June 27, 2014

ISSUES IMPACTING ACCESS TO TIMELY CARE AT VA MEDICAL FACILITIES

There is a strong sentiment among many Veterans and stakeholders that in general VA provides high quality health care "once you get in the door" and that the current system needs to be fixed, not abandoned or weakened. The vast majority of VA employees are dedicated, hardworking, and committed to the Veterans they serve. VA doctors, nurses, and staff could choose to work at other facilities, often for greater compensation. They choose to work at the VA because they believe in this Nation's promise to its Veterans, and they work each day to realize that promise and deliver the quality care Veterans have earned and deserve. However, I also believe that it is clear that there are significant and chronic systemic failures that must be addressed by the leadership at VA.

- The 14-day scheduling standard is arbitrary, ill-defined, and misunderstood. The manner in which this unrealistic goal was developed and deployed has caused confusion in reporting and, in some cases, may have incentivized inappropriate actions. It is a poor indicator of either patient satisfaction or quality of care and should be replaced with a more insightful measure.

- The Veterans Health Administration (VHA) needs to be restructured and reformed. It currently acts with little transparency or accountability with regard to its management of the VA medical structure. The VHA Leadership structure is marked by a lack of responsiveness and an inability to effectively manage or communicate to employees or Veterans.

- A corrosive culture has led to personnel problems across the Department that are seriously impacting morale and, by extension, the timeliness of health care. The problems inherent within an agency with an extensive field structure are exacerbated by poor management and communication structures, distrust between some VA employees and management, a history of retaliation toward employees raising issues, and a lack of accountability across all grade levels.

- The Department's failures have generated a high level of oversight. The Department must be more agile and responsive in addressing legitimate oversight inquiries.

- The technology underlying the basic scheduling system used by VA medical facilities is cumbersome and outdated. However, with regard to increasing access to care, the software underlying the scheduling system is secondary to the need for additional resources to actually schedule – doctors, nurses, and other health professionals; physical space; and appropriately trained administrative support personnel.

- Many of the resource issues VA faces are endemic to the health care field (for example, shortages of certain types of specialists, an aging patient base, or geographical shortages around the country) or to the Federal government (for example, slowness in the hiring process or an inability to compete with private sector wages). However, VA has also demonstrated an inability to clearly articulate budgetary needs and to tie budgetary needs to specific outcomes.

- VA needs to better plan and invest now for anticipated changes in the demographics of the veterans. This includes geographical changes, an increased number of female veterans, a surge in mental health needs, an increase in the special needs of younger veterans returning from Iraq and Afghanistan, and specific needs associated with a growing number of older veterans.

ASSESSMENT: ISSUES IMPACTING ACCESS TO TIMELY CARE AT VA MEDICAL FACILITIES

The 14-day scheduling standard is arbitrary, ill-defined, and misunderstood. The manner in which this unrealistic goal was developed and deployed has caused confusion in reporting and, in some cases, may have incentivized inappropriate actions. It is a poor indicator of either patient satisfaction or quality of care and should be replaced with a more insightful measure.

Background:

In 1995, the Veterans Health Administration (VHA) set a 30-day goal for scheduling primary and specialty care medical appointments. In 2011, VHA shortened that goal to 14 days. VHA includes these performance measures in the performance contracts for Veterans Integrated Service Network (VISN) and VA Medical Center (VAMC) directors. VA also includes these measures in its budget submissions and performance reports to Congress. Also from FY2005 to FY2012, the number of appointments scheduled through VHA has increased approximately 19 percent from 5.3 million to 6.3 million.

Recognizing the inherent issues associated with the 14-day scheduling goal, VA has removed it from employee performance contracts.

Observations:

- The 14-day standard creates an unrealistic comparison between VHA and the private sector. Directly comparable data is not available for the private sector, primarily because experts seem to believe that time-to-appointment is only one component of overall patient satisfaction. Further, anecdotal evidence suggests that wait times for appointments are often times equal to, if not longer, in private facilities.

- The performance goal is complicated to compute and to understand because of vagaries around which "date" is being entered. For new patients, wait times are measured from the "create date" or the date on which an appointment is made. For existing patients, the wait times are measured from the "desired date" or the date on which the patient or health care provider wants the patient to be seen. Because the "desired date" is manually entered by a scheduler, it is more susceptible to manipulation. The "create date" is computer-generated date.

- The 14-day standard was included as a measure in employee performance contracts. This may have created an incentive for employees to try to reduce a number over which they personally had very little direct control. In 2010, William Schoenhard, Deputy Under Secretary for Health for Operations and Management, authored a memo detailing a number of "gaming strategies" used to artificially make wait times look lower. Schoenhard noted, "[w]orkarounds may mask the symptoms of poor access and, although they may aid in meeting performance measures, they do not serve our Veterans. They may prevent the real work of improving our processes and design of systems."

Solutions:

- The Department plans to establish a panel of health care experts and industry leaders to catalogue best practices for measuring timely delivery of health care to Veterans and make recommendations to the new Under Secretary for Health.

- Certain performance measures, like wait time data, should be used as management tools to help identify proper deployment of resources but not as a measure of whether high-quality health care has been delivered in an appropriate fashion.

VHA needs to be restructured and reformed. It currently acts with little transparency or accountability with regard to its management of the VA medical structure. In its most modest form, this insularity has impeded innovation and change. In its more extreme manifestations, it has impeded appropriate management, supervision, and oversight. The VHA leadership structure often is unresponsiveness and unable to effectively manage or communicate to employees or Veterans.

Background:

VHA is America's largest integrated health care system with over 1,700 sites of care, serving 8.76 million Veterans each year. In addition, VHA is the Nation's largest provider of graduate medical education and a major contributor to medical research. In 2013, VA obligated approximately $150 billion. Approximately 98 percent of total funding went directly to Veterans in the form of monthly payments of benefits or for direct services, such as medical care. The existence of such a vast and geographically widespread field structure makes communication to and from the VA Central Office all the more critical.

Observations:

- VHA delivers quality care, but is resistant to reforms and change. Many recommendations or directives from VA Central Office or from oversight entities are minimized, slowly implemented, or ignored.

- The VHA field structure is not accountable or transparent to Veterans, the Secretary, or the Department as a whole. For example, performance data from the field is often slow to be reported and sometimes openly contested by VAMCs through the press in direct contravention of facts and established procedures.

- The VHA leadership team is not prepared to deliver effective day-to-day management or crisis management. Instead, VHA is marked by an inherent lack of responsiveness and a belief many issues raised by the public, the VA Leadership, or oversight entities are exaggerated, unimportant, or "will pass."

Solutions:

- VA needs increased transparency into the way VHA operates. VHA needs a better structure and more accountability in how to manage the field structure.

- VA Central Office needs to be much more hands on with the VHA field structure.

- The reforms needed at VHA are not political – they are structural and operational. VHA requires significant leadership and management restructuring that:

    - One, allows for increased, consistent flow of information from the VA Central Office to the regional and local field structure; and

    - Two, allows for unobstructed flow of information from the field structure to regional and National management and leadership.

A corrosive culture has led to personnel problems across the Department that are seriously impacting morale and, by extension, the timeliness of health care. The problems inherent within an agency with an extensive field structure are exacerbated by poor management and communication structures, a corrosive culture of distrust between some VA employees and management, a history of retaliation toward employees raising issues, and a lack of accountability.

Observations:

- The vast majority of VA employees are dedicated, hardworking, and committed to the Veterans they serve. VA doctors, nurses, and staff could choose to work at other facilities, often for greater compensation. They choose to work at the VA because they believe in this Nation's promise to its Veterans, and they work each day to realize that promise and deliver the quality care Veterans have earned and deserve.

- There is a culture across much of the Department that encourages discontent and backlash against employees. Whistleblower complaints suggest poor management and reflect a palpable level of frustration at the local, regional, and National levels. As an example, approximately one-fourth of all whistleblower cases OSC is currently reviewing across the Federal government come from the Department of Veterans Affairs.

- There is a tendency to transfer problems rather than solve problems. This is in part due to the difficulty of hiring and firing in the Federal government.

- There is culture that tends to minimize problems or refuse to acknowledge problems all together.

Solutions:

- The Department should strengthen management and reporting structures at the VA Central Office and throughout the VHA field structure as referenced above.

- The Department must take swift and appropriate accountability actions. There must be recognition of how true accountability works.

- The tone at the top should encourage employees to speak up about problems, but also to think of and be a part of solutions.

The Department's failures have generated a high level of oversight. The Department must be more agile and responsive in transparently addressing all legitimate oversight requirements.

Background:

There is an incredible amount of oversight on the Department's activities. The IG, OSC, GAO, and several Congressional committees have conducted investigations and reviews into the Department's provision of timely care to Veterans. Over the last 4 1/2 years, VA has provided responses to over 104,000 Congressional inquiries. Over the last 2 1/2 years, VA has responded to over 7,500 requests for policy-related information. And, in the first 6 months of this fiscal year alone, the Department has participated in 33 hearings and 213 briefings for Congress. In the last five weeks, VA has sent over 100 letters to Members of Congress and delivered over 10,000 pages of documents. Twenty-one VA witnesses have provided hours of testimony at 11 hearings. In addition, VA has conducted daily outreach and information exchange between local VA facilities and local Congressional offices. VA has endeavored to be receptive to recommendations and responsive to requests for information – but could still do more.

Observations:

- There have been a number of problems identified and recommendations made by the IG, GAO, OSC, Congress, and others. VA has not followed through on sufficiently addressing those problems or implementing those recommendations.

- The IG is currently conducting investigations at 77 VA facilities. Since at least 2005, GAO and the IG have been identifying concerns regarding scheduling practices and data reliability.

- As of June 23, the OSC had over 50 pending cases, all of which allege threats to patient health or safety. Of those, OSC has referred 29 cases to the VA for investigation. This represents over a quarter of all cases referred by OSC for investigation government-wide. Additionally, 5 U.S.C. § 2302(c) requires agencies to ensure that employees are informed of the rights and remedies available to them under the Whistleblower Protection Act and related laws. OSC has a whistleblower certification program to provide agencies with a process for meeting this requirement. VA is not certified.

Solutions:

- VA should more proactively engage with its various oversight bodies.

- VA should track oversight reports and recommendations. The Department should release quarterly metrics on recommendations made by oversight bodies and VA's response.

- The Secretary should separately meet with the IG, OSC, and the Comptroller General on a quarterly basis. The General Counsel should separately meet with representatives of the IG, OSC, and GAO on a monthly basis.

- The Department should review its process for responding to OSC whistleblower cases (underway), and should designate an official to assess the conclusions and the proposed corrective actions in OSC reports.

- VA should also complete OSC's whistleblower certification program.

The technology underlying the basic scheduling system used by VA medical facilities is cumbersome and outdated. Lack of certain functionalities cause scheduling delays and, in some cases, reporting inaccuracies. However, with regard to increasing access to care, the software underlying the scheduling system is secondary to the need for additional resource to actually schedule – doctors, nurses, and other health professionals; physical space; and appropriately trained administrative support personnel.

Background:

VA began using the VistA electronic health records system in 1985. VistA is the single integrated health information system used throughout VHA in all of its health care settings. VistA is open source and has been used in a number of civilian hospitals.

The VA's VistA system has not changed in any appreciable way since 1985. This system predates the widespread use of the internet. From an engineering or work order management perspective, VistA has many flaws. But, it is state of the art in terms of providing an integrated health record that captures all documentation associated with a patient and it enables the collaboration of the delivery of that care. A 2011 survey by the American Academy of Family Physicians and a similar 2012 Medscape poll found that VistA was better than a large majority of health IT solutions, including those offered by market leaders McKesson and Epic.

VA plans to overhaul the outdated scheduling system and bring an innovative scheduling product into the electronic health record system. VA hopes to award a contract for the new patient-scheduling system by the end of this fiscal year and have the system in place in fiscal 2015.

Observations:

- Dated scheduling systems and practices are causing significant problems for the Department of Veterans Affairs' ability to deliver timely access to quality health care. But neither the systems – nor the schedulers – are the source of extended wait times for Veterans seeking care.

- Many of the resource issues VA face are endemic to the health care field (for example, shortages of certain types of specialists or geographical shortages around the country) or to the Federal government (for example, slowness in the hiring process or an inability to compete with private sector wages). However, VA has also demonstrated an inability to clearly articulate budgetary needs and to tie budgetary needs to specific outcomes.

Solutions:

- Immediate problems with scheduling systems and practices can and are being addressed. The Department will procure new technology and will train frontline personnel on a stronger, modern system.

- VA needs additional resources to ensure adequate and appropriate health care for our Nation's Veterans. Those resources include:
    - Primary Care Physicians
    - Specialty Care Physicians
    - Administrators and Support Staff
    - Space (parking, examination, and surge space)

- VA needs to start planning and investing now for anticipated changes in the demographics of the Veterans. This includes geographical changes, an increased number of female Veterans, a surge in mental health needs, an increase in the special needs of younger Veterans returning from Iraq and Afghanistan, and specific needs associated with older Veterans.

- In the short term, VHA is working to increase the use of contract care. However, VHA must proceed with this carefully as proper oversight of the quality and timeliness of contract care is essential.