

July 16, 2014

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Good Morning Ladies and Gentlemen and thank you for allowing me to speak about something that I am passionate about and has been continuously part of my life for over 30 years- the care of our Veterans.

I have no personal conflicts to declare but as you know I am employed by Duke University Health System which does work with the Veterans Administration and other federal agencies. I also consulted to one VISN over ten years ago on how to apply private sector business analytics in the VA system using inpatient and outpatient dialysis services as the example.

Before I begin my assigned task of talking about where the VA might benefit by more closely aligning with the trends in the private sector, I would first like to say that I am proud of the overall improvement in the quality of care in the VA system over the years and I am happy to say that my brother and step father continue to receive care in the VA system. In addition, my mother insisted that I take the time to make sure you all knew how appreciative she is for the care that the VA provides for her family.

So as you can see from both my professional experience listed on my biography that was provided prior to the meeting and my personal experience, I am deeply committed to the care of our Veterans. I understand the issues Veterans face in choosing whether to use their VA, Medicare, or private benefits from both the provider and patient side; so while my comments may be difficult to hear and more specific than your other witnesses here today, my comments should always be interpreted as an attempt to continuously improve the system rather than to criticize it.

We should not forget that the VA is doing many things well and in many cases are doing it better than the private sector.

Things are definitely improving and much of this can be attributed to the fact that the pay scale of VA physicians and nurses is now competitive in most specialties so the VA can now attract and retain the best clinical physicians and nurses. Work still needs to be done for other VA positions to achieve the best efficiency and outcomes.

The VA Career Research awards continue to be the standard that allows the VA to attract and mentor new talent and improve the care of patients for issues that are most important to Veterans.

Medication monitoring by non-physicians and use of non-face to face encounters by the VA are well ahead of many private sector systems of care.

The VA mail pharmacy system and National TeleRadiology programs are great models that need to continue to evolve.

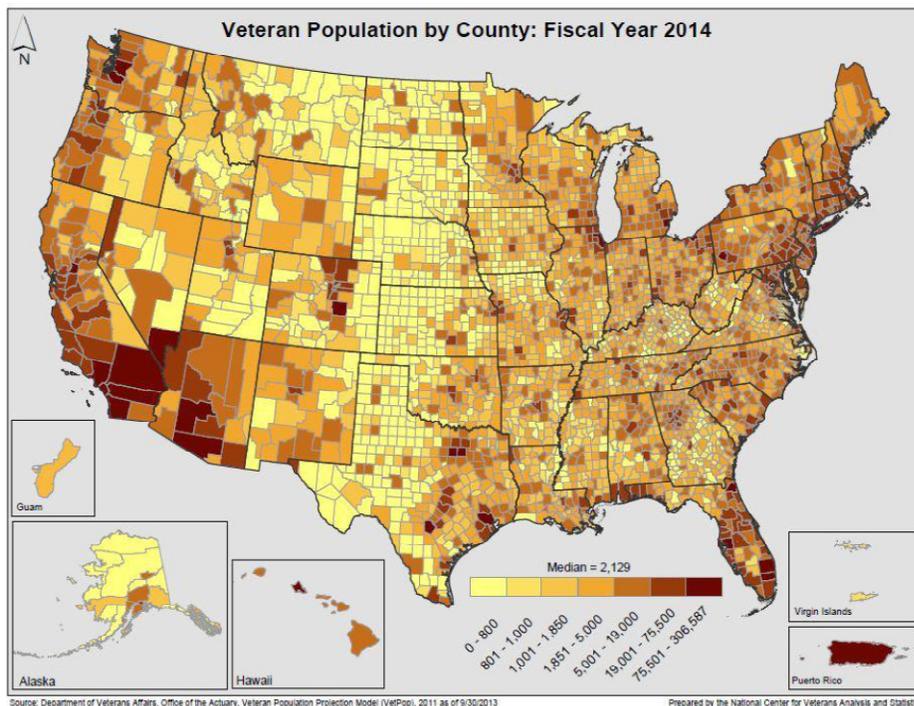
These are just a few of the examples where the private sector should learn from the VA experience.

On the flip side; the key to success that the private sector benefits from, and that the VA does not enjoy, could best be described as flexibility, flexibility, and flexibility.

On the clinical side both the private sector and the VA are striving to achieve standardization of best practice through evidence based medicine, but this always includes local clinical judgment by the one with **all** of the facts- in this case the provider. This is not happening on the administrative side of the VA where the local administration is not allowed to use its judgment to adapt to the local environment.

The VA has so centralized the “big three” of IT, HR, and contracting that the local entities cannot maximize their use of local resources or make rapid changes to meet the needs of the rapidly changing health care environment.

Having been a part of several large health care systems over the years, including the VA, a county, Stanford University Hospital, Partners Healthcare System, and now Duke Medicine; I can tell you that how you manage and how best to deliver care needs to be different in different parts of the country. One system does not fit all. This is clearly demonstrated by just looking at the population density of our Veterans by county as displayed below.



Despite blue ribbon panels and being listed as key strategic priorities by VA leadership, the IT, HR, and contracting policies and procedures, as well as their interpretation and execution of these directives, are getting worse from the perspective of those who live it every day.

Contracting:

The regionalization of contracting continues to be the single most frequent complaint I hear from those who deal with the VA. While the rationale that contracting would be improved by having “centralized experts” in contracting involved; nothing could be further from the truth. With the exception of bulk supplies, by regionalizing contracting, the VA has placed a huge barrier between those who understand the exact services needed and the prioritizing of those services with no improvement in cost, service or outcome. Some examples of issues:

- 1) High turnover of contracting positions
- 2) New contracts take years to accomplish.
- 3) Contracting officers are not always familiar with regulations.
- 4) Existing contracts are often extended time after time for short periods of time over years as the authority for longer contracts has expired; leading to increased administrative costs on both sides.
- 5) Request for even simple things like redline changes have been denied causing increased administrative costs.
- 6) The academic affiliate is the one who has to track contract timelines and ensure lapses in services do not occur. (i.e. when contracts are set to expire, often times contracts have to be urgently signed so that Veteran care is not interrupted leaving the clinicians in limbo as to whether they can continue to schedule care; thus causing delays in care).
- 7) Contracts with wrong vendor, tax id, or even wrong services in contracts (i.e. radiology terminology in a lab contract)
- 8) Standard VA clinical contracts have been interpreted as contingent upon federal budgets placing clinicians in ethical dilemmas.
- 9) New IT restrictions regarding IT security and co-mingling of data has caused us to eliminate lab contracts; so specialized labs that were previously done within 24 hours are now shipped off site, which can lead to delays in diagnosis and care; further increasing costs.
- 10) VA can only approve up to \$300,000 locally for a lease. For various reasons VA facilities are unable to give the minimum number of exam rooms (2 per provider) that they need to be efficient. Large contracts can

take years thus limiting the size of a new clinic to a less efficient configuration or location.

- 11) VA contracting often has to go to the lowest “reasonable” cost, which is often interpreted as the lost cost. The lowest cost is not always the best for the organization as it can lead change orders/amendments etc. Rarely is the criteria established to equally weight cost and other priorities including operational efficiency.

The VA should review and revise its contracting policies and procedures to give local entity control of existing procedures and new ones to give them much greater latitude. One rapid improvement would be to more broadly define the use of sharing agreements with the academic affiliate to include sharing of excess academic resources with the VA at fair market costs. Currently VA sharing authority is limited to excess VA resources. For example if the academic affiliate has excess space can this be shared with the VA under a sharing agreement? If so we could quickly improve VA access.

Information Systems;

While the VA has an excellent centralized standardized clinical information system (IS); where the VA and the private sector differ is that the VA has divorced IS from the clinical operations by segregating it into a separate reporting structure; whereas the private sector is placing more and more emphasis on the strategic nature of IS and thus its management and decision making process is integrated into the fabric of every decision.

The VA has swung the pendulum too far to where the organization is now less responsive to the needs of the organization and the priorities are not always aligned. Having computers to open new clinics, updating outdated phone switches to improve customer service are no longer within the purview of the local director. Furthermore, the VA has stipulated that new computers and IT equipment cannot be approved locally unless it is included in the budget for new space. This has resulted in some cases where providers have to share outdated equipment or complete clinical notes after hours.

There is nothing you can do in healthcare that does not involve IT.

How do you hold local officials accountable for the outcomes when they don't control the deployment of one of its most critical assets? In the private sector, even when resources are centralized there is a single point of accountability locally that is

accountable to local management and budgets are jointly agreed upon based on the strategy of the organization and local conditions.

HR

HR Issues are not unique to the VA but are significant. Most providers working in the VA would disagree with the recent focus that many positions in the VA have been overpaid as they were misclassified. They would argue that the VA does not pay enough for support staff and that the classification system is the problem. This is supported by the construct of Patient Align Care Team where it appears that the VA is using RNs to perform non RN duties in its clinics.

Other significant HR issues

- a. Too long to recruit and on board positions.
- b. Job descriptions and pay band revisions are back logged, thus current position descriptions may not accurately account of the level of skill required including computer skills.
- c. Market adjustments need to be more flexible and reviewed annually to keep pace with market demand. Example echo tech techs and PA
- d. Retention pay being limited to only one year at a time is not a sustainable way to retain employees.
- e. Excessive mandatory annual training leading to lost productivity.
- f. Rules do not always make best practice. I.e. \$147K limit on fee basis cap for contractors gives management less flexibility and increases costs.
- g. Except in nursing, time keeping rules make it difficult to flex full time employee staffing to meet unpredictable needs. You don't always know your workload a week in advance. One simple solution is to allow flex time for full time employees in much the same way that the VA does for part time employees.
- h. Providers are not authorized partial day leave from the VA to handle personal issues such as their own health. Instead, providers must take a full day of leave to simply attend their own annual physical causing an incentive not to return to work that day to see patients.
- i. Local Senior Management Pay. The current VA pay scale for physician leadership limits the VA's ability to attract and retain the best physician leaders. For example, the Chief of Staff (COS) position at our most complex VA medical centers has a cap of \$275,000. This is one of the most important

roles within the VA structure. As you can see from the attached VA pay table, anyone with any service level experience or any clinician other than a primary care or non-invasive specialist would have to take a pay cut to become the COS. If you want good outcomes we need to hire good leaders with experience and let them lead.

- j. The salaries are even more out of touch with the market for Director/Hospital President or CEO, Associate Director/Hospital Vice President or COO; thus the VA cannot compete with the private sector.

DEPARTMENT OF VETERANS AFFAIRS Veterans Health Administration Title 38, U.S.C. Sec. 7431,

Physician and Dentist Annual Pay Ranges

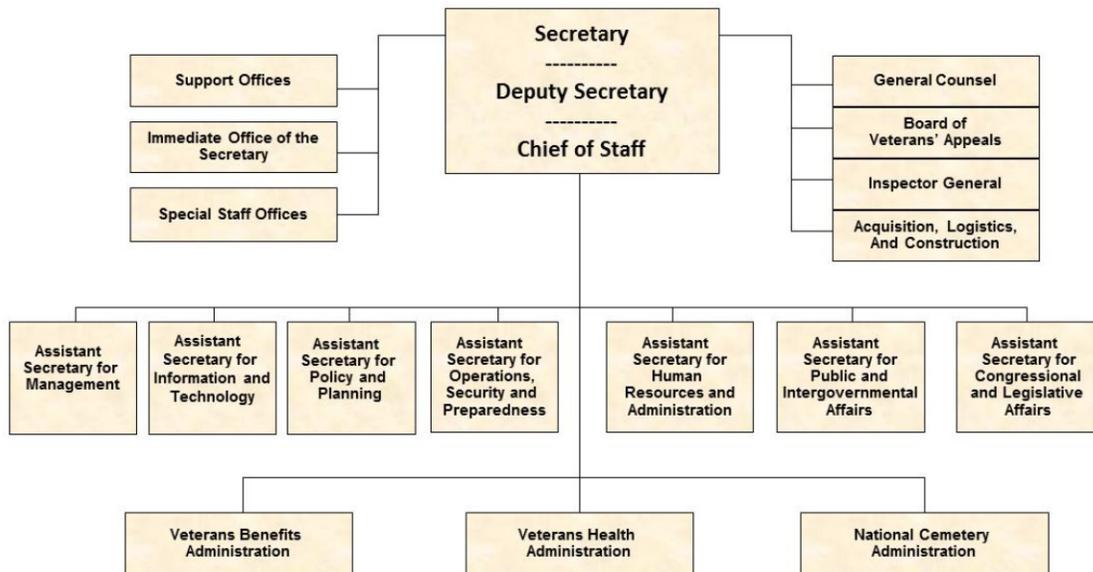
PAY TABLE 5 - CHIEF OF STAFF MINIMUM	MAXIMUM	COVERAGE	
TIER 1	\$150,000	\$275,000	Complexity Level 1a and 1b Facilities
TIER 2	\$145,000	\$255,000	Complexity Level 1c and 2 Facilities
TIER 3	\$140,000	\$235,000	Complexity Level 3 Facilities or Facilities with no designation level

Other private sector trends that the VA might want to explore include the following:

- 1) Quality/Performance Services

Organizations that have been most successful in making quality the top priority have quality reporting to the top of the organization. Performance services also reporting directly to the Secretary would mean that the data would be presented in an unbiased way to upper management. The same could be done at the local entity level where there appears to be inconsistency of where quality reports.

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2) Everyone practicing to the top of their license:

- a. Example: In the VA Patient Aligned Care Team (PACT), a primary care provider (physician, nurse practitioner, or physician's assistant) leads an inter professional teamlet in care delivery. The VA "teamlet" includes a registered nurse as care manager, a health technician or licensed practical nurse (LPN), and a medical clerk. This RN/provider ration is 3 to 4 times the private sector ratio.
 - i) Is the fact that the medical clerk VA job descriptions are not up to date and have therefore been downgraded meant that RNs are really doing clerical work? If the administrative staff were working to their full "license" would you need an RN for every provider? This is an expensive model and not typical of a private primary care practice.
 - ii) What percentage of the RN duties really requires an RN, are they practicing at the top of their license?
 - iii) Has the VA fully empowered the use of PA and RNP to meet the workforce needs of the VA in this model?

- b. Role of Registered Nurse Practitioners and Physician Assistants in work force needs. The private sector is rapidly moving in this direction in order to meet its workforce needs. Since patient preference and satisfaction surveys have shown that patients not only are satisfied but often prefer a non-physician as their primary contact; Duke has set an initial goal in its primary care clinics to achieve an equal mix as part of its team approach. Has the VA done everything they can to make maximal use of this important workforce in both primary and specialty care? The VA needs to evaluate its role all the way from expanding VA training of RNP and PA to recruitment practices, job duties, classification, pay, flexibility, retention, and career development. Example why are some primary care jobs listed for RNP, others as PA and why are they under two different systems of pays?

3) Expanded Hours:

- a. Clinics: Why is it that the VA still lists its primary duty hours as 8 am to 4:30 pm. By merely expanding to 5:00 pm across the entire VA system just think about the productivity gain vs the fixed costs that the VA has. It could add capacity for 5 million more outpatient visits to the 86M that were provided in 2013. So why hasn't this been done? Just ask the local leadership about the issues they face in accomplishing this.
- b. Urgent Care: A huge national trend is the use of urgent care. This is being delivered by a combination of traditional providers, focused for profit urgent care companies, and non-traditional providers like pharmacies. The VA should explore urgent care centers, collaborations with other providers of urgent care to avoid ED visits at the VA or the private sector that they end up paying for. This fiscal analysis should include any potential cost savings for avoided travel pay. Is it cheaper to have private pharmacies deliver the annual flu shots?

4) Matching Workload to Need

- a. In the private sector an annual budget determines baseline staffing needs based on the current and projected year needs; and flex budgets are established to account for fluctuations in volume during the year. In the VA the resources lag by two years.
- b. On the day to day physician staffing VA, you can use flex time for part time physicians but this is not available for full time providers. The VA should extend flex time to full time providers and possibly even other staff.

5) Conversion from Inpatient to Outpatient: Facility Implications

	Owned Assets			Leased Assets		Land	Facility
	Buildings	Historic Buildings*	Square Footage	Leases	Square Footage	Acres	Replacement Value**
VHA	5,439	1,878	145,588,523	1,636	14,776,785	15,733	\$103,495,166,889
VBA	22	0	767,032	212	4,512,700	0	\$461,796,934
NCA	404	121	1,008,266	4	19,716	19,454	\$894,580,302
Staff Offices	8	1	1,696,608	90	2,166,182	165	\$808,386,508
Grand Total	5,873	2,000	149,060,429	1,942	21,475,383	35,352	\$105,659,930,633

Frank Bell FY 2102 Office of Construction and Facilities Management

Both the VA and private sector are moving to the outpatient but the VA continues to maintain outdated and underutilized inpatient facilities often driven by politics rather than what is best for patient care. Based on the table above from 2012 and the projected decline in the Veteran population; it would appear that the VA might want to reconsider its strategy regarding building and owning new space verses developer owned and operated space which would give more flexibility in the future and possibly allow for greater collaboration with the private sector. The VA should consider a BRAC like process where the future locations and services are based on current and forecasted patient needs. (Currently I understand that any reduction in inpatient beds must go to VA Central Office and any closures must go to Congress, causing delays in decisions.) Modernization of the type of facilities to meet the current delivery model would result in better care of the patient in their communities as resources could be redirected to support the services that are actually needed. I.e. why maintain an outdated or underutilized inpatient facility? This results in the inability to adequately maintain the existing buildings, even at our flagship facilities; and limits the VA's ability to expand its access sites. The VA would then be able to make rational decisions to rent most outpatient space while owning inpatient and outpatient facilities where the work load and expertise will continue to be needed long into the future. Long term facility determination should include ability to attract and retain providers, not just work load.

6) Consumerism

The VA has the opportunity to continue to be the market leader in this area regarding quality and access. Making real time access data available to Veterans rather than implementing more reporting and compliance metrics could be an alternative method to assure that reported access measures were accurate; as the Veterans themselves would let you know in real time if the data was inconsistent with their experience.

But consumerism is not always the best way to solve a problem, as often the data itself is not enough to make an informed decision. An example is that it appears that in recent draft language the VA would be required to inform patients of the training and certification of the surgeon prior to surgery. This appears to be an attempt to make sure that only qualified providers are performing specialized surgery. In this case, it is the Medical Staff who should be accountable for only granting privilege to the appropriate providers; not trying to make the patient decide what is the appropriate training.

7) Management Contracts;

The Private sector makes much greater use of management contracts. This can range from management of a particular service like EVS or food service to management of entire hospitals or systems without a change in ownership. In North Carolina, Carolinas Healthcare Systems employs the management while staff remains employed by the local entity of over 20 hospitals.

For years, county leaders have found it much more efficient to outsource the management of their county facility to either a local or national expert in hospital management. This can take many forms. Should the VA consider similar models?

Since there would be no cost savings in consolidation of purchasing the savings would have to come from elimination of duplications, improved coordination of care for Veterans using both their private sector and VA benefits. Local management would be incentivized to find more cost effective sharing of resources and would likely improve care by elimination of services that are rarely used. (I.e. it is hard to maintain competency if the task is rarely done). Expensive equipment or services would not need to be duplicated. Management costs could be reduced.

8) VA utilization of other Government Services and Contracts

The VA does not have a core competency in the revenue cycle and thus continues to struggle with the ability to process non VA care claims. The VA is the only “payer” where we have to drop the claim to paper and include a copy of the medical record with the claim. This copy is a duplicate of what we send the Durham VA for clinical care purposes. Our days in accounts receivable is much higher than private sector payers and is often an obstacle to convincing private physicians to take VA patients. Since we receive an authorization number that is specific to that Veteran and the specific medical condition, and the authorization is time limited by the “valid dates”; why doesn’t the VA just utilize the same contractors as CMS to process these claims? It can then be automated like all our other claims and would reduce costs for all parties.

9) VA collaboration with the community including academic affiliates

The VA would benefit with new policies and procedures that would allow the VA to benefit from shared resources.

For example:

- A) Many part time VA providers also provide care at their academic affiliate or other local community hospital. Yet the VA has their own credentialing office where the provider’s medical license, educational background check etc. must all be duplicated. While JCAHO requires separate privileging committees, the administrative functions could be done more cost effectively if there was better sharing. The same goes for annual training in HIPAA, infection control, etc. that is similar between most facilities.
- B) Often the rate limiting resource is OR time, not VA physicians. Rather than building more ORs in VA facilities the VA should encourage through enhanced authority the use of private facilities by VA employed providers where appropriate to meet patient’s needs. This can be more cost effective than simply outsourcing the care through non VA care service.
- C) The VA should evaluate its recent use of a third party for non-VA care coordination. Simply using CMS as listed above could be more effective and restore the relationship between the VA providers and the community.

10) Standardized Quality Metrics

The country is overrun with every agency and insurance company trying to establish its own set of quality metrics. The same is true of the VA where they have reached metric fatigue. The VA and CMS should agree upon the same set of standard and same methodology so we can do national comparisons. For example if Medicare defines 30 day readmission to include readmission to any hospital, not just the index system, the VA should use the same definition and thus must use a combination of private sector and VA data.

11) Management Structure:

With the changing landscape of healthcare from inpatient to outpatient and the improvements in technology, the VA should once again reexamine its management organization from top to bottom including VACO, VISNs, and the Assist, Associate and Director Positions.

A March 27, 2012 **Veterans Health Administration Audit of Management Control Structures for Veterans Integrated Service Network Offices** stated that "VHA established the VISN offices to improve access to medical care and ensure the efficient provision of timely, quality care to our Nation's veterans. In 1995, VHA submitted a plan to Congress called *Vision for Change* that restructured VHA field operations into VISNs. VHA estimated that 22 VISN offices could operate annually at a cost of about \$26.7 million or for approximately \$9.3 million less than the cost at that time to operate 4 medical regions. VHA specifically decentralized its budgetary, planning, and decision making functions to the VISN offices in an effort to promote accountability and improve oversight of daily facility operations.

In FY 2011, VA's information systems reported that the VISN offices spent about \$202.5 million for the salaries and benefits of 1,495 staff and their related expenses. Based on data in VA's automated information systems, VHA's 21 VISN offices expended about \$164.9 million during FY 2010 to support their own operations. VA's Personnel and Accounting Integrated Data (PAID) system showed the VISN offices expended about \$124.9 million for the salaries and benefits of 1,098 staff. VA's Financial Management System (FMS) showed the offices expended an additional

\$40.0 million, excluding centralized purchases on travel, rent, utilities, equipment, supplies, and services.”

The report concluded that “VHA lacked adequate management controls and needed to improve the quality of VISN office data to oversee and evaluate the effectiveness of VISN staff and organizational structures. First, despite improvements, VHA lacked assurance that its performance management system allowed the effective monitoring, evaluation, and comparison of VISN office performance. Second, VHA had not adequately monitored and managed the growth in the offices’ organizational structures and staffing. These lapses occurred because VHA focused on the performance of its healthcare facilities and allowed VISN offices to operate autonomously. Consequently, VHA could not adequately justify the VISN offices’ organizational structures and staffing levels and ensure that they provided optimal oversight, facilitated improved healthcare facility performance, and reflected the effective stewardship of VA funds.”

In the private sector, the independent audit team would be required to do a follow up audit and report to the board to assure that management’s corrective actions were completed. I was unable to find such a follow up audit.

While I am not able to find a comparable comparison on the growth of VACO during the same period it appears that VACO positions seem to have grown disproportionately to the services delivered to Veterans. Should the VA review all VACO programs, policies, and directives to see if they are appropriate for modern management? Should VACO review all of its programs to see if older programs have been superseded by other programs, and which ones are actually evidence based, or might best be administered at the local level rather than centrally?

An alternative structure would be to return to the original intent of the VISN or to simply make the major medical center in each VISN accountable for the VISN strategy and metrics so that the majority of the resources are totally aligned with the best outcome for the region and performance for all directors in the VISN heavily weighted to the whole VISN outcome rather than the individual medical center performance.

Selected Veterans Health Administration Characteristics: FY2002 to FY2013				Calculated
Fiscal Year	TOTAL ENROLLEES¹ (in millions)	OUTPATIENT VISITS² (in millions)	INPATIENT ADMISSIONS (in thousands)	visits/veteran/ y r.
2002	6.8	46.5	564.7	6.8
2003	7.1	49.8	567.3	7.0
2004	7.3	54.0	589.8	7.4
2005	7.7	57.5	585.8	7.5
2006	7.9	59.1	568.9	7.5
2007	7.8	62.3	589.0	8.0
2008	7.8	67.7	641.4	8.6
2009	8.1	74.9	662.0	9.3
2010	8.3	80.2	682.3	9.7
2011	8.6	79.8	692.1	9.3
2012	8.8	83.6	703.5	9.5
2013	8.9	86.4	694.7	9.7
¹ Includes non-enrolled Veteran patients.				
² Includes fee visits.				
Source: Department of Veterans Affairs, Veteran Health Administration Office of Policy and Planning				
Prepared by the National Center for Veterans Analysis and Statistics.				

