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United States Senate

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April 23, 2015

The Honorable Robert McDonald
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue
Washington, DC 20420

Dear Mr. Secretary:

I appreciate your outreach to me for ideas as to how we can improve the Veterans Administration. It is exciting to know the VA has leadership with past experience seeing through large-scale transformation projects to a successful conclusion in the private sector. I firmly believe the VA has an opportunity to move forward with an enterprise transformation initiative that will bring tremendous benefits to the veterans who rely on the VA in so many ways.

Coming up on your first anniversary as the head of the VA, I am sure you have already developed a list of short-term initiatives that may provide some relief as you outline a long-term enterprise strategy. My discussions with VA staff and medical center leadership has galvanized my belief that a comprehensive transformation plan that focuses on short-, intermediate-, and long-term improvement strategies for the people, processes, and technology in the VA is essential to addressing the current challenges, while laying the groundwork for continuous improvement. I look forward to working with your staff to accelerate the development of the plan and playing a role in helping you achieve the vision for a leading healthcare provider.

I have followed up on your request from our earlier conversations that I provide examples, based on my private sector experience, as to how we can inject good business practices into the VA System to ensure that all veterans receive timely access to quality healthcare, and that they receive that healthcare from the most qualified medical professionals in America. Since you and I last met, I have visited three of North Carolina's four VA medical centers in Fayetteville, Durham, and Salisbury, and plan to visit the medical center in Asheville, North Carolina, soon. As a result of these trips, I have outlined several proposals for your consideration. I must also thank the Veteran's Affairs office at Duke University Hospital for their dedication and willingness to reach out to explore new solutions for veterans' care. I have taken much from their trail blazing efforts and their testimony before the Veterans Affairs Committee.

You and I both come from the private sector.

We have run complex organizations that constantly required an infusion of new ideas and practices to make the enterprise viable. The one common battle we waged was against the inertia of over-centralization. In a state with as many medical and military resources as North Carolina, we are often unable to make use of those resources because the expanding bureaucracy at the Washington VA

Headquarters and Veterans Integrated Services Network (VISN) level mitigates against change and rapid response to a shifting environment. This is especially true for contracting where centralization of the process in the hands of "contracting experts" has created another layer of bureaucracy that must be overcome by the people in the states, who actually understand what the patients in their care need. The localities cannot make changes to big VA contracts based on their needs. New contracts, often based on an outmoded industrial age concept of care, now take years to fill.

In terms of the actual cost of centralization, the explosion of the VISN bureaucracy is instructive. When VISN was first authorized the estimated cost for staffing the 22 regional offices was $25 million with the intent to push VA decisions down to the regions. The salary cost for the VISN management level is more than $200 million yearly for approximately 1600 staff. My understanding is that based on at least one audit, there are no adequate controls on the expansion of cost for the VISN. Would those costs not be better used at the medical center level to help veterans?

Additionally, in the private sector yearly budgeting determines baseline staffing numbers based on the current and projected year needs; and you appreciate better than anyone that flex budgeting can account for changes in need and volume during the year. In the VA the resources lag by two years and the one-size-fits-all approach may work in a small state but not in a state like North Carolina where close to one in 10 citizens are veterans and the shifting needs of such a large population are often unforeseen.

As you know, North Carolina is home to outstanding medical schools and community medical centers as well as thousands of former military doctors, nurses, physician assistants and corpsmen. North Carolina would benefit from a new credentialing system for VA providers. Currently, doctors, nurses and physician assistants accredited at hospitals like Duke or the University of North Carolina have to undergo duplicate educational and licensing background checks from the VA when they are already accredited at the finest hospitals in the world. As a result, it takes too long to recruit and investigate to get health care providers in the system. The same applies for annual training required by the state and host medical institutions that is in turn duplicated by the VA. Redundant training lowers morale and hampers productivity.

My office received information that the VHA continues to have serious challenges in effectively addressing recruiting and retention issues for PAs and nurse practitioners. In some cases, job descriptions for these positions are woefully out of date.

The private sector is rapidly moving toward making PAs and nurse practitioners a more visible part of its medical workforce in order to meet patient needs. Patient surveys have shown that patients are not only satisfied but often prefer a non-physician as their primary contact; Duke Hospital for example, has set an initial goal in its primary care clinics to achieve an equal mix as part of its team patient approach. Has the VA done everything to make maximal use of this important workforce in both primary and specialty care? The VA needs to evaluate its role all the way from expanding VA training of RNP and PA to recruitment practices, job duties, classification, pay, flexibility, retention, and career development.

With the existing reported disparity in pay between PAs employed by the VA and the private sector market, this problem grows. The recent VA Office of Inspector General (OIG) Report #15-00430-103, January 30, 2015; conducted an investigation of VHA occupations with the largest staffing shortages as required by Section 301 of the Veterans Access, Choice, and Accountability Act of 2014. VAOIG

determined that the six occupations with the "largest staffing shortages" were Medical Officer, Nurse (RN), Physician Assistant, Physical Therapist, CRNA, and Psychologist.

It would probably be beneficial for the VA to allow local flexibility in creating targeted plans to include those categories in all VHA health-care staffing, recruitment, and retention initiatives to include Special Pay Rates and Nurse Locality Pay.

Despite the increased need for veterans' medical care access, the Department's rural health and primary care initiatives, and known projected primary care physician shortages, there is no evidence of plans to include PAs in VA Nurse Locality Pay Rates, or include PAs in Education Debt Reduction Program (EDRP) when VA facilities advertise vacant PA positions. For instance, employees at the Durham VA are included in locality pay scales while those at the Fayetteville VA are not. These changes would allow the VA to take advantage of the talent in an area like southeastern North Carolina where so many medical professionals have returned home after years of honing their skills in actual combat conditions.

Also changing the rules to allow providers to take partial leave when they have an issue with a child in school or have to address other family or personal issues would improve morale and efficiency and encourage providers to return to the VA to take care of patients. Currently, an employee has to take a full day of leave to address even a minor matter.

The latest VA figures from 2013 show that there were 86 million regular appointments at VA centers. However, my understanding is that VA clinics close between 4 p.m. and 4:30 p.m. every day, unusual hours for medical clinics in the US. The figures, given to me by Duke, show that by keeping regular 8 a.m. – 5 p.m. hours, an additional five million veterans could be seen across the country.

Rather than build more operating rooms in VA facilities the VA should encourage through enhanced authority the use of private facilities by VA employed providers to meet Veterans' needs. This requires enhanced cooperation between the VA and military hospitals with underutilized space, such as that of Fort Bragg, as well as with community hospitals and community health centers. In other words, local control is the best control. I encourage VA headquarters to expand the use of sharing agreements with academic partners like UNC, Duke, East Carolina and Campbell that will include sharing of excess academic resources with the VA at a fair market value.

The private sector is also swiftly moving toward more regular use of urgent care. In North Carolina urgent care is being provided by regular practitioners as well as by non-traditional providers such as pharmacies, some of which are even located in grocery stores. The focus in North Carolina in many instances is to make sure a patient stays out of the Emergency Room by giving him access to care such as flu or shingle shots. The urgent care spectrum is certainly worthy of further study by the VA.

Your tenure at the VA is a breath of fresh air and I appreciate everything that you are doing to help those who have borne the battle. I stand ready to help and please take my cursory look at ways to address the Department's concerns as a step in helping you with the vital position you hold.

Sincerely,

Thom Tillis

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