network officials, including senior network management, care and patient service line managers, facility managers, information technology managers, quality management officials, and strategic planners to learn about network structures and the use of performance information in decision making at the networks.

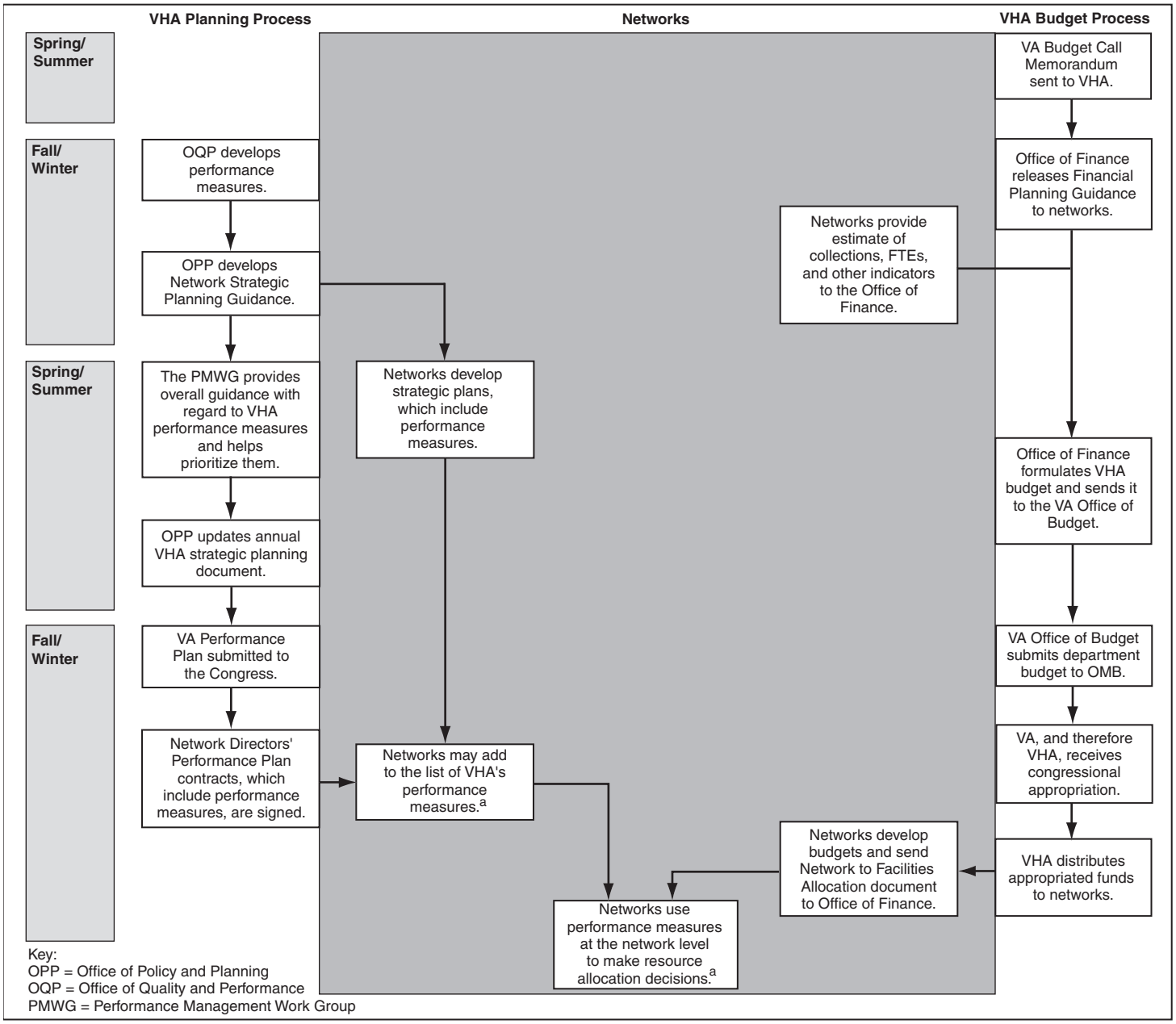
We also reviewed a number of background documents on administration initiatives and performance budgeting implementation, as well as recent public administration literature and GAO reports for general background and context.

We conducted our work between January 2002 and June 2002 in accordance with generally accepted government auditing standards.

Budget Formulation and Planning Efforts Are Centrally Managed, While Budget Execution and Planning Are Linked in Networks

Although VHA's budget formulation and planning processes are both centrally managed, they are not closely linked. The agencywide budget request is based primarily on the previous year's appropriations with some adjustments for workload and new policies. Distribution of funds to networks is largely driven by a system that is heavily based on the veteran population served at each network. Budget and performance are more clearly linked at the networks we visited. See figure 2 for an overview of VHA's budget and planning processes.

Figure 2: VHA's Budget and Planning Processes



Source: GAO analysis of VHA information.

[a] May occur throughout the fiscal year.

VHA's Budget Formulation and Planning Processes Are Centralized but Not Integrated

VHA reported that its budget formulation processes for fiscal years 2002 and 2003 were developed centrally with limited input from the networks and reflected an incremental approach, with some adjustments in fiscal year 2003 for projected workload increases and administrative efficiency assumptions. Prior to the development of the fiscal year 2003 budget, senior budget officials told us that VHA sought selected information from the networks, such as estimates of collections and long-term care expenditures. In preparing the budget that would eventually be included in VA's submission to OMB, VHA generally used the current appropriations levels as a baseline and added an adjustment for workload, as well as an increase for new programmatic initiatives. One VHA official commented that the process was very "top down." For fiscal year 2003, the main change to this process was the introduction of some enrollment growth projections from an actuarial model and administrative efficiency adjustments for reducing resource requirements.

VHA receives guidance on how to formulate its budget through a budget call memorandum issued by VA in April. This memorandum includes VA strategic goals and objectives and stresses the need to focus on outcome and performance goals and measures. Once VHA's Office of Finance formulates the administration's budget, it is sent to VA's Office of Budget where the VHA request is reviewed and recommendations are made by VA senior staff, culminating in a department budget request for VHA and the other two administrations. This submission is sent to OMB in September. Decisions made by OMB are incorporated into the President's Budget presented to the Congress. Following congressional action and enactment of the appropriations bill, OMB apportions and VA allots the funding provided in the VHA appropriations, thus beginning the execution phase of VHA's budget cycle.

While the VHA-related information in VA's annual Performance Plan describes goals, strategies, and performance measures, the relationship to the budget formulation process is unclear. VHA officials told us that they use strategic planning information as source material for departmental reports (e.g., the Accountability Report and VA's Annual Performance Plan), to review networks' policies for consistency, and generally to have the information on hand in an organized format. VA's Annual Performance Plan outlines resource requirements by strategic goal, and each strategic goal is accompanied by performance goals and measures. However, a VHA official told us that planning documents are typically finalized after VHA's budget is formulated.

VHA Resource Allocation Is Largely Formula-Driven

About 90 percent of VHA's medical care appropriation, which is approximately 86 percent of VHA's total budgetary resources, is allocated to networks through the Veterans Equitable Resource Allocation system (VERA), which uses a formula that calculates resource allocation based on workload.[7] The remainder of the appropriated funds is allocated to networks either through Specific Purpose Funding,[8] which is designated for certain programs such as state home funds or Vietnam veterans' readjustment counseling. Monies in the no-year Medical Care Collections Fund (MCCF), as well as other small nonappropriated funds, are also available to the networks.[9]

Network Planning and Budget Execution Processes Are More Closely Related

Decisions regarding resource allocation and planning are closely aligned at both networks we visited. The same officials are involved in strategic planning and budget execution, and network-produced documents show some alignment between planning efforts and resource allocation.

The Office of Policy and Planning prepares VHA Network Strategic Planning Guidance, directing networks on how to develop their individual strategic plans. According to the guidance, strategic plans must associate performance measures with each strategic objective. For example, the fiscal years 2003-2007 Guidance for Strategic Objective 1, "Put Quality First Until First in Quality," identifies the first strategy as, "Systematically measure and communicate the outcomes and quality of care," and the related performance measure as "Improve performance on the Chronic Disease Care Index II." Networks must then identify their plans to meet each performance measure.

VHA's Office of Finance issued guidance that required networks to provide financial or operating plans for a range of possibilities. According to officials, networks prepare plans in anticipation of final appropriations actions. Once VHA receives its appropriations and VERA allocations are

[7]Most of the elements in the VERA formula are contingent upon workload (the number and type of veterans served).

[8]This designation may come about as a result of a legislative mandate or VHA determination.

[9]MCCF monies, mainly veterans' copayments and third-party insurance payments, can be used by networks for a wide variety of purposes.

calculated, networks submit plans to the Office of Finance that lay out the networks' spending plans for their VERA funds.

The two networks we visited, Network 2 and Network 13, are structured somewhat differently with regard to resource allocation authority. At Network 2, service delivery is organizationally divided into Care Lines;[10] Care Line Directors have resource allocation authority across all medical facilities in the network. For example, according to network officials, the Geriatrics and Extended Care manager can make resource allocation decisions concerning nursing home care at all Network 2 facilities. Network 13, on the other hand, is structured around Patient Service Lines (PSLs).[11] PSL Chief Executive Officers (CEOs)[12] share resource allocation authority with the Chief Operating Officers (COO) at each medical center. PSL CEOs make allocation decisions for the facilities that support their PSL at the beginning of the fiscal year, while day-to-day smaller resource decisions during the fiscal year are handled primarily by each medical center COO. CEOs and COOs collaborate on larger budget-related decisions across the PSL. The subject of the resource decision determines which PSL CEO is involved; for example, the PSL CEO for Mental Health is involved with decisions regarding psychiatric care. Annual budgets are developed by the PSL CEOs in conjunction with site COOs and Chief Financial Officers (CFOs).

At Network 2, network leadership works with Care Line Directors in developing and prioritizing strategic goals and targets. Network 2's strategic plan shows a link between VHA strategies and performance measures, and network-specific actions to achieve them. (See fig. 3 for an example of this linkage.) The plan also shows how expected increases in annual funding will be used by program line.

[10]Network 2's care lines include Medical, Diagnostics and Therapeutics, Geriatrics and Extended Care, and Behavioral Health.

[11]The PSLs include Primary Care, Specialty Care, Extended Care and Rehabilitation, and Mental Health. Even though Networks 13 and 14 combined in January 2002 to become Network 23, the new network's structure had not yet been determined at the time of our audit work; thus, we focused on the processes of Network 13.

[12]PSL CEOs are now called PSL Directors.

Figure 3: Example of Linkage Between VHA Strategies, Performance Measures, and Network Strategies/Actions

VHA Strategy 3: Emphasize health promotion and disease prevention to improve the health of the veteran population.

VHA Performance Measure: Increase the scores on the Prevention Index II KEY

VISN Strategy	VISN Actions for FYs 2003-07
Increase the scores on the Prevention Index II.	Network 2 will meet the needs of the veteran population through a wellness model of patient care management, promoting preventive health and wellness initiatives, disease screening, application of disease management protocols and standardized application of recommended clinical interventions and clinical practice guidelines. An aggressive approach to patient screening shall be introduced for cancer screening including breast, cervical, colorectal and prostate cancer. Increased use of clinical reminders will be used to identify those patients in need of cancer screening.

Source: Network 2 2003-2007 Strategic Plan.

Network 13 senior managers told us about annual 2-day tactical planning meetings that were designed to provide an outlet for stakeholders to plan and share information on performance and strategic planning, cost information, performance measures, successful practices, and lessons learned. Participants include PSL CEOs, a PSL COO, PSL managers under COO control, union representatives, and congressional stakeholders. A network official stated the purpose of including managers with resource allocation authority in tactical planning meetings was to strengthen the link between the processes of resource allocation decisions and planning.

Performance Information Influences Resource Allocation Decisions in a Variety of Ways at These Networks

Integrating performance information into resource allocation decisions is apparent at the network level during budget execution. At the two networks we visited, managers told us that they use an internal data system that compares cost and performance data across facilities as a tool to make resource allocation decisions. Network performance is monitored by VHA, and networks establish their own processes to monitor their performance. Network managers also use various communication methods, both within their networks and across other networks, to share information on performance measures and ways to meet those measures. Managers reported that they were accountable for performance and provided examples where they used performance information to make resource allocation decisions.

Cost and Performance Data Used in Managerial Decision Making

Network managers told us that they use data from the Decision Support System (DSS) to make resource allocation decisions to their facilities and programs. DSS is an executive information system designed to provide VHA managers and clinicians with data on patterns of patient care and patient health outcomes. It is also used to analyze resource utilization and the cost of providing health care services. For example, a manager in Network 2 said that he uses DSS data for comparisons of facilities, population and market share data, and veterans' length of stay in inpatient units. Since veterans are staying in inpatient units for fewer days in certain facilities, the manager has been able to reallocate money across facilities because of DSS data.

Networks' Performance Monitored

As we noted in "Results-oriented Budget Practices in Federal Agencies,"[13] it is important for agency management to monitor performance. VHA leadership uses several methods to monitor network performance and hold network officials accountable for that performance. At its quarterly meeting, the VHA Executive Leadership Council (ELC), which includes the deputy secretary, managers from all three administrations, network directors, other key staff, interest groups, and the public, monitors the status of performance measures at each network. In addition, the Deputy Secretary of Veterans Affairs began holding monthly meetings in late 2001 with the Under Secretary of VHA and all the network directors. At these meetings, the senior officials provide information on each network's successes in meeting VHA-established performance measures and share best practices in meeting performance measures. Networks must provide remedial action plans at these meetings for measures that are not being met. For example, one network was deemed deficient in testing patients for Hepatitis C. Its action plan included a review of patients who had not been tested and an electronic clinical reminder to help service providers identify patients who have risk factors but were not tested.

To make sure network directors understand the importance VHA places on performance, directors sign an annual performance agreement with the Under Secretary for Health called the Network Performance Plan. The agreement includes expectations regarding VHA-level performance measures and their associated strategic goals. According to VHA guidance, a network director's appraisal is affected by his or her network's

[13]GAO-01-1084SP.

performance in relation to agency goals. As a result, the director's compensation may also be affected. For example, in 2001 a network director received a bonus because his network exceeded VHA-established performance goals.

Networks Establish Their Own Processes to Monitor Performance

The two networks we visited each had its own ELC to review performance measures on a network level and commissioned task teams to work on areas where performance has not met the intended goal. Quality Management Officers (QMOs) also serve as performance monitors. The QMO at Network 2 keeps track of the network's action plans to improve upon deficient performance measures, and reports on performance-related data at the Transforming Systems Performance & Quality Council (TSPQ), a forum to address issues across care lines and facilities to work collaboratively toward addressing performance measure issues, quality management, information systems, and related operational issues. Membership includes top network management, care line managers, and network office staff.

Network 2 uses its Web site in various ways to maintain up-to-date information on performance measures. For example, Network 2 managers told us about the Web-based Pulse Points, which are performance indicators that assist management in monitoring achievement of performance measures. Additional performance-related information is available to network staff on the intranet.

Communication Important to Help Managers Meet Performance Measures

Sharing information about lessons learned and strategies to achieve performance measures can lead to more informed resource allocation decisions. Between networks, managers have a number of opportunities to learn from each other via regularly scheduled meetings and conference calls. Network managers told us about periodic meetings where they interact with managers from other networks and share lessons learned with regard to cost-saving measures and approaches to performance measures. Within a network, staff may also use a variety of communication tools to share information to improve performance. For example, two Network 2 care line managers jointly established a team to discuss ways that the network could better meet performance goals for length-of-stay rates. This team, which spanned multiple care lines, worked on the issue and communicated its recommendations quarterly. Also, VA sponsors a "Lessons/Innovations" database on the Internet, where network managers can read ideas for performance improvement.

Network Managers Reallocate Resources in Response to Performance Measures

In both of the networks we visited, managers provided examples where performance information and the responsibility to meet performance targets affected the way in which they allocated resources. The examples incorporated a number of different approaches to improve performance, including investing in telemedicine and technology advancements, resource reallocation, low-tech methods to improve performance, and the use of outside contractors.

Performance target: *100 percent of diabetic veterans should receive retinal eye exams to decrease the potential incidence of blindness.*

Network manager approach*: Use telemedicine and special equipment to allow diabetic veterans who receive care at locations that do not have ophthalmologists the ability to have their exam results read by qualified specialists.*

An initial investment of network resources in advanced telemedicine techniques led to an increased percentage of diabetic veterans receiving a necessary test. To reduce the potential for blindness later in life, all diabetic veterans are supposed to have retinal eye exams to monitor their vision. However, this requires the services of an ophthalmologist who must interpret the exam results. The network did not have resources to maintain an ophthalmologist on staff at each site, so many diabetics were not being tested. A Network 2 manager found that a particular piece of equipment could record test results, then transmit them to an ophthalmologist at another location. Thus, the network invested resources in a number of these machines for Community Based Outpatient Clinics (CBOCs) to use, thereby increasing the network's capacity for meeting this performance target.

Performance target: *Annual cost per patient must be below a given threshold.*

Network manager approach: *Moved $100,000 from one facility that was not taking on as many patients as expected to another facility with an increased workload.*

A manager at Network 13 noted that facilities are expected to keep their average cost per patient down. Regular monitoring revealed that one facility was not taking on as many patients as planned, which led to higher average costs. To reinforce his expectation that this performance target should be met, the manager chose to transfer financial resources from this facility to another facility that required additional staffing to meet other performance targets. According to the manager, the facility that received the funds was able to improve its outcomes in the targeted area.

Performance measures: *Reducing the number of falls out of bed and the use of restraints.*

Network manager approach: *Buying lower beds (9" off ground).*

A Network 13 manager noted that veterans were falling out of their beds and thus incurring injuries, and the manager searched for a way to reduce this incidence. He also wanted to reduce the use of restraints, another performance measure. Based on staff recommendations, the manager agreed to invest in beds that were only 9 inches off the ground. This investment prevented more serious injuries from occurring, reduced the need for restraints, and directly improved the network's performance in these areas.

***Performance target**: Veterans should be able to obtain appointments with mental health professionals within 30 days of request.*

***Network manager approach**: Reviewed various staff practices and made recommended improvements.*

A PSL manager in Network 13 noted that wait times for veterans to obtain appointments with mental health specialists exceeded the performance target. The manager hired an outside consultant who looked at a variety of factors, including (1) how physicians' time was being spent, (2) physicians' practices regarding rescheduling appointments, and (3) hiring psychiatrists instead of contracting for them. According to the manager, after the network adopted the consultant's recommendations, including hiring (instead of contracting for) psychiatrists and hiring administrative staff to prescreen patients, Network 13 met the performance target by eliminating wait time completely.

Challenges

VHA has undergone a cultural shift over the past 7 years that has helped to integrate budget and performance, but managers face continuing challenges to further integration and in defining areas for improvement. The agency's budgeting and planning processes are not directly linked, so opportunities are missed to fully use planning information in the budget process. Additionally, VHA does not use the most complete information available when making resource allocation decisions.

Planning and Budgeting Linkage Could Improve

VHA's planning and budgeting processes are not fully integrated (see fig. 2 for an overview of these processes). VHA officials acknowledged the offices in charge of these processes did not work closely together in the past, but steps are being taken to improve this linkage. For example, a member of VHA's Office of Finance now works in the Office of Policy and Planning on the agency's demand model, which will be used to project costs for fiscal year 2004. According to VHA, this model projects workload for VHA nationwide and was partially used to prepare the fiscal year 2003 budget request. Future workload is projected through the use of a detailed formula that includes enrollment, anticipated utilization, and reliance on VA services. It does not assume an incremental increase over current workload.

Performance Information is Available but Not Included in Resource Allocation Decisions

VHA does not include the most complete information available when allocating resources. As we noted in *VA Health Care: Allocation Changes Would Better Align Resources with Workload* (GAO-02-338), VA does not adequately account for important variations in patients' health care needs across networks nor does it include all veterans who use health care services in its resource allocation decisions. Without complete

information, it is difficult for agencies to consider fully the relative priorities of programs and activities and, when funding tradeoffs are necessary, where adjustments can be best made. Producing reliable funding estimates requires an agency to include reasonable assumptions about factors affecting program costs or budgetary resources, assess the accuracy of previous estimates, and if necessary, make appropriate adjustments to its estimating methods.

Agency Comments and Our Evaluation

In its comments, VA agreed with our observations but asserted that our report does not give the reader an adequate grasp of the depth and breadth of managing such a large health care system. VA also included three enclosures: the first was intended to clarify certain points in the draft report, the second provided information on VA's actuarial model, and the third outlined VA's new budget account structure.

In the first enclosure, VA suggested three clarifications regarding our report language.

1. VA stated that the fiscal year 2003 budget was based on actuarial projections of workload broken down by specific disease and veteran priority level using prior years' costs; it also noted that administrative efficiency assumptions were further included for reducing resource requirements. During our interviews, officials told us that the process was generally incremental, but actuarial projections were used only to calculate potential increases in workload for fiscal year 2003; these projections were not used to reassess the base. For the fiscal year 2004 budget and beyond, officials expected to use the actuarial projections to calculate the entire workload, not just the potential increase. We made changes in our report language to reflect this process.

2. VA noted that it does not include all Priority 7 veterans[14] in its VERA calculations because it does not want to provide financial incentives that encourage network managers to provide care to Priority 7 veterans at the expense of higher-priority veterans. As we recommended in our February 2002 report,[15] networks with a disproportionately large number of Priority 7 veterans already have fewer resources under VERA to treat higher-priority veterans on a per-patient basis. To remedy this problem, we recommended that VA align measures of workload with actual workload served, regardless of veteran priority group. Doing so will help provide comparable resources for comparable workload. Thus, we maintain that complete information allows agencies to better consider the relative priorities of programs and activities.

3. VA also noted that the funds it received under the Emergency Supplemental appropriation were not intended for homeland security-related activities. We changed our report language appropriately.

VA's second enclosure was a report that describes the actuarial model it uses to project the demand for health services. This report was prepared for the Senate Appropriations Committee, in response to a congressional mandate identified in S. Rpt. 107-156. During our fieldwork, we were told that there was no documentation available regarding this model. We received the documentation when the draft report was sent for agency comment and therefore did not review the model and its ability to project VA's workload.

The third enclosure focuses on VA's budget account restructuring for its fiscal year 2004 budget submission. VA notes that this structure will allow it to more readily determine the full cost of each of VA's programs and make resource decisions based on programs and their results rather than on other factors. We did not review this new structure or its ability to more effectively link resources with results since the outcome will not be available until the administration's budget proposal is released in early 2003.

[14]Priority 7 veterans are veterans who have either incomes or net worths above a certain threshold, no service-connected disability that results in monetary benefits from VA, and no other recognized statuses such as former prisoners of war.

[15]See GAO-02-338.

As agreed with your office, we will distribute copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. We will make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

Please contact me on (202) 512-9573 or Denise Fantone, Assistant Director, on (202) 512-4997 if you or your staff have any questions about this report. Major contributors to this report are Kimberly Gianopoulos, Kelli Ann Walther, and James Whitcomb.

Sincerely yours,

Paul L. Posner
Managing Director, Federal Budget Analysis
Strategic Issues

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

November 14, 2002

Mr. Paul Posner
Managing Director
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Posner:

The Department of Veterans Affairs (VA) has reviewed your draft report, ***MANAGING FOR RESULTS: VHA's Efforts to Strengthen the Link Between Resources and Results*** (GAO-03-10). The report describes the Veterans Health Administration's (VHA) process in integrating its budgeting and planning efforts to meet the health care needs of our Nation's veterans. However, in doing so, it provides only a limited description that does not give the reader an adequate grasp of the depth and breadth of managing a health care system unmatched in complexity and size in the free world.

To address this huge challenge, VHA has developed and continues to reformulate its method of identifying current and future health care demands: the Veterans Equitable Resource Allocation (VERA) model. Using VERA, VHA distributes its resources across a nationwide system of over 1,000 health care delivery points. It must be recognized that this budget formulation/execution system is in the context of the ever-changing nature of modern medicine.

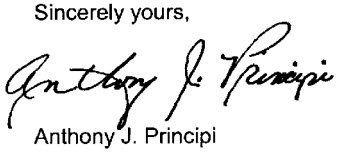
VA is in overall agreement with the General Accounting Office's (GAO) observations but believes additional description would be useful in helping the reader to understand the unique challenge of planning for and managing the largest health system in the United States. Enclosure 1 contains information for GAO to improve its description of VHA's linking its resources and results as well as clarifications to some inaccuracies in the draft report. Enclosure 2 provides information on the Milliman actuarial model. In September, VHA prepared and transmitted this white paper to Congress to describe actions VA is taking, and expects to take, to ensure that accurate estimate of workload and resource needs are met. VA believes GAO's report should provide more emphasis on how the actuarial model will improve the accuracy and reliability of VHA's budget forecasts. Enclosure 3 provides information on VA's efforts to more effectively link resources with results through the implementation of a new budget account structure.

Page 2

Mr. Paul Posner

Thank you for the opportunity to comment on your draft report.

Sincerely yours,



Anthony J. Principi

Enclosures

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