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The President of the Senate
The Speaker of the House of Representatives
The Secretary-designate of Veterans Affairs

This report highlights important issues identified through our work over the past several years that affect the nation's ability to deliver effective and equitable services to its veterans. The four issues that we believe should be included in the agenda the Congress and the Secretary set for the new department are (1) improving overall departmental management, (2) planning to meet the long-term care needs of a burgeoning population of aging veterans, (3) reassessing the schedules used to set compensation levels for disabled veterans, and (4) modernizing information systems.

VA has begun to take steps to address these issues. A new Secretary of Veterans Affairs will need to direct efforts to improve the overall management of the medical and benefit programs and thereby enhance the delivery of services to the nation's veterans.

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Assuring Quality of Field Facilities' Services

After years of debate, the Congress voted to elevate the Veterans Administration to cabinet status. Long-time supporters of this change expect that it will lead to higher quality services for the nation's veterans. The new Secretary will be judged, in large part, on how well these expectations are met.

Improving the quality of VA's services will be a challenge because VA provides medical and compensation services through a network of 172 medical centers and 58 regional benefit offices located throughout the country. In such an environment, a decentralized approach to management is appropriate. But such an approach makes it essential that systems are in place to enable managers at headquarters to determine whether field facilities are providing quality services.

Over the years, our work has identified many instances where VA's systems did not provide this kind of key information. We believe this occurred because VA had not

- determined what information was needed to assess service quality and established reporting requirements that would provide the needed information or

- followed through to assure that field facilities were complying with established information reporting requirements.

For example, we found that medical centers were not reporting, through appropriate quality assurance systems, most of the more serious patient injuries at the centers. In addition, managers at headquarters were not using the information they did have to detect the underreporting. Also, we found that one-third of the medical centers with surgical residents were not submitting the required reports on their supervision. As a result, headquarters' managers did not know that supervision at many centers was inadequate.

We reviewed VA's agent orange examination program and found that headquarters' managers had not asked for (and were not receiving) the information they needed to realize that they had serious problems in service quality. Managers required facilities to report the number of examinations performed and the number pending, but neglected to collect data on how long veterans had to wait for appointments. Thus, managers could not tell from the reports which facilities were having problems with timely service delivery.

We also found instances where managers at headquarters did not take appropriate action to improve field facilities' services despite having information suggesting the need for such action. For example, several cardiac surgery centers reported mortality rates above VA's standard. However, VA managers did not take appropriate steps to determine why these centers were not performing at an acceptable level.

While most of GAO's work has focused on the quality of services at VA's medical facilities, the House Committee on Government Operations recently reported on VA's system for measuring the performance of VA's 58 regional benefit facilities. The Committee found that managers did not have adequate information to effectively monitor the facilities' processing of veterans' benefit claims. The limited work we have done in this area generally supports the House Committee's report.

VA has taken some steps to get better information on the quality of services at field facilities. But the Secretary needs to assure that these efforts continue and that managers at headquarters have and use systems that will provide sufficient information to assess quality.

Improving Efficiency of Medical Centers

As budget pressures grow, VA must also continue to look for ways to provide quality services to veterans more efficiently. Toward this goal, in 1985, VA initiated a resource allocation methodology designed to provide a financial incentive to medical centers to improve their efficiency and productivity. However, this new approach cannot realize its full potential without improved medical cost accounting systems. Under the new approach, VA allocates a portion of a medical center's budget based on the ratio of its total annual workload to its expenditures. The centers are to compete against each other and transfer money, through VA's budget process, from the less efficient centers to the more efficient ones.

While the goal is good, unfortunately VA's systems do not provide the types of information that medical center managers need to identify inefficient processes. For example, medical centers are credited a specific amount for each type of illness they treat but do not have information about their actual costs of treating any specific patient or illness. Although centers can generate cost estimates, they are sometimes inaccurate. Without accurate information on the costs of producing individual components of its total workload, VA's centers have

limited capability to identify ways to control costs and, thereby, improve their cost-effectiveness.

VA has efforts now in process to improve the reliability of both clinical and financial data needed to support the methodology. They include installing new medical information systems and adopting a decentralized cost accounting system. Completion of these two efforts is critical if the resource allocation methodology is to achieve its goal of improving the efficiency of operations.

Providing high-quality services efficiently requires that VA continually monitor the appropriateness of the size, condition, and location of its vast network of facilities. Because of current demographic trends, planning for long-term care facilities will assume increased importance over the next few years. In particular, VA needs to analyze more systematically the relative costs and benefits of the different long-term care options available to it, assure that it will have sufficient access to facilities operated by state governments and private sector firms, and do a better job of assessing the particular needs of the veteran population.

Planning to Meet Increased Demand

The number of veterans 65 years old and over increased from 3 million in 1980 to 6 million in 1987; it is expected to reach 9 million by the year 2000. The number of veterans with the greatest need for long-term care, those 75 years old and over, is expected to grow even more rapidly. Most veterans are eligible to receive long-term care from VA. A major task facing VA is determining how to deal with the projected increase in demand; decisions will have to be made soon because it can take, on average, 8 years to plan, design, and build a new facility.

VA does not know the relative cost of obtaining long-term care services through the different nursing home options it has available. VA has three alternatives: (1) facilities it owns and operates, (2) private community facilities with which it contracts, and (3) veterans' homes operated by states. VA determines its average daily expenditure for each alternative, but the results are not comparable because all costs are not included for each option.

VA's accounting and information systems are intended to capture all direct and indirect costs of care provided in its nursing homes. These costs include depreciation on the physical plant and costs of medical services for veterans residing in the homes. Given the current state of its systems, VA does not have reliable information on its medical care costs.

For its comparisons, VA includes only the daily stipends that it pays to the state and private facilities for each veteran residing in the facilities. However, many other costs are not considered, including the federal share of state home construction, VA pension costs, and some medical care.

In order to plan effectively to serve the needs of an aging veteran population, VA needs to analyze the relative costs of each

of the options available to it for supplying nursing home care.

Current projections suggest that the number of veterans in need of long-term care will peak and then decline before the baby boom generation reaches the age of greatest dependency on long-term care. In fiscal year 1987, VA revised its planning goals to emphasize greater reliance on community and state veterans' nursing homes. Analyses of the kind discussed previously must be performed before we can know whether the particular allocation among the three different alternatives that are now being planned is the most cost-effective one. But based on what we currently know about the expected demographic pattern nationwide, it makes sense for VA to limit the amount of capacity added in its own facilities.

No matter what degree of reliance is placed on each of the three alternatives, VA will have to make substantial use of community facilities. Therefore, VA must take steps to assure that its plans for increased reliance on facilities it does not own prove to be realistic from a regional perspective. Many factors affect the availability of community nursing home beds. Although high nationwide, nursing home occupancy rates vary substantially from

place to place. In some areas it may not be realistic to expect that VA can gain access to additional private sector capacity, whereas other areas may have plenty of room. Regional variation in nursing home vacancy rates needs to be taken into consideration in VA's planning.

Even if the supply in a given community is expanded, VA may not get access to the new beds because of disincentives for community nursing home operators to accept VA-supported patients. These disincentives include administrative burdens and VA length-of-stay limitations. To help assure the availability of beds, VA should begin now to outreach to community nursing home operators and make acceptance of VA-supported patients as desirable as possible.

Also, several factors hinder expansion of beds in state veterans' homes, including the availability of federal and state funding to construct and expand them and the length of time required to develop, approve, and fund individual projects. While VA can fund up to 65 percent of the cost of a state home, states must approve funding for a project before VA can request federal matching funds. To date, 20 states have not approved any funds for state homes. VA must encourage states to

increase their participation and decrease the length of time from project development through the approval process to the actual funding.

Assessing Veterans' Nursing Home Needs

While the availability of beds in community and state veterans' homes is critical, increased reliance on such homes depends to a large extent on their ability to meet veterans' medical and nursing needs. VA assumes that all patients can be treated in any type of VA-supported home. In addition, VA does not identify the specific services that homes are to offer. Although the missions of VA-owned, community, and state veterans' homes are similar (all are intended to provide needed skilled or intermediate nursing care), the specific medical services available at individual facilities vary.

In 1986, we reported that VA lacked a management information system that collects comparable data on the medical conditions and nursing needs of all patients in VA-owned, community, and state homes, such as severity of illness, types and frequency of services needed, and levels of care required. To effectively plan for the types of facilities needed, VA should determine the nursing home needs of its current and future patient populations and match these needs with the varying capabilities

of the facilities in each medical district or each medical center's primary service area.

VA pays about $8.4 billion in compensation benefits to 2.2 million veterans disabled by injuries or diseases that were incurred or aggravated while in the military service. But to do this, it uses an outdated disability rating schedule that was developed over 40 years ago. This schedule must be reviewed and updated if VA is to give fair and uniform treatment to disabled veterans.

VA uses its rating schedule to convert medical findings on a veteran's condition to a percentage of disability. The rating schedule is divided into 14 sections representing the various body systems and lists about 720 medical conditions that veterans may be compensated for. The schedule is used to assign each condition a percentage rating that represents the average loss in earnings capacity the veteran can be expected to experience because of the disability. The percentage of disability determines the amount of the veteran's compensation.

VA is required by law to update the rating schedule periodically to reflect medical advances in the treatment of disabilities and diseases. VA has made some revisions to the schedule over the years, but many medical advances have not been recognized. Since 1978, 4 of the 14 ratings

schedule sections have been updated, but 10 have not. The entire rating schedule has not been comprehensively updated since 1945.

GAO asked medical school physicians to review aspects of the current schedule and asked physicians at VA and the Department of Defense, as well as VA rating specialists, for their views of the current schedule. All groups responded that substantial improvements are needed. They cited examples of outdated terminology, as well as medical conditions that should be added. The VA physicians believe that all sections of the schedule need improved medical criteria. We believe that, as a result of this situation, VA cannot assure that veterans are receiving the correct amounts of compensation. Because the criteria are often needlessly vague and outdated, a particular veteran may be getting too little or too much and two veterans with the same condition may be compensated differently.

Fair and equitable adjudication of disability cases is a difficult task under the best circumstances; achieving equity becomes nearly impossible with an outdated rating schedule. Therefore, the rating schedule should be comprehensively reviewed and updated as appropriate to reflect medical

advancements so that VA can better ensure that disabled veterans are fairly and equitably compensated.

Clearly, major improvements both in the quality of VA services and in the efficiency with which they are provided depend heavily on VA's managers being able to get the right information at the right time. To help achieve this objective, VA has embarked on major systems modernization and integration efforts for both its medical and benefit programs.

We believe that the current program to modernize the medical information systems should continue, but both GAO and the Office of Technology Assessment have urged VA to undertake a major reassessment of this program before making another substantial investment. With respect to the benefit programs, GAO has also urged VA to continue to support the full implementation of the long-range information management plan.

The modernization of VA's medical information system is being carried out under the Decentralized Hospital Computer Program. As part of this program, VA has installed new computer hardware and internally developed software in nearly all of its medical centers. While we believe this program shows great promise, in a 1987 report we suggested several important and necessary improvements. These included better controls over the software

development process and security procedures for the data centers, improved analysis of the costs and benefits of the new software, and more effective procedures for managing hardware capacity. VA has begun action on these suggestions, but the Secretary should make sure that they are fully implemented.

VA's reliance on the current program to provide automated support to its medical centers is a reasonable approach for now. However, in a few years VA will need to make additional and substantial investments in this system. At that time, alternatives to continuing the current approach could include adapting other systems or developing a new system using an alternative approach. Before making these additional investments, GAO once again urges VA to evaluate the full range of available options.

VA has developed a 12-part, 9-year plan to modernize the information systems supporting its benefit programs. Implementation is to be completed in 1994. Successful implementation of this program should greatly improve the quality of VA's benefit services. To date, VA has completed 3 of the 12 parts of the plan. For the modernization effort to be successful the other 9 parts must be completed effectively.

In addition to this effort, VA has identified 13 interim, short-term projects that address the critical needs of its existing information systems. These interim projects should introduce significant benefits for VA, but they do not address fully all of the critical shortcomings of the existing information systems. VA must sustain its commitment to the timely completion of the 12-part modernization plan, and not consider the interim projects as a substitute.

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The Public Service (GAO/OCG-89-2TR)

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