

**NATIONAL ASSOCIATION OF VETERANS AFFAIRS PHYSICIANS AND
DENTISTS**

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STATEMENT FOR THE RECORD

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**NATIONAL ASSOCIATION OF VETERANS AFFAIRS PHYSICIANS AND
DENTISTS (NAVAPD)**

**BEFORE THE
COMMISSION ON CARE**

CONCERNING WORKFORCE PERSPECTIVES

**THURSDAY JANUARY 21, 2016
8:30 A.M.**

Chairperson and Distinguished Members of the Commission on Care

Thank you for the opportunity to address your Commission this morning.

I am here as a practicing physician who has spent 45 years with the VA, and as the President of the National Association of Veteran Administration Physicians and Dentists usually referred to as NAVAPD.

NAVAPD is the official national organization of VA physicians and dentists who proudly serve our nation's veterans. Our nonprofit organization is

dedicated to improving the quality of patient care in the VA health care system and ensuring the doctor-patient relationship is maintained and strengthened. In fact, our bylaws state that “NAVAPD has as its highest priority the preservation and strengthening of the VA Health Care Delivery System so that it is able at all times to give veterans quality medical care equal to or better than can be obtained elsewhere in our society.” I appear today in pursuit of that purpose.

NAVAPD believes that a key means of enhancing the care of the Veterans is by employing the best physicians and dentists. To that end, we work to ensure that physicians and dentists are enabled to positively influence care; that the professional working conditions encourage VA physicians and dentists to increase access to high-quality health care for our veterans; and that incentives assure that the best physicians and dentists are attracted to the VA health care system. NAVAPD believes it is essential for physicians and dentists to be in charge of decisions regarding delivery and quality of care.

Although I began my involvement with the VA during the Vietnam War era as a resident in internal medicine in Boston, it wasn't long before I arrived in DC and began my long tenure at both the DC VA Medical Center and George Washington University and over these many years I have held various titles and positions.*

During these years, I have also witnessed firsthand many changes in the VA, some good and some not so good. I have had the opportunity to meet nearly all the Secretaries of the VA over the last 35 years, got to know got to know several of them, and saw a few as patients. I believe all of these individuals have been good people and all had the best of intentions. I am sure Secretary McDonald, whom I have also met with, also has good intentions.

*1981- Professor of Medicine George Washington University School of Medicine
1975-1976 Acting Chief, Medical Service, VA Medical Center, Washington, DC
1978-1993 Director, Division of Pulmonary Diseases George Washington University Medical Center
1976-1994 Chief, Pulmonary Diseases Section, VA Medical Center, Washington, DC
1998-1999 Chief of Staff, VA Medical Center, Washington, DC
2000- Senior Attending in Pulmonary Diseases and Medical Director Respiratory Care

Notwithstanding the good intentions of these good people, however, the role of the physician within the VA system as the leader of medical care has greatly diminished over this same period, to the detriment of patient care and organizational operations.

Diminishing the role of physicians and dentists in the VA's decisions regarding delivery and quality of care is a primary cause of – if not **the** primary cause of: difficulty in recruiting physicians and dentists, VA physician and dentist retention problems, and the drop in veterans' confidence in their care.

Currently, in the VA, the single greatest impediment to recruiting and retaining physicians and dentists is the disenfranchisement and marginalization that many of the current physicians and dentists experience daily. Today, most VA physicians and dentists feel like their opinions are neither helpful nor requested. In many facilities, their suggestions are summarily rebuffed as inconsequential. At many centers, physicians and dentists are no longer even considered professionals but referred to as simply the “workers”. These observations do not just come from NAVAPD leadership, but directly from our members, VA docs and dentists. Men and women who want to help improve “the system.”

In the late 1960s and 1970s nearly all of the VA Medical Centers were led by Directors who were physicians. Today, very few medical centers have physician directors. The position now called the VA Undersecretary for Health was known as the Chief Medical director. At that time there was a direct line from the Chief of Staff at the medical centers to the Chief Medical Director. Issues of delivery and quality of medical care were raised and addressed by medical professionals. Today the Chiefs of Staff report to a Clinical Specialist in the Veterans Integrated Service Networks (VISN). All too frequently it appears that the Clinical Specialist has different priorities and has little care or interest in what the Chief of Staff has to say. In more recent times there has been a strong movement to eliminate the need even to have a physician in the role of Undersecretary for Health. Would it be wise, or even possible to run the Defense Department without Generals and Admirals in leadership positions?

The single greatest possible source of knowledge to improve care, enhance access, and advance improved outcomes is the VHA's physicians

and dentists and it's Medical Staff. Some of the best health care systems in the country are managed by physicians: Mayo Clinic, Massachusetts General Hospital, Cleveland Clinic, if not actually by physicians in the corporate offices, at least through incorporation in decision making and strategic planning.

The VA touts its superb physicians and dentists when they speak of VA's many accomplishments in clinical care and research while at the same time physicians and dentists are generally being ignored, isolated, and disrespected. An organization that strives for medical excellence should be encouraging its professionals to maintain and enhance their skills and education. However, the VA's budget allotment for physicians' continuing medical education (CME) continues to decline and burdensome forms and approvals keep increasing. A further, biased and manipulative productivity assessment of physicians continues within some specialty departments.

We are not saying that there is no role for non-physicians in the administration of hospitals or medical care. We are saying, however, that medical judgments should be based on years of education and patient care. Professional health care judgments should be made and evaluated by physicians and dentists, not MBAs. Yet at the VA a variety of non-physicians have been elevated to the role of "overseers" of physicians and dentists. In recent years VA non-physicians have taken on roles traditionally reserved for physicians. In the name of cost-savings and efficiency, nurses have been granted authority over physicians and judge and evaluate competency of physicians and dentists.

Physicians are being loaded with additional duties more appropriate for non-physicians, such as typing letters, filing, follow-up calls, patient reception, and preparation. Similarly, it is not a cost saving nor is it efficient to have physicians routinely escort patients from waiting rooms to exam rooms. These short-sighted, inappropriate duty reassignments greatly reduce physician efficiency resulting in fewer patients being seen on any given day. They deflect physicians from seeing more patients. Merely increasing the VA budget has not and will not solve the problem; more money alone will not provide more timely access to physicians. The problem is the many practices that decrease efficient use of physician time.

There is a growing trend to add non-physicians and there is a growing concern that a veteran may never be seen or treated by a physician while a

patient in the VA system. Veterans are seen by non-MD doctors without ever realizing they have not seen a medical doctor. We believe this is dangerous for patients and their families and may raise ethical issues.

In fact, members recently have contacted me about clinical pharmacists managing patients not only with diabetes but also with hypertension and other medical issues. The Endocrinologists have no input and if they wish to do anything to the patient they are now challenged to justify on an evidence basis. Another example are the clinical pharmacists decide which medications to supply Hepatitis C patients to a cheaper one with the most side effects (not unusual to have 5). Typically, the physicians prescribe the least expensive with minimal side effects.

Additionally, LPNs with little or no psychiatric experience are taking the place of psychiatrists doing intake counseling and assessments in some psychiatric departments. Psychologists instead of M.D. psychiatrists are doing Veterans' Compensation & Pension (C&P) Examinations.

I want to call the Commission's attention to the following selected findings from Independent Assessment on Staffing/Productivity/Time Allocation prepared by Grant Thornton that have been noted in many previous studies, and continue to go unfixed, follows:

- Insufficient exam rooms and poor configuration of space limits providers' productivity, ability to maximize patient throughput, and reduces patient access.
- Clinical and administrative support staff ratios are insufficient and may limit provider productivity.
- Insufficient clinical and administrative support staff results in providers and clinical support staff not working to the top of their licensure.
- While there has been widespread implementation of the Patient Aligned Care Team (PACT) model in primary care, there are no current VHA standards for staffing levels and/or mix in specialty clinics, with the exception of eye clinics.

- Organizational siloes and separate reporting lines exist for physicians, nurses and medical service administrators at a majority of VA Medical Center (VAMCs). As a result, service chiefs do not have control over the resourcing and performance of their clinical support staff (nurses) or clerical and administrative support staff.

Further, we have read the October 1, 2015 New England Journal of Medicine Article "Reforming the Veterans Health Administration - Beyond Palliation of Symptoms" authored by Drs. Giroir and Wilensky which addressed "Core Issues" that must be addressed before any significant, sustainable improvements in the VHA can be ensured. NAVAPD concurs with the recommendations in this report.

Congress has provided additional funds to add physicians and clinical staff to meet the needs of Veterans. Unfortunately, the additional funds are all too frequently misapplied. For instance in some facilities it is reported that newly hired junior physicians are being paid as much as \$40,000 more than senior attending physicians and the additional funds were applied only to new physicians. If continued, this will clearly cause the loss of experienced VA physicians.

2014 was a crisis year for the VA where confidence in the entire system was badly shaken. New leadership was put into place and all are still hopeful for better things to come. However, our latest survey of NAVAPD members say things may gotten worse. The VA has even published their Blueprint for Excellence, a rather lengthy 50-page document full of wonderful pronouncements about the future of VA care.

What is the implementation strategy???

Taking care of patients and providing excellent care has a lot to do with providing the basics and using a lot of common sense.

For example, when patients are asked what is important to them you will hear simple straight forward common sense questions such as:

- Will I be admitted quickly?
- Is the room clean?
- Is there a bathroom in the room?

- Does the call button work and does someone answer and arrive quickly if I need them?
- Does everyone speak so that I can understand them?
- If I need help to eat will someone be there to help me?
- Do my doctors and nurses spend time explaining things so that I can understand what is happening?

Patient surveys indicate that none of the above questions are being answered very well in the VA.

Although the crisis in the VA did focus on access to care, this is but one small piece of the total package. Getting timely initial access is of little value if it still takes months to get a hip replaced or have a lung cancer removed or a colonoscopy screening because there may not be sufficient physicians or adequate access to operating room time. Timely access must be assured throughout the course of care, not just on initial visits.

VHA is referred to as a health care system. At best, it is a collective of hospitals and other medical facilities operating under a common umbrella identity. The operation and standards of every facility are different. The hiring process is different, the process for scheduling patients is different, and the way Performance Pay and Travel Pay are processed and approved is different. As one Congressman commented to the then-Acting Secretary in a House Veterans Affairs Committee meeting last June, “During my visit to the medical center I was told that there is “our” way and the VA way, and here we do it our way.”

In reality there is no unified “VA way.” The common chatter throughout the organization is “If you have seen one VA, you have seen one VA.” There may be increased efforts to align the processes across the organization, but from the frontline perspective, it is not apparent. The facilities operate as individual fiefdoms with little interference from the VISNs or the Central Office. In that same House VA Committee meeting in June, 2014, health care experts from Humana and the Studer Group noted that operating in such non-aligned, inconsistent ways is a major challenge to efficiency and consistent outcomes. The process of hiring, terminating, promoting, or evaluating an individual should not vary building-to-building.

There must be a unification and simplification of processes across the organization to achieve any order of efficiency and common outcomes. An

employee should not have to guess or learn totally different processes when shifting from one building to another.

Within the VA there remains a lack of a valid staffing or productivity system. For over 34 years, the VA has been under a Congressional mandate to develop and implement such a plan. So far to our knowledge no such comprehensive plan has been put forth for review. We believe there exists in some facilities a striking imbalance in physician ratios between specialty sections and services. This imbalance also exists within nursing services when compared to the private sector. We have heard that one VA medical center has more than 50 nurse managers for a facility with only 150 in-patient beds. In addition, in some facilities the physicians and dentists' productivity is severely reduced because they can utilize only one exam room. In a southern VA medical center requests to hire additional dentists are denied because only 8% of veterans access dental care, despite more than 500 restorative appointments being booked more than 90 days out.

A customer service program implemented a few years ago called "I CARE" has been resurrected. Initially, this was only through circulation of a document reintroducing the program. Fortunately, after complaints from Veterans Service Organizations (VSOs) and various groups including NAVAPD, a few in-person sessions were added. However, most employees are only required to do an online review and self-certify that they are committed to the program. Changing a culture is difficult but not impossible. Simply reviewing a few slides periodically will not do the trick. The "I CARE Quick Reference" spells out the desired core values of the VA: Integrity, Commitment, Advocacy, Respect and Excellence. After a year of focused attention many agency employees and veterans are questioning the "I CARE" program as a cosmetic effort that has done little to improve services. Many feel that management's approach has made a mockery of the program.

In reality, according to VA employees from around the Nation, announced programs and changes to date have not resulted in improvements in their facilities. Employees are no more empowered than before and feel less trusted and less respected.

Despite recent additional funding from Congress, employees report that acquiring critically needed patient care staff is harder than before. However, staffing has increased for additional non-patient care and for

management. Impediments to improved care and operations have not been removed.

No operational or structural changes that would increase the efficiency of physicians and dentists have been implemented. Changes announced by the current Secretary are not being consistently implemented in local facilities, perhaps because the facility leaders have not understood that these changes are mandatory.

In summary, as physicians and dentists in the VA Health Care System our goal above all others is to provide world-class care to our nation's veterans.

The VA/VHA issues are largely due to the fragmentation of the Agency and its standard operations. The VA/VHA operates not as a system but as a loose collective with wide variation. This seems to be the key failing, whether discussing Human Resources issues or supply chain problems. Procedures are too complex involving too many decision points, too many decision makers, and too much variation facility-to-facility. These points have been made repeatedly, in numerous committees, articles, and reports. But significant change has not come. Strategies to resolve these fundamental problems are:

- streamline the agency and its processes, and make them transparent;
- unify the processes across the organization to bring consistency of operations to the system;
- simplify the processes to allow rapid improvements and decisions, instead of languishing for months or years in an endless review process;
- restore the leadership role of VA physicians and dentists to make patient care decisions and lead the patient care team and appoint physicians as Medical Center directors;
- expedite the current committee and commission review process so that systemic changes can be made in a timely manner before operations further erode."

Above and beyond the Hippocratic Oath, our duty is to care for and provide the very best treatment to those who put their own lives at risk for our

freedom. When roadblocks or unethical practices prevent us from doing so, it is our duty and responsibility to speak up.

Sessions like this are important and helpful and NAVAPD appreciates the opportunity to be heard. I believe that this Commission, Congress and the Nation WANT to “fix” the medical care “problem” at the VA. The unfortunate truth however, is that it is far easier to “throw money” at the problem than it is to fix it. We at NAVAPD ask that as new efforts and strategies are explored to improve delivery and quality of care to our Nation’s veterans, that the physicians and dentists who treat them are included in the process and the solution.