

THE RISE AND FALL OF VA HEALTH CARE: 1994-2014



VA Commission on Care
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PRESENTATION OBJECTIVES

- PROVIDE A BRIEF OVERVIEW OF THE TRANSFORMATION OF THE VA HEALTH CARE SYSTEM IN THE LATE 1990S
- REVIEW SOME KEY FACTORS WHICH HAVE, OVER THE PAST DECADE, UNDERMINED THE VA'S NASCENT CULTURE OF QUALITY AND ACCOUNTABILITY THAT HAD TAKEN ROOT IN THE LATE 1990S
- HIGHLIGHT SOME OF THE FACTORS WHICH MUST BE ADDRESSED TO RESTORE VA TO ITS POTENTIAL LEVEL OF PERFORMANCE

DISCLOSURE: THIS PRESENTATION HAS BEEN INFORMED BY:

- SERVICE AS VA'S UNDER SECRETARY FOR HEALTH, 1994-1999
- SERVICE ON MULTIPLE NATIONAL ACADEMY COMMITTEES AND EXPERT PANELS, INCLUDING AMONG OTHERS:
 - ✓ ANALYSIS OF THE VA FEE CARE PROGRAM (NAPA¹, 2011 REPORT)
 - ✓ ASSESSMENT OF THE TREATMENT OF PTSD (IOM², 2012 & 2014 REPORTS)
 - ✓ ASSESSMENT OF READJUSTMENT NEEDS OF MILITARY PERSONNEL, VETERANS... (IOM², 2013 REPORT)
 - ✓ GULF WAR AND HEALTH – #9 LONG TERM EFFECTS OF BLAST EXPOSURES (IOM², 2014 REPORT)
 - ✓ GULF WAR AND HEALTH – #10 [FINAL] (IOM², 2016 REPORT)
 - ✓ EVALUATION OF VA MENTAL HEALTH SERVICES (IOM², IN PROGRESS)
 - ✓ EVALUATION OF VBA PROCESSES (NAPA¹, IN PROGRESS)

¹ NAPA-National Academy of Public Administration

² IOM-Institute of Medicine, National Academy of Sciences

DISCLOSURE: THIS PRESENTATION HAS BEEN INFORMED BY:

- SERVICE ON VARIOUS VA-RELATED COMMISSIONS AND ADVISORY BOARDS, INCLUDING:
 - ✓ HUMANA VETERANS HEALTHCARE SERVICE, ADVIS COMM (2007-2012)
 - ✓ COMMISSION ON THE FUTURE OF AMERICA'S VETERAN (2006-2008)
 - ✓ VETERANS POLICY OVERSIGHT COMMITTEE, AMERICAN LEGION (2008-PRES)
 - ✓ UC PRESIDENT'S ADVISORY COMMITTEE ON STUDENT VETERANS (2014-PRES)
 - ✓ USH NOMINATIONS COMMISSION (2004, 2009, 2014)
- CONSULTANT ON NUMEROUS VA PROJECTS, INCLUDING:
 - ✓ PATIENT SCHEDULING AND WAIT TIMES IMPROVEMENT (BAH, 2008)
 - ✓ ALASKA VA HEALTH SYSTEM REDESIGN PROJECT (2009-2011)
 - ✓ VAMC ROSEBERG ASSESSMENT (BAH, 2009-2010)
 - ✓ VA-DOD EHR INTEROPERABILITY (BAH, VARIOUS)
 - ✓ OTHERS

DISCLOSURE: THIS PRESENTATION HAS BEEN INFORMED BY:

- ORIGINAL INVESTIGATOR ON VARIOUS VETERAN/VA ISSUES
 - ✓ PERFORMANCE MEASUREMENT (JGIM 2012)
 - ✓ VETERANS AND THE AFFORDABLE CARE ACT (JAMA 2012)
 - ✓ VA-MEDICARE DUAL ENROLLEE ISSUES (JAMA 2012, HSR 2015)
- CONSULTANT REVIEWER OF NUMEROUS VA/VETERAN-RELATED REPORTS
- CURRENT WORK AT IPHI, INCLUDING:
 - ✓ QUALITY OF CANCER CARE IN CALIFORNIA
 - ✓ CA' S VETERANS HOUSING AND HOMELESSNESS PREVENTION PROGRAM
- EXTENSIVE INVOLVEMENT WITH PRIVATE AND OTHER PUBLICLY FUNDED HEALTH CARE SYSTEMS

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VA TRANSFORMATION, 1994-1999

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WHEN ASKED TO LEAD THE VA HEALTH CARE SYSTEM IN 1994, MOST EVERYONE WAS UNSATISFIED WITH ITS PERFORMANCE. THERE WAS WIDESPREAD AGREEMENT ABOUT WHAT WAS WRONG, BUT LITTLE AGREEMENT ABOUT WHAT TO DO TO FIX IT.

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Key Problems with VA Health Care in 1994

- Care was fragmented and uncoordinated; hospital-centric; specialist-based; episodic and reactionary
- Care often difficult to access – e.g., long waiting times, long distances to hospitals for many patients
- Irregular and unpredictable quality
- Rapidly rising costs
- Highly bureaucratic; centralized and hierarchical management; extreme micro-management; little accountability; highly risk-averse; little innovation; staff demoralized; veterans unsatisfied
- Organizational leadership frequently changed and not always selected on the basis of health care management competency
- Governance issues and capital investment decisions were highly politicized; parochial political needs often conflicted with health care system and veteran care needs

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Investing in Nukes • Saving Sotheby's • Coke at a Crossroads

FORTUNE

TECH

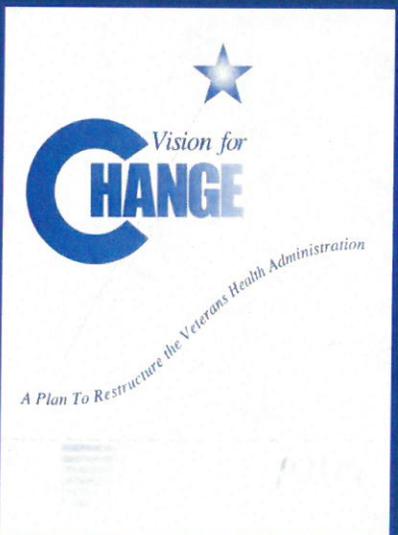
HOW THE VA HEALED ITSELF



Veterans' hospitals used to be a byword for second-rate care or worse. Now they're national leaders in efficiency and quality. What cured them? A large dose of technology. BY DAVID STONES

An avuncular man with a gravelly voice, Dr. Michael Smith is 60. He's up to his chest in a hospital bed, a large monitor to his right that lists a patient's complete health record, including office visits, drug prescriptions, and lab tests. "Absolutely everything is available," says the chief of staff at the Manhattan campus of the VA New York Harbor Health Care System. It's gone a considerable distance from the patient—a 64-year-old veteran who has been in the hospital for a week and a half. Smith is the director of the system's information systems department. He's been at the VA for 15 years, and he's been instrumental in the system's transformation into a national leader in efficiency and quality. The system's success is the result of a large dose of technology. Smith is the director of the system's information systems department. He's been at the VA for 15 years, and he's been instrumental in the system's transformation into a national leader in efficiency and quality. The system's success is the result of a large dose of technology.

Reform began with a new vision of how the system would operate



The Veterans Health Care System will provide a seamless continuum of consistent and predictable high quality, patient-centered care that is of superior value.

The New Vision was Based on Concepts of Value and Accountability

1. The system must demonstrate health care value that is equal to or better than the private sector
2. Superior quality will be predictable and consistent throughout the system
3. System-wide and local performance goals and expectations will be clearly identified
4. Performance (against goals and expectations) will be measured and continuously improved
5. Decision making will be at the lowest appropriate level in the organization

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Health Care Value Defined

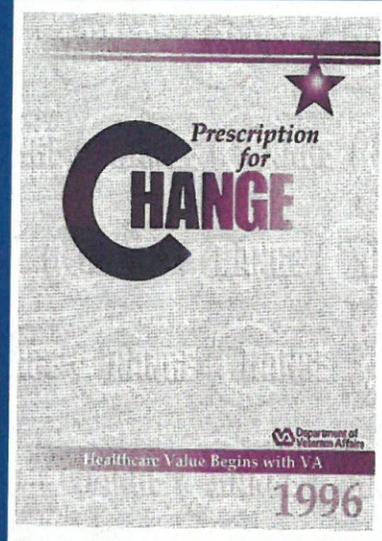
$$V = \frac{A+TQ + FS + SS}{C}$$

- V = Value
- C = Cost/price
- A = Access or Accessibility
- TQ = Technical quality
- FS = Functional status
- SS = Service satisfaction

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VHA's Strategic Reform Strategy

1. Increase accountability
2. Integrate and coordinate care
3. Improve and standardize superior quality
4. Modernize information management
5. Align finances with desired outcomes



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Strategic Objective 1: Increase Accountability

Tactics Used to Increase Accountability

- Created a new accountable management structure based on the concept of integrated delivery networks
- Implemented a new performance management system having clearly identified performance expectations and tracked results
- Decentralized decision making to the lowest appropriate level
- Worked to ensure consistency in messaging and communications

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The New VA Health Care System Management Structure

- Established 22 Veterans Integrated Service Networks (VISNs)
 - ✓ Each network had a defined patient population and geographic service area and was able to provide a continuum of primary to tertiary care
 - ✓ Based on long-standing patient referral patterns and other criteria
 - Placed “a premium on improved patient services, rigorous cost management, process improvement, outcomes and ‘best value’ care.”
 - Expected network leaders to “utilize data-driven methods to manage total performance” in ways that deliver care in a patient-centered manner and that improves the overall health and functionality of the population

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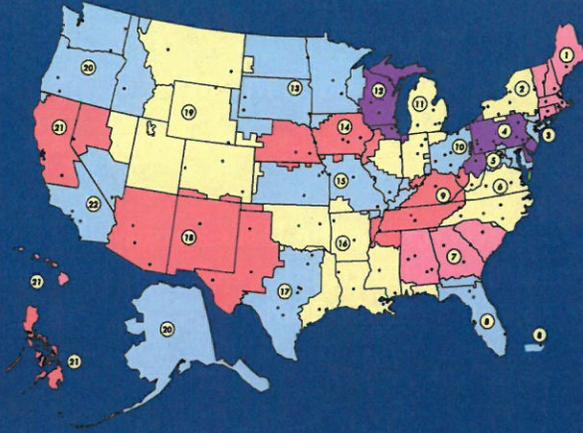
VISNs → Prototype ACOs

In the VISNs, the hospital was envisioned to be an important but less central component of “larger, more coordinated community-based network of care” in which emphasis is placed “on the integration of ambulatory care and acute and extended inpatient services so as to provide a coordinated continuum of care.”*

*Vision for Change, 1995

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Veterans Integrated Service Networks (VISNs)



Typical VISN Assets

- 7-10 hospitals
- 25-30 clinics
- 5-7 long term care facilities
- 10-15 counseling centers
- 1-2 residential care facilities

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Strategic Objective 1: Increase Accountability

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Tactics for Integrating and Coordinating Care

- Implemented universal primary care
- Instituted comprehensive “care management”
- Established community-based clinics (mostly for primary care) to improve access
- Convinced the Congress to change the laws about what care could be provided and who could provide it (Veterans Eligibility Reform Act of 1996)
- Instituted network-based “service lines”
- Merged nearby hospitals under common management
- Focused on population health management

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Tactics for Standardizing Superior Quality

- Implemented clinical performance measurement and public reporting of results
- Instituted patient service standards
- Implemented a National Formulary for drugs
- Continued implementation of the National Surgical Quality Improvement Program
- Undertook targeted clinical improvement initiatives based on the “collaborative” model
- Established quality awards and recognitions
- Promoted a new organizational culture based on continuous quality improvement

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Strategic Objective 4: Modernize Information Management

Tactics for Modernizing Information Management

- Implemented a system-wide electronic health record (CPRS/VistA)
- Standardized IT systems and data bases
- Instituted a “semi-smart” patient identification and registration card

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Strategic Objective 5: Align Finances with Desired Outcomes

Tactics for Aligning Finances

1. Designed and implemented a new capitation-based “global payment” resource allocation system
2. Diversified the funding base – increased private insurance billings
3. Reduced operating costs
4. Expanded VA’s authority to partner and contract with private providers (Eligibility Reform Act 1996)
5. Focused on population health management

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Veterans Equitable Resource Allocation “Global Payment” System (VERA)

- Allocated funds (“payment”) to the VISNs according to the number of patients they provided care for (averaged over the prior 3 years), adjusted for patient acuity and certain other factors
- Tiered payment according to type of care
 - ✓ Basic Care – 96% patients, 62% funds (1998)
 - ✓ Complex Care - 4% patient, 38% funds (1998)
- VERA changed the funding model from being hospital-based to network-based (i.e., population-based) and created incentives for providing services that were more effective and more efficient

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SOME RESULTS OF THE CHANGES AFTER 5 YEARS

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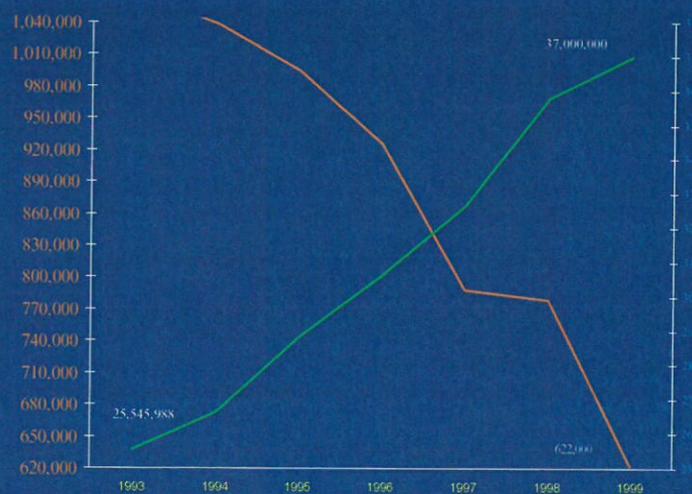
Selected Results, 1995-1999

- Treated more patients (>700,000 more in 1999)
- Reduced staffing by 12% (25,867 less FTEs), but relatively more caregivers
- Implemented universal primary care
- Closed 55% of the acute care hospital beds (28,986 beds)
- Improved access – opened 302 new community clinics; reduced waiting times
- Implemented a national formulary – improved evidence-based drug utilization and reduced purchase price of pharmaceuticals by \$650 million/yr by 1999
- Reduced 'Bed Days of Care per 1000 patients' by 68%
- Reduced in-patient admissions by 350,000 per year

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VA Healthcare Transformation

Selected Results, 1995-1999



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Selected Results, 1995-1999

- Implemented a system-wide electronic health record
- Instituted a universal “semi-smart” patient identification and registration card
- Reduced waste and bureaucracy
 - ✓ 2,793 forms (72%) eliminated
 - ✓ Merged 52 hospitals into 25 local multi-campus facilities
- GAO reported annual operating costs were reduced by >\$1Billion/year between 1996 and 1998
- Decreased per patient annual expenditures by 25.1% in constant dollars

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Selected Results, 1995-1999

- Improved patient service satisfaction
 - ✓ In 1999, 80 percent of VA users were more satisfied than two years earlier
 - ✓ Every year since 1999, VA's patient service satisfaction ratings have been higher than for private sector hospitals and clinics on the ACSI
- Improved quality and safety
 - ✓ Robust peer-reviewed and grey literature subsequently documented improvements
 - ✓ Culture of quality and accountability began to take hold
- Not all quality problems were fixed

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Funding the VA Health Care System Reforms (1995-1999)

- Essentially no funds were appropriated specifically for the reforms
- Reforms were funded by achieving savings and redirecting those funds to other uses
- 5 year VA Health Care System budget increases
 - ✓ Before the reforms (1990-1994) – 37%*
 - ✓ During the reforms (1995-1999) – 10%*,**
 - ✓ After the reforms (2000-2004) – 45%*,***

*average annual medical care inflation about 6%

**number of users increased 24%

***number of users increased 73%

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BEST U.S. HOSPITAL SYSTEM (P. 50) | PARKER ON WINE FUTURES (P. 78)

The McGraw-Hill Companies

BusinessWeek

JULY 17, 2006 www.businessweek.com

Health Hospitals

The Best Medical Care In the U.S.

How Veterans Affairs transformed itself—and what it means for the rest of us

BY CATHERINE ARNST
RAYMOND B. ROEMER, 83, has earned his membership in "the greatest generation." A flight engineer during World War II, his

is a hellish health-care world, understaffed, underfunded, and uncaring. They couldn't be more wrong. According to the nation's hospital-accreditation panel, the VA outpaces every other hospital in the Buffalo region. "The care here is



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VA Transformation

The transformation of the VA health care system in the late 1990s has been called the largest and most successful healthcare “turnaround” in US history and the “new VA” was widely cited as a model for 21st century health care.



CASE (FIELD)
Turnaround at the Veterans Health Administration (A)
by Amy C. Edmondson, Brian R. Golden, Gary J. Young
Source: Harvard Business School
20 pages | Publication date: Jul 20, 2007 | Prod # 608061-PDF-ENG

Investigates the challenges that Dr. Kenneth W. Kizer confronted in seeking to create organizational change at the largest integrated health care system in North America, the Veterans Health Administration (VHA). Kizer was appointed as the Under Secretary of Health, to oversee the VHA, in 1994. Upon Kizer's arrival, it was immediately apparent that the management style that pervaded the VHA was ineffective and out of date. At the same time, the VHA faced inefficient health care delivery systems ... [Read More](#)



YALE CASE 07-017 FEBRUARY 19, 2007

Veterans Health Administration

Dr. Kizer Considers Radical Surgery on an Ailing System

Allison Mitkowski¹
Jonathon Feinstein²

THE VA SCANDAL OF 2014

What caused things to deteriorate?

What Went Wrong at VA? Key Manifestations:

- Substantially delayed access to care for tens of thousands of veterans
- Unofficial or “secret” lists of veterans awaiting care reportedly maintained at many facilities
- Widespread “gaming” and reporting of inaccurate wait time data
- Hospital leadership reported to have encouraged manipulation or falsification of data at multiple facilities
- Disregard and/or punishment of staff who expressed concern or complained about delayed care; many claimed whistleblower status
- Some evidence of growing uneven quality of care

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Root Cause Analysis of the VA Scandal

**Proximal (tactical) vs Distal (Strategic)
Causes**

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Proximal Causes of Access and Delayed Care Problems

- Materially increased demand for services
- Clinician and other staff shortages
- Insufficient and inconsistent support staff training
- Complex and cumbersome recruitment and hiring processes
- Lower than market salaries
- Inadequate and poorly designed clinical space
- Outdated scheduling systems and difficulty obtaining basic IT hardware; IT separated from its end users
- Poorly designed specialty consultation process
- Others

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“About 80 percent of the findings identified in this Integrated Report are aligned with or reflect those previous findings.”

Referring to the findings of 137 assessments of VHA conducted by GAO, VAOIG, and multiple other entities between 1998 and 2015, 77% of which were done between 2010-2015

Page 13, Volume 1: Integrated Report
Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs
Required by Section 201, VACAA of 2014 (PL 113-146)

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Distal Causes of Access Problems and Delayed Care

What prevented VA from addressing well recognized problems (especially in light of its dedicated and committed work force)?

What were the factors or forces which eroded the culture of quality and accountability that had taken root at VHA?

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Distal Cause #1: Inadequate and inconsistent leadership

- **Insufficient leadership selection, development, and management processes resulted in variable leadership competence, capacity and functionality**
- **Frequent leadership changes; frequent changes in priorities**

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Distal Cause #2: Frequently changing and unclear priorities

- Political and external pressures drove attention to the 'priority of the moment' instead of maintaining steady progress toward strategic goals
- Exceptional amount of stakeholder, political and media oversight
- Highly partisan political environment nurtured adversarial relationships and encouraged a reactive and risk-averse culture that, among other things, stifled innovation

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Distal Cause #3: Inadequate Governance

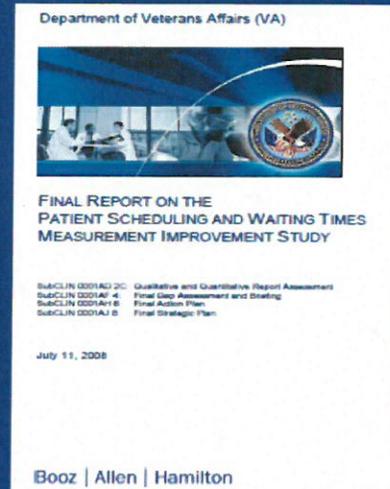
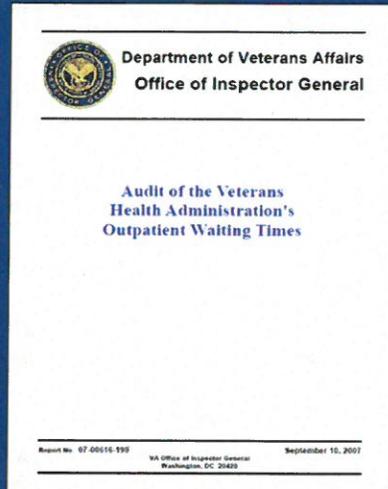
- Inadequate governance structure to bridge leadership transitions and maintain focus on long term strategic needs and priorities of the system.
- Congress not well prepared or designed to provide governance to a science and technology-based enterprise

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What Went Wrong at VA? Key Contributing Factors

Failed to Address Longstanding Known Problems

Scheduling system inadequacies and access problems were known since 2005



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2010 VA memo targeted 'inappropriate' patient scheduling practices

Army Times | By Patricia Kime | May 20, 2014

A memo sent to all Veterans Affairs Department health directors in 2010 warning them against using “gaming strategies” to improve scores on patient appointment reports has resurfaced as part of the ongoing probe of scheduling failures at some VA medical centers.

William Schoenhard, deputy under secretary for health for operations and management, sent a detailed memo in April 2010 to the regional directors calling for “immediate action” to review scheduling practices to eliminate “inappropriate” strategies.

Department of Veterans Affairs

Memorandum

Date: APR 26 2010

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Inappropriate Scheduling Practices

To: Network Director (10N1-23)

1. The purpose of the memorandum is to call for immediate action within every VISN to review current scheduling practices to identify and eliminate all inappropriate practices including but not limited to the practice specified below.

2. It has come to my attention that in order to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices sometimes referred to as “gaming strategies.” Example: as a way to combat Missed Opportunity rates some medical centers cancel appointments for patients not checked-in 10 or 15 minutes prior to their scheduled appointment time. Patients are informed that it is medical center policy that they must check in early and if they fail to do so, it is in the medical center's right to cancel that appointment. This is not patient centered care.

3. For your assistance, attached is a listing of the inappropriate scheduling practices identified by a multi-VISN workgroup chartered by the Systems Redesign Office. Please be cautioned that since 2008, additional new or modified gaming strategies may have emerged, so do not consider this list a full description of all current possibilities of inappropriate scheduling practices that need to be addressed. These practices will not be tolerated.

4. For questions, please contact Michael Davies, MD, Director, VHA Systems Redesign (Michael.Davies@va.gov) or Karen Morris, MSW, Associate Director (Karen.Morris@va.gov).

William Schoenhard

William Schoenhard, FACHE

Attachment

Distal Cause #4: Excessive centralization of decision making

- Excessive centralization of decision making – driven in substantial part by political and external pressures - resulted in extreme micromanagement and disempowerment of local leaders, divorcing accountability from the authority to manage resources locally

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Number of Mandatory Guidance Documents Issued from VA Central Office

YEAR	NUMBER OF MANDATORY GUIDANCE DOCUMENTS DISTRIBUTED
1996 - 2000	17
2001 - 2005	57
2006 - 2010	289
2011 - 2015	263

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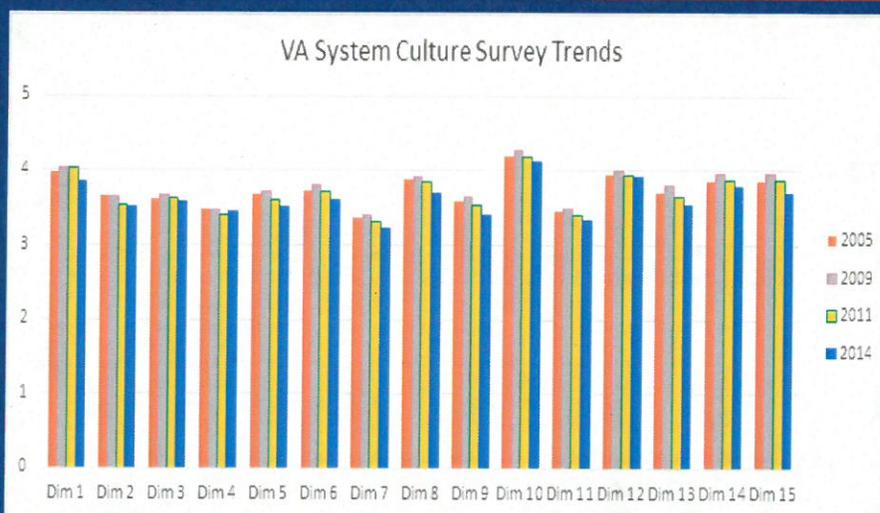
Distal Cause #5: Development of a punitive, highly risk averse culture

- Deterioration of the organizational culture making it feel unsafe to dissent or report bad news; stifled innovation; loss of trust
- Accountability became less about problem solving than scape-goating and punishment
- VHA became increasingly inward-looking and isolated from the rest of the health care sector; decreased participation in industry-wide initiatives and reform activities

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What Went Wrong at VA? Key Contributing Factors

VA's Deteriorating Work Environment

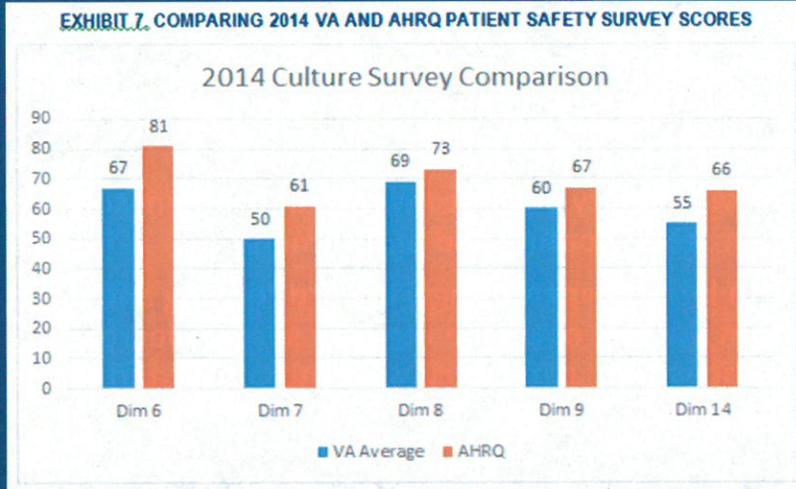


Patient Safety Culture Survey measures staff perceptions of patient safety culture in their work area and in the hospital as a whole. Highest possible average score is 5.

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VA's Deteriorating Work Environment

EXHIBIT 7. COMPARING 2014 VA AND AHRQ PATIENT SAFETY SURVEY SCORES



#6 Teamwork within hospital units
#7 Teamwork across hospital units
#8 Organizational learning/continuous improvement

#9 Feedback & communication about error
#14 Frequency of event reporting

VA Accounts for More Than One-Third of Government's Whistleblower Complaints

By Charles S. Clark, Government Executive, September 22, 2015

Employees of the Veterans Affairs Department have filed a stunning 35 percent of the 4,000 prohibited personnel practice complaints the government has received so far in 2015, surpassing the rate of the much-larger civilian workforce at the Defense Department, a Senate panel learned Tuesday.



VA whistleblowers are sworn in before a hearing of the Senate Homeland Security and Governmental Affairs Committee. Jacquelyn Martin/AP

Distal Cause #6: Inadequate and reactive communications

- **Fragmented, competing, and reactive communications undermined efforts to implement progress and drive change**
- **Communications excessively unidirectional from headquarters to the field**
- **Communication primarily by memo**

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Distal Cause #7: Human resources management and other support services disconnect

- **Cumbersome and convoluted human resources management disconnected from strategic priorities and goals, front line needs**
- **Pretty much the same for contracting processes and IT**

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Distal Cause #8: Bloated and misaligned performance management system

- Performance management system was not well aligned to organizational priorities and did not leverage industry standard measures
- Performance measures of variable validity, importance and significance; generated substantial cynicism

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What Went Wrong at VA? Key Contributing Factors

Unfocused, Bloated Performance Management System

1. Too many measures (>400)
2. Measures not clearly linked to strategic goals or budget; unclear and often changing priorities
3. Many measures not validated and results known to be based on inaccurate data; no internal audits or validation of reported data
4. Compliance focused; became driven by political objectives and an exercise in 'checking the box'; viewed as a tool to beat up career employees
5. Individual financial rewards linked to reported data
6. Set unrealistic expectations

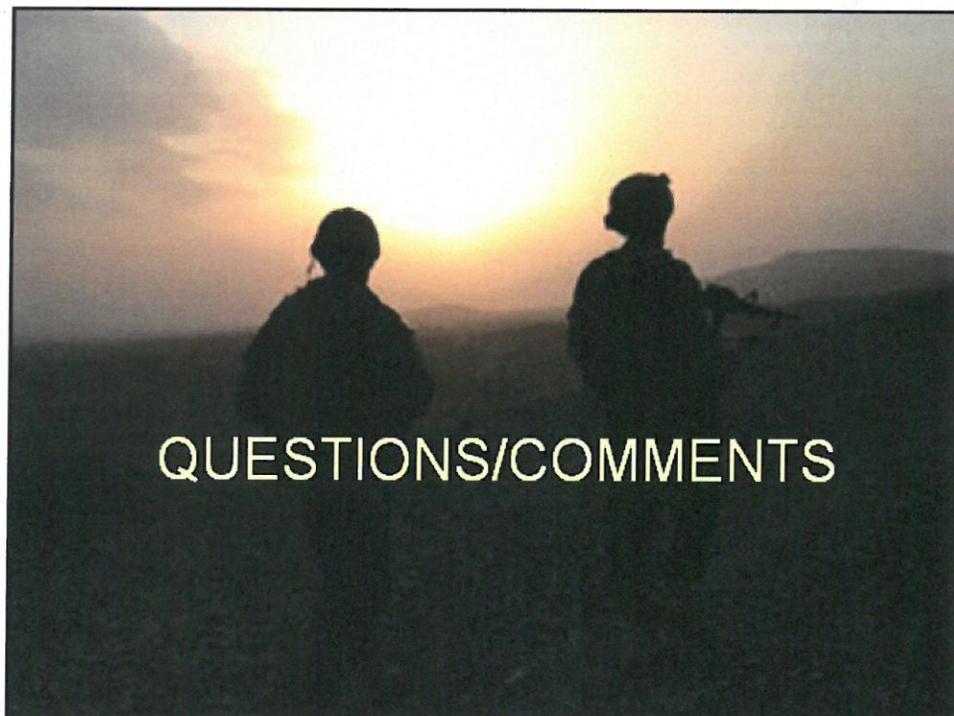
The Double Edged Sword of Performance Measurement

Kizer KW & Kirsh SR. 2012.
J Gen Intern Med 27(4):
395-397.

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THE PROBLEMS ARE FIXABLE!

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QUESTIONS/COMMENTS