

Veterans' Health Care: The State of Affairs



Internal Medicine Grand Rounds
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This is to acknowledge that Jeffrey L. Hastings, M.D. has disclosed that he does not have any financial interests or other relationships with commercial concerns related directly or indirectly to this program. Dr. Hastings will not be discussing off-label uses in his presentation.

Dr. Jeffrey L. Hastings is an Assistant Professor in the Division of Cardiology at the University of Texas Southwestern Medical Center and is currently interim Chief of Staff for the North Texas VA Health Care System. He spent many years in the lab of Dr. Benjamin Levine studying human exercise physiology in regards to adaptations to aging and a sedentary lifestyle. His current clinical specialties are in heart failure, 3d echocardiography, rehabilitation, and exercise testing. However, since moving into an administrative role in 2013, his focus has turned towards performance measures and productivity.

Purpose:

The purpose of this grand rounds is to inform on the history of the National and local VA system, recent National developments, and the future of VA health care.

Overview:

This presentation will address the history of benefits and health care for soldiers from prior to the Revolutionary War up to modern day, followed by the history of our local VA from 1940 to present day. Recent patient access issues from the media and national systems will be discussed, in addition to VA performance measures, and Physician Productivity, with a demonstration of how the North Texas VA Health Care System is working on these problems.

Objectives:

- state the modern day motto for veterans' health care.
- describe the how veterans can receive care in the community.
- list the key performance metrics in the VA health care system.

VA History

American Colonies

Benefits for soldiers, in the form of pensions, were first brought in to law in 1636 by Plymouth for those veterans disabled in the defense against the Pequot Indians. In 1776, the Continental Congress granted half pay for life in cases of serious disability to help encourage enlistment for the Revolutionary War.

However, the Continental Congress did not have the authority or funds to make

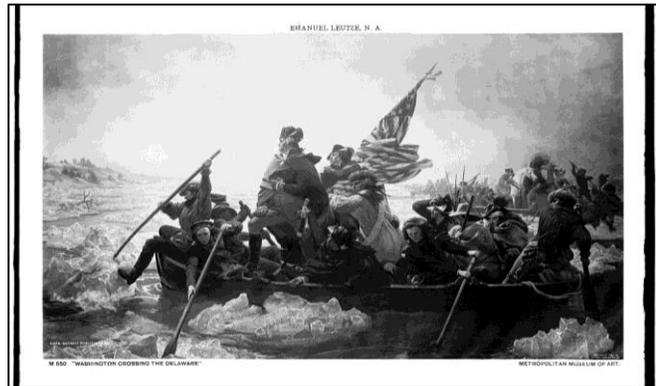
pension payments, so the pensions were left up to the individual states. This changed in 1789 with ratification of the U.S. Constitution, now allowing Congress to fund veteran pensions.

By 1816 there were only 2,200 pensioners on the rolls, and Congress was able to increase allowances for the disabled veterans while also granting half-pay for five years to widows and orphans of veterans from the War of 1812. A new law, the 1818 Service Pension Law, provided benefits on the basis of need for the veteran. Each veteran from the Revolutionary War who was in need would receive benefits for life at a rate of \$20/month for officers and \$8/month for enlisted men.

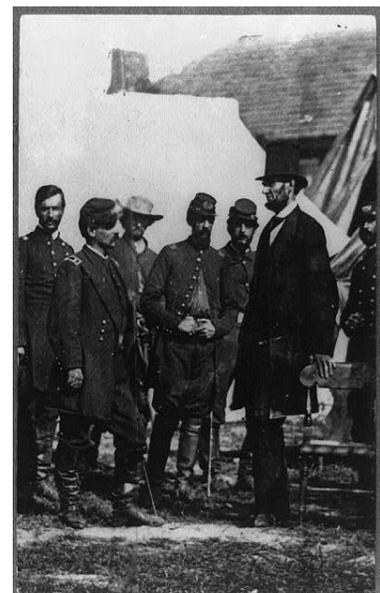
The number of pensioners had increased to 17,730 by 1820, with an associated increase in cost from \$120,000 to \$1.4 million – or about \$28.6 million in today's dollars. Benefits were increased for widows and the orphan children of all veterans in 1858 with half-pay to until reaching the age of 16.

Civil War

At the time of the Civil War in 1861, there were 80,000 Union veterans. This increased to 1.9 million over the next 4 years. The General Pension Act of 1862 again improved benefits by paying based on rank and disability, increased funds for windows, children and dependents, as well as adding coverage for peace time service and diseases incurred while in service.



Washington crossing the Delaware. Emanuel Leutze 1907. Library of Congress: det 4a26226



Abraham Lincoln on battlefield at Antietam, Maryland. Library of Congress: cph 3a05990.

After the Civil War, Abraham Lincoln penned the future motto of the Veterans Administration in his second inaugural address by calling his fellow-countrymen “to care for him who shall have borne the battle and for his widow and his orphan”. Immediately after the war, Congress authorized the National Asylum for Disabled Volunteer Soldiers.

In 1873 the Consolidation Act revised pensions to pay on degree of disability without consideration for rank. The Dependent Pension Act of 1890 increased eligibility beyond those discharged due to illness or disability and resulted in an increase of enrollment from 489,000 to 996,000 pensioners (veterans and dependents).

The Sherwood Act of 1912 awarded pensions to all veterans, now to include those from the Mexican War and the Union soldiers from the civil war. This act granted pensions starting at the age of 62, regardless of disability.

World War I

Of the 4.7 million Americans fighting in World War I, about 204,000 were wounded and 116,000 died in service. The War Risk Insurance Act of 1917 provided subsidized life insurance for Veterans.

In 1919 the law gave responsibility for veterans’ health care to the Public Health Service. Although some military hospitals were also transferred to the Public Health Service, the demand for care and growth were too great and contracted care through private hospitals was allowed.



President Abraham Lincoln at his second inaugural address. Photo courtesy of Andrew Gardner, Library of congress: ppmsca 23718.



Frank W. Buckles, 1901-2011, was the last surviving WWI Veterans in the United States.

World War II

Prior to World War II, the 1940 Selective Training and Service Act authorized the first peacetime draft for Americans, but also guaranteed reemployment for those who had to leave work. Due to need for medical care during the war, many VA physicians, nurses, dentists, were called up or volunteered for service.

In WWII, 671,817 men and women had been wounded, while 405,399 were killed. Due to the country's need, Congress put forth the Servicemen's Readjustment Act, also called the GI Bill of Rights in 1944. This first of many GI bills provided for four years of education, federally guaranteed home and business loans with no down payment and unemployment compensation for 52 weeks. Providing higher education and home ownership was a major boost to the US economy. By 1956, 7.8 million Americans had received education and 5.9 million loans had been guaranteed through the bill. That same year, the Veterans Preference Act was signed, giving preference to veterans in federally funded jobs.



FDR signs the G.I. Bill in the Oval Office; June 22, 1944.
FDR Library Photo Collection, NPx 64-269.
<https://fdrlibrary.wordpress.com/tag/g-i-bill-of-rights/>

In 1946 the Hines VA hospital in Chicago became associated with the University of Illinois and Northwestern, becoming the first VA facility to have an affiliation with a medical school.

Korean War

The Veterans' Readjustment Assistance Act of 1952 again provided unemployment, job placement, and loans for Veterans, but educational benefits were significantly reduced. During this time the number of hospitals increased from 97 in 1942 to 151 in 1950. 1952 saw 164,000 employees, with an average of 128,000 veterans receiving daily care with a total of 2.5 million veterans receiving care annually.

Vietnam War

The Vietnam War saw over 6 million veterans come out of military service. Due to advances in medical and transportation there was a much higher rate of disability. This was compounded by the economic recession and an increasing number of unemployed veterans. In efforts for assistance Congress passed the Veterans' Readjustment Benefits Act (Vietnam GI Bill) which restored the educational assistance that had been limited by the Korean GI Bill. Of those eligible, about 76% of veterans participated with 5.5 million veterans receiving funded education. At the same time group life insurance was provided for the veterans. However, this coverage was not administered by the VA but was purchased from a commercial insurer.

Further Wars listed below led to a significant change in veterans' benefits and eligibility, through Agent Orange exposure, Gulf War Syndrome, Post-Traumatic Stress Disorder, and Traumatic Brain Injury.

Persian Gulf War - Desert Shield (1990-1991) – Desert Storm (1991-1991)

Iraq War - Operation Iraqi Freedom(OIF) (2003-2010) / Operation New Dawn (OND) (2010-2011)

War on Terrorism - Operation Enduring Freedom (OEF) (2001-present)

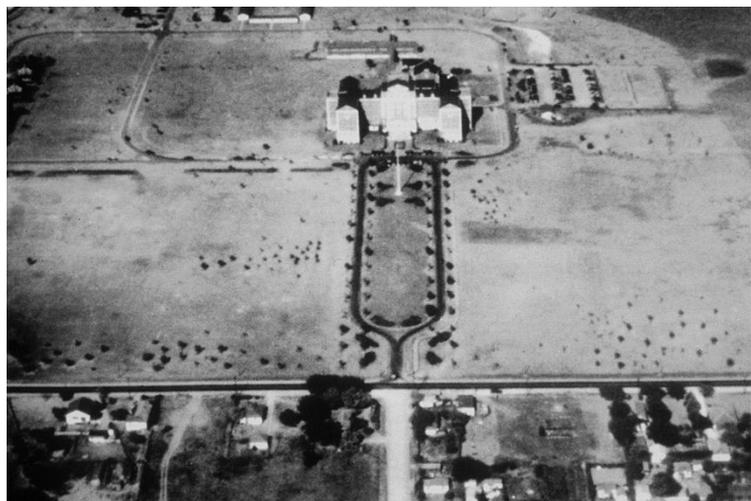
In the current day the Veterans Health Administration is one of the largest health care delivery systems in the United States. The system covers 9.1 million enrolled veterans, utilizes 20,000 physicians, 1600 facilities, 288,000 employees and a 59 billion dollar budget.(1,2)

North Texas VA History

The Dallas Chamber of Commerce organized a campaign by concerned community organizations in the 1930s to have a VA hospital placed in their community. Dallas won over eight other cities in Texas which were competing for the facility. The 245 acre property was purchased from Byrd Earl White of Lancaster.

Work begun on the hospital in

1937, at a planned \$1,250,000 situated in the corporate entity of Lisbon on a "high hill" overlooking Lisbon, Trinity Heights, and downtown Dallas. The original site included the



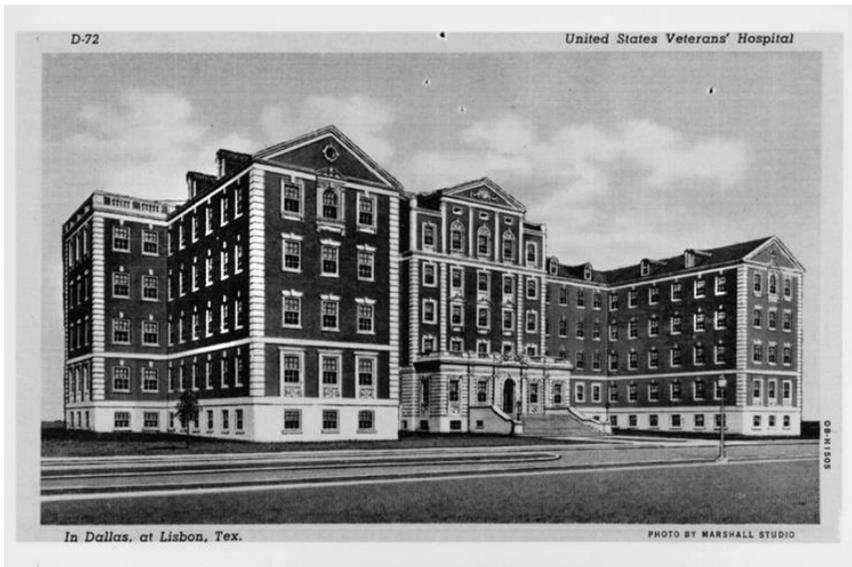
Manager's house, the nurses' home, attendants' building, officers' rooms, garage, and steam plant with two hundred employees and an annual payroll of \$300,000. Services included a "complete clinical laboratory with three technicians, an x-ray department, a physiotherapy department, and a library."

The first patient was admitted in August of 1940, although the facility dedication came in October of 1940. By 1944 the hospital was running at 85-90% capacity of its 300 beds. In those next few years, authorized beds increased to about 342. In 1944 plans were announced for the construction of a 500 bed addition to the hospital. Per the Dec 10th, 1994 Dallas Times Herald, the addition

would "make the general medicine and surgical hospital one of the major Veterans' centers in the country."

In 1945 the plans for the new facility changed to include six new buildings: a seven story hospital, auditorium, supply warehouse, laundry, occupational therapy, and mechanics building. However, in 1947 there was discussion of relocating the VA to a completely new \$5,000,000 hospital on the grounds of the Southwestern Medical Foundation, at the corner of Harry Hines and Inwood, in order to have the VA close to the city so that services of outside personnel could be easily available. This proposed site change became controversial, and by mid-1948, there was significant

protest against moving the VA site adjacent to the proposed Southwestern Medical school location. The American Legion and the Veterans of Foreign Wars posts were proponents of the move, stating that dissenters were "long on vapid noise and foolish argument, but short on intestinal fortitude",



but the local Disabled American Veterans groups claimed that “Veterans would be used as guinea pigs if the hospital were linked to the medical school.” In 1951 VA administration decided it would be more economical to build at the Lisbon (Lancaster) site and turned the Harry Hines property over the General Services Administration. A December 12th, 1951 editorial in the Dallas Morning News states that “economy in any federal project deserves a note of commendation”.

Work was started on the new 500 bed hospital in April 1952, and the new facility was completed in August of 1955. Final costs for the new facility was \$8.5 million.

1982 saw the groundbreaking ceremony for a new 120 bed nursing home care unit, which opened in 1984 costing \$6.5 million and adding 63,000 square feet. Dr. David Hales joined the VA in 1994 and has been Chief of Geriatrics and Extended Care since 1995. Under his guidance a hospice unit was opened adjacent to the community living center (CLC) in 2010.

A three part \$150 million construction project began with a new campus energy center that opened in 1994, followed by a 30 bed Acute Spinal Cord Injury Center in 1997. The last piece was the \$100 million Clinical Addition which added ICU beds, 13 new operating rooms, new space for Radiology, Pharmacy, Pathology and Laboratory, and specialty clinics with 886,000 square feet.



This year the campus will see a new 29,046 square foot ER expansion, with a renovation of the previous space for observation and fast-track use. Plans are in place to begin phased construction of a new 26,359 square foot Ambulatory Surgery Center on the Dallas campus. A new 10,000 square foot Community Based Outpatient Clinic (CBOC) will be opened in Plano in mid-2016. The CBOC in Bonham, Texas, will soon start on a 16,500 expansion to the Ambulatory Care clinics and Laboratory. The CBOC in Tyler is anticipated to move from the current two 10,000 square foot facilities to a new 48,425 square foot facility in 2020.

Media Incident: Secret Waiting Lists

In February 2014, and on the heels of a government report on possible deaths related to delays in endoscopy procedures, a retired veteran physician spoke out as a whistleblower alleging the

death of 40 veterans waiting for an appointment. He did not provide that names of the deceased. The whistleblower also alleged that two lists were in the Phoenix VA for scheduling patients. One official list and a secret list where 1,400 to 1,600 patients could be waiting for appointments for over a year. An Office of the Inspector General review of 3,409 veterans patients did find 45 cases that had unacceptable lapses in follow-up, coordination, quality, and continuity of care, but no direct evidence of deaths due to delays in care. Many of the problems identified were incorrect scheduling procedures. After the story first appeared in the National media, there were 445 allegations about manipulated wait times at other VA facilities.

Veterans Access, Choice, and Accountability Act of 2014

Due to the National concerns about patient access and timeliness of care for the veterans, on January 3rd, 2014, the 113th Congress passed the Veterans Access, Choice, and Accountability Act. Signed into law by President Obama on August 7th, 2014, this Act has multiple measures to reform and improve access to care. (3)

The first element of the VACA was for the VA will administer the \$10 billion dollar Veterans Choice Fund to implement the Veterans Choice Program for 3 years or until the funds were depleted. The Choice program was to be used for Veterans who met eligibility criteria based upon enrollment date or recent discharge as a combat veteran and were living more than 40 miles from a VA site of care or were not able to be scheduled in the VA within 30 days from their clinically indicated or desired date. Although every veteran received a Choice Program card, often confused with an insurance card, only those Veterans who met the 40 mile or 30 day criteria were eligible for care. (4)

The Choice program was to be administered by a third party administrator, either Tri-West or Health-Net, depending on the locality. Eligible non-VA entities or providers were required to enter an agreement to furnish care at Medicare rates, maintain similar credentials and licenses as VA providers, and submit copies of the veterans' medical records for inclusion into the VA electronic health record. (4)

A second element of the act was for the VA to establish and implement a system to process and pay claims for care delivered through the Choice program. This implementation was started through the VA Central Business Office. (4)

Third element provided \$5 billion dollars to improve VA staffing in areas of shortages that were limiting access to care. In addition, there was an expected increase of 1,500 Graduate Medical Education residency positions over the next five years, again with specific expectations to

improve access to care. There were also authorizations for 27 major medical facility leases in 18 states. (5)

The last of the major relevant elements was that each VA facility would post the wait times for scheduling primary care, mental health, and specialty care appointments. The VA was mandated to develop these wait times into a comprehensive data set available to the public. (5)

Patient Access in the North Texas VA System

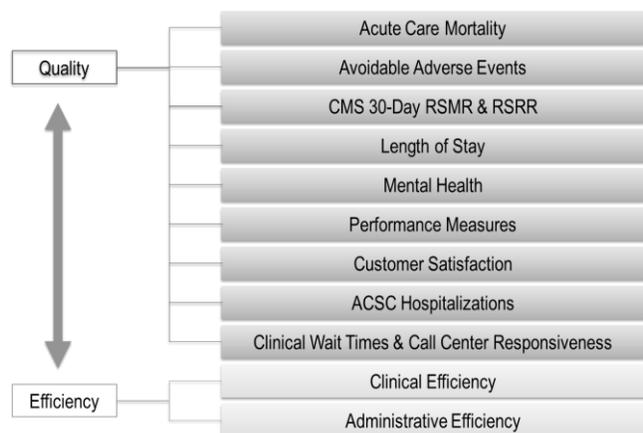
On December 7th, the North Texas VA had 106,235 scheduled appointments with only 3.6% scheduled more than 30 days from the preferred date. There were also 32,320 in the system pending or scheduled, with approximately 1,700 new consults entered daily.

As an effort to identify any potential patients waiting for an appointment or a pending consult, the Quality, Safety, and Value section at the North Texas VA began an Analytics and Information Management (AIM) database in mid-2014. This database is updated with daily data from the national Corporate Data Warehouse (CDW).

A Scheduling Tracking tool was developed using the real-time database in order to facilitate a facility and service level view, while also being able to immediately show the data for specific sections, graph trends, and identify any patients who could be potential outliers. The North Texas AIM database and the Tracking tool have been recognized Nationally by the Secretary and Undersecretary of Veterans Affairs as innovative methods to improve patient access to care.

Strategic Analytics for Improvement and Learning Value Model (SAIL)

During the access crisis, the VA also began to change how Quality and Efficiency were measured in the VA. SAIL was developed by the VA Office of Operational Analytics & Reporting as statistical model in 2012. The original model included 28 weighted measures of healthcare quality, employee satisfaction, quality of life and efficiency. Each measure was standardized to the appropriate peer group determined by complexity of care delivered. Updated



quarterly with a 3-6 month delay, these measures have been more up-to-date than the typical CMS Hospital Compare measures available to the public.

This model allowed health care facilities to find areas for improvement while identifying a high performing peer for possible consultation. The improved communication between facilities was expected to lead overall improvement in quality and efficiency across the VA system. Beginning in 2014, the SAIL metrics were used for performance assessments of the individual facilities, leadership, and the networks.(6)

Clinical Productivity

A more recent focus from the VA Central Office has been on facility and clinical productivity. The robust data system in the VA allows for queries of facilities, services, and individual providers utilization and performance. The VA Office of Productivity and Efficiency Staffing developed a Specialty Productivity – Access Report and Quadrant (SPARQ) tool which rates facilities and specialties based on peer complexity groups for productivity (RVU/clinical time MD) and various measures of patient wait times. (7)

Historically the VA has not been held to the same RVU and productivity standards as private institutions, and in fact, coding and documentation in the VA system has been performed for workload capture rather than for billing. Much of the funding for VA hospitals is through the Veterans Equitable Resource Allocation (VERA) system, where the funds follow the number of veterans and the complexity or “case-mix” of the veterans’ illnesses.(8) Because it is linked to the VA Network and facility funding available for staffing, equipment, and facilities, there has been a push to ensure all workload gets appropriately captured.

In late 2015, the North Texas VA developed a tool to use the SPARQ and available productivity data together to view service level performance for workload, staffing, and access. Due to evidence that physician feedback on practice patterns relative to peers results in reduction in resource use, a feedback report for the individual providers was also developed.(9) Our teaching services are also beginning to add emphasis on documentation and coding for the residents and fellows.

Conclusions

As one of the largest health care systems in the Veterans Health Administration, it is imperative that the North Texas VA set an example for high-quality and timely care to the veterans. The last few years have seen multiple challenges in the Federal system. The changing demographics

of new veterans brings new expectations for health care. Congress has begun two parallel pathways for improved access to care, one using increased staffing and utilization, the other providing non-VA care to veterans in need. The metrics of quality health care will remain a moving target. Maintaining Federal dollars in modern times will require adjustment of current practices. These are all challenges in which the North Texas VA will succeed.



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