



## Veterans Access, Choice, and Accountability Act of 2014 -Independent Assessment



## Blue Ribbon Panel Presentation to the Commission on Care

October 19, 2015



**Brett P. Giroir, M.D.**

Panel Chair

# Blue Ribbon Panel Charter

- As part of the Independent Assessment under the Choice Act, MITRE created and convened a select Blue Ribbon Panel, to be a high level cross-cutting advisory and review board
- The Panel's original objective was to perform an independent review of MITRE's interim report and draft integrated final report to ensure that the recommendations serve our U.S. veterans and to transform the VA into an effective 21<sup>st</sup> Century model of service
- The Panel was independent and free to evaluate the findings based on its subject matter expertise and communicate those findings as recommendations to MITRE without interference

# Blue Ribbon Panel Membership

**Brett Giroir, MD, Chair**

Senior Fellow, Health Policy Institute, Texas Medical Center; Former CEO Texas A&M HSC and Director of the DARPA Science Office

**Gail Wilensky, PhD, Co-Chair**

Senior Fellow Project Hope; Former Director of Medicare and Medicaid and WH Advisor to Bush '41. Former Pres Defense Health Board, Regent at USUHS

**Katrina Armstrong, MD, MSCE**

Physician-In-Chief, MGH Dep. of Medicine

**Debra Barksdale, PhD, NP**

Prof and Director DNP Program, UNC Chapel Hill; Board Member, Patient Centered Outcomes Institute

**Ronald R. Blank, DO, Lt. Gen. USA (Ret)**

39<sup>th</sup> SG of the US Army; President of Univ. of North Texas Health Science Center

**W. Warner Burke, PhD**

Thorndike Prof of Psychology and Education, Columbia University

**Christine Cassel, MD**

Pres and CEO, National Quality Forum

**Peter W. Chiarelli, Gen. USA (Ret)**

32<sup>nd</sup> Vice Chief of Staff, US Army

**George Halvorson**

Chairman and CEO Kaiser Permanente (2002-13)  
Former Chair and CEO Health Partners of Minnesota

**Robert L. Mallett**

Pres and CEO Accordia Global Health Foundation;  
Former Dep Sec Dep of Commerce; Former SVP Pfizer

**Robert Margolis, MD**

Former Board Chair DaVita HealthCare and CEO of HealthCare Partners

**George Poste, PhD**

Webb Professor of Health Innovation, Arizona State.  
Former Chief Scientist at SmithKline Beecham

**Robert Robbins, MD**

CEO Texas Medical Center; Former Chair CV Surgery at Stanford

**Mark D. Smith, MD**

Former CEO California HealthCare Foundation  
Chair, IOM Committee on the Learning Health Care System

**Glenn D. Steele, MD, PhD**

Former Pres and CEO Geisinger Health System

**Beth Ann Swan, PhD, CRNP, FAAN**

Dean and Professor, Jefferson College of Nursing

# Blue Ribbon Panel Activities

- Panel did not perform primary data collection or site visits: data were snapshot in time
- Four 2-day meetings at MITRE following extensive review of written materials; numerous teleconferences and discussions
- Reviewed data acquisition plan and sampling methodologies; recommended priorities for focus to elucidate root causes
- Reviewed individual subcontractor data, interim assessments, and interim recommendations
- Identified high performing non-VHA systems and best practices
- Fully participated in iteration of core issues along with recommended action plans



The Panel unanimously supported the Integrated Report as documented by a signed letter in the Preface

# Blue Ribbon Panel Editorial



*The* NEW ENGLAND JOURNAL *of* MEDICINE

Perspective

## **Reforming the Veterans Health Administration — Beyond Palliation of Symptoms**

Brett P. Giroir, M.D., and Gail R. Wilensky, Ph.D.

September 30, 2015

# Executive Summary

“...VHA’s health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.”

“...the organization is plagued by many problems: growing bureaucracy, leadership and staffing challenges, and an unsustainable trajectory of capital costs”

“...there are bright spots throughout VHA that illuminate best practices that work effectively within the VHA environment.”

# Executive Summary

“VHA must adopt systems thinking to address its most challenging problems including access, quality, cost, and patient experience

## Systemic Findings:

- Misalignment of demand, resources, and authorities
- Bureaucratic operations and processes
- Widespread crisis in leadership
- Lack of fundamental enterprise systems and data tools

## Recommendations:

- New governance to clarify vision, allocate resources, assure accountability, and simplify purchased care
- Patient centered care model with appropriate local autonomy
- Heal broken culture and increase appeal of senior positions
- Deploy modern, common tools to assure data integrity, transparency, and continuous improvement

# Major Findings - Access

- Patient access to *many* VHA Medical Centers does not achieve VHA or patient expectations
  - **VHA Data (example)**
    - At 91 top-performing VA facilities, >96% of new primary care patients receive appointments within 30 days of preferred date.
    - At 14 VA facilities only 84% received appointments within 30 days of preferred date
  - **Veterans Survey (example)**
    - At top performing VA facilities, >60% of Veterans report they “always got urgent care appointments as soon as need”
    - At the worst-performing VA facilities, this rate was closer to 20%

# Major Findings - Access

- The VHA metric of “preferred date” for appointments is not the industry standard, and was generally assessed to be subject to negotiation and manipulation

The Report recommends use of objective parameters such as “same day availability” or the “third next available appointment” which are more difficult to manipulate and provide opportunity to benchmark to non-VHA health systems

# Major Findings - Quality

- On most quality measures for *outpatient care*, VHA outperformed other health care systems  
(Example: eye exams in patients with diabetes)
- VHA performance on quality measures of *inpatient care* was mixed, with some better and some worse  
(Worse performance on 3/6 measures of “Mortality and Readmissions” and 6/10 measures of “Patient Centeredness”)

There is significant variability across the VHA suggesting need for systematic approach to sharing best practices and lessons learned

## Major Findings - Costs

The legislative timeframe and requirements did not support an exploration of VHA costs relative to the private and other public sector health systems

# Major Findings – VHA \$ Inefficiencies

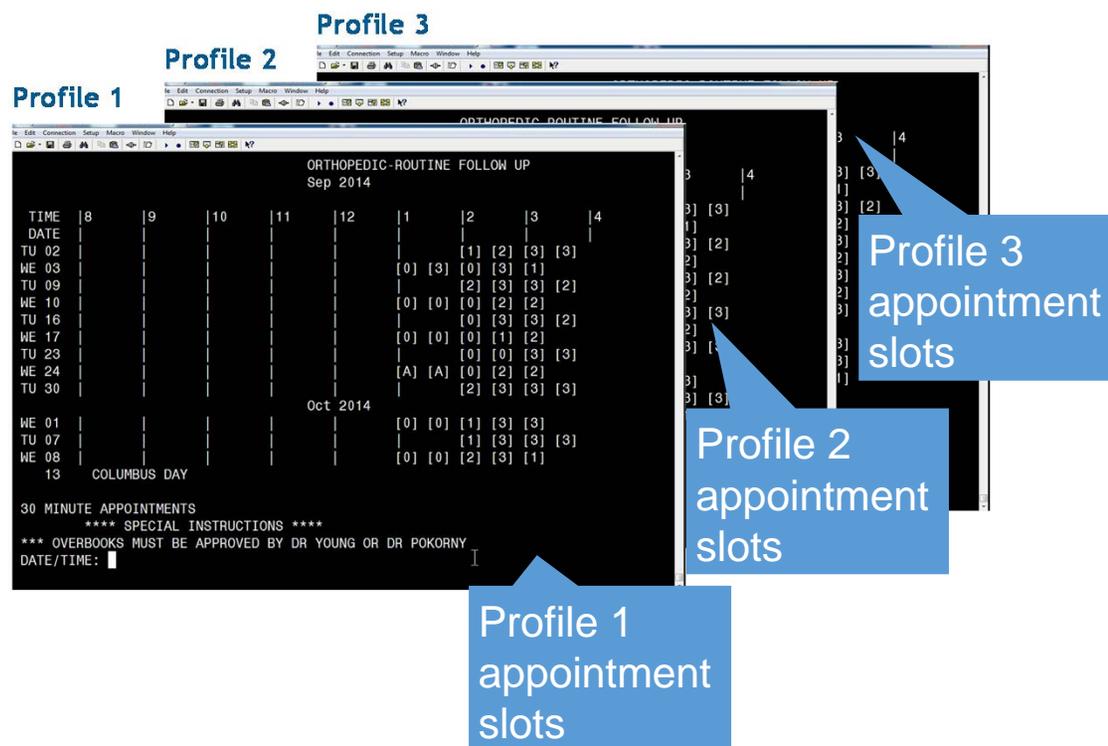
- 25% of VHA admissions fail to meet criteria for admission
- Inpatient length of stay is at least 57% higher than the Medicare average (VHA LOS > 30 days are coded as 30 days). Less than half of in-patients have case management
- 38% of VAMCs reported closing beds due to staffing or construction: VAMC case study– only 51% of authorized beds were actually available
- VA Construction 2X cost of private sector and 3X time to completion
- 10-20% lost outpatient appointment opportunities due to ineffective scheduling system, training, and other factors
- VHA specialists are significantly less productive than private sector (with notable exception of mental health)
- VHA primary care physicians have 14% fewer patients on their panels than ideal severity adjusted panel size
- >\$580 million in claim denials in 2014 due to antiquated, manual systems and insufficient staff training

# Improving Physician Productivity – *A Systems Approach*

- Identified Barriers to Physician Productivity
  - Lack of exam rooms
  - Lack of clinical and administrative support staff
  - Poor patient scheduling practices
  - Insufficient realignment of resources to meet changing patient demands
- Root Cause Systems Issues Preventing Fixes
  - Facilities construction and leasing processes that cost 2x as the private sector and take 2X-3X longer to complete
  - Hiring processes that take 3X more time than private sector
  - Lack of a common electronic scheduling system that is transparent to staff and patients
  - Central bureaucracy, color of money issues, and insufficient empowerment of local leaders to allocate resources

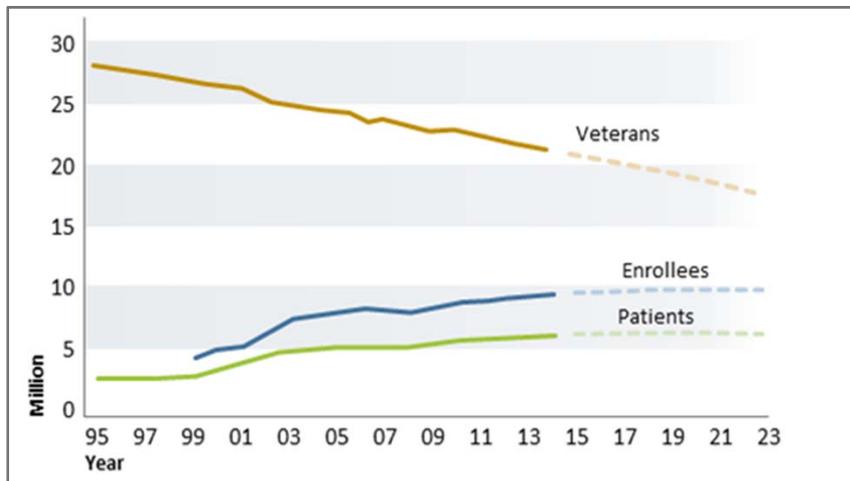
# Improving Physician Productivity – *A Systems Approach*

## Example view of clinic profiles for single provider



# Recommendations - Governance

## Demand Estimate from Integrated Report Assessment A (Rand)



## 2014 VHA Demographics

- 21.6 million US Veterans
- 12.8 million eligible to enroll
- 9.1 million enrolled
- 5.8 million were actual VHA patients
- VHA patients received much less than 50% of care from the VHA

Demand for VHA services is highly dynamic and could increase or decrease significantly depending on VHA patient experience as well as external factors such as the Affordable Care Act

# Recommendations - Governance

Establishment of a new governance board that is representative, expert, and empowered to make dynamic decisions and allocate resources

**Define the benefit,  
accurately forecast demand,  
align resources to achieve  
objectives**

**Simplify programs and  
processes for purchased care  
to provide the best value for  
the Veteran**

**President and Congress  
should consider a new  
structure for VHA, e.g.,  
federal non-profit corporation**

# Critical Strategic Decisions

Should the VHA aim to be the comprehensive provider for all Veterans health needs?

Or should the VHA provide highly specialized care, and use non-VHA providers for majority of Veterans health needs?



The specific balance may vary by geographic region and time. VHA will likely need to expand its role as a care coordinator in addition to its traditional role as a care provider.

# Strategic Decisions



**VA**  
**HEALTH**  
**CARE**

Defining  
**EXCELLENCE**  
in the 21st Century



**Current  
Transformation**

Increase RVU productivity and provision of basic services including fee-for-service purchase options with non-VHA providers



**Required  
Transformation**

How does the VHA become a modern value-based health care system, coordinating care with non-VHA providers, incentivized for outcomes: **quality, cost-effectiveness, and patient experience**

# Recommendations- Leadership

- 39% of senior leadership teams at VAMCs had at least one vacancy
- 43% of network directors had “acting” status
- More than 2/3 of network directors, nurse executives, and chiefs of staff are eligible for retirement, as are 47% of medical center directors
- Why the crisis?
  - Compared to peers and global benchmarks, VHA is in the 4<sup>th</sup> quartile in every measure of organizational health
  - Descriptors: risk averse, distrustful, and occasionally toxic culture with limited authority to effect change
  - Lack of strategic direction and “whack a mole” operational mentality
  - Dramatically less compensation than private sector equivalents

# Recommendations- Leadership

- Stabilize, grow, and empower leaders
- Galvanize them around priorities and clearly iterated vision and strategy
- Build a healthy culture of collaboration, ownership, and accountability

# Recommendations– Operations and Culture

Growing centralized bureaucracy has led to lack of customer focus and reduced prioritization of VHA front line needs

VHA scored in the 4<sup>th</sup> quartile in 35 of 37 management practices as compared with peers

- Reorient VHA Central Office to focus on support to the field
- Fix substandard processes that impede quality of care and access
- Implement a systematic approach to dissemination and adoption of best practices

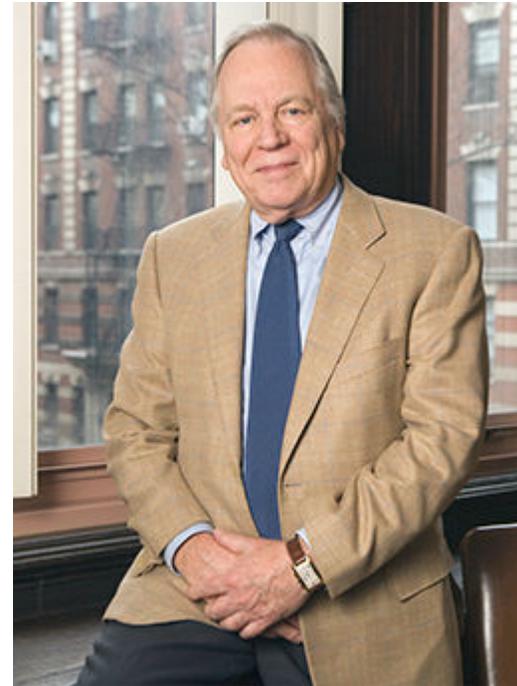


# Recommendations– Operations and Culture

“You change organizations and organizational culture by first changing behaviors.”



**“Never Say No”**



**W. Warner Burke, PhD**  
Member, Blue Ribbon Panel  
Leading International  
Authority on Organizational  
Change

## Recommendations– Information Systems and Data

- Implement standardized clinical and administrative data to assure accuracy and interoperability
- Implement a single, integrated set of system-wide tools including scheduling, hiring, supply chain, billing, claims, and patient centered navigational tools
- Perform rapid, objective, independent analysis of continued support and maintenance of the VistA EHR versus adoption of a commercial EHR
- Transparently develop and share performance metrics across VHA to identify and adopt best practices for continuous improvement

# VHA Integrated Report



“To care for him who shall have borne the battle and for his widow and his orphan”

Abraham Lincoln