CREATING EFFICIENCY THROUGH COMPARISON: AN EVALUATION OF PRIVATE SECTOR BEST PRACTICES AND THE VA HEALTH CARE SYSTEM

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CREATING EFFICIENCY THROUGH COMPARISON: AN EVALUATION OF PRIVATE SECTOR BEST PRACTICES AND THE VA HEALTH CARE SYSTEM

Wednesday, July 16, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 10:01 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Michaud, Takano, Brownley, Ruiz, Negrete McLeod, Kuster, O'Rourke, Walz

OPENING STATEMENT OF JEFF MILLER, CHAIRMAN

The CHAIRMAN. Good morning, everybody.

The Committee will come to order.

Welcome to today's full committee hearing entitled, "Oversight, Creating Efficiency Through Comparison: An Evaluation of Private Sector Best Practices and the VA Health Care System."

Over the last eight weeks, the Committee has held ten full-committee hearings encompassing just over 35 hours of testimony. You know, at these hearings, we have heard from VA leaders and a diverse collection of expert witnesses about the many and varied access accountability, integrity, and data-reliability failures that are plaguing the Department of Veterans' Affairs health care and benefits system.

In their testimony this morning, the American Hospital Association states that, "Successful organizations have cultures that set clear, measurable, and actionable goals and make sure that they are communicated to and understood by all employees, embrace transparency, and engage their clinicians as partners, not as employees." By this measure, which I believe is a fair one, the VA health care organization as we know it today cannot be considered a successful organization. VA has failed to set and embrace clear measurable and actionable access and accountability goals, as evidenced by a recent Administration report which stated that VA's 14-day scheduling standard was, and I quote, "Arbitrary, ill-defined, and misunderstood," unquote. VA's culture tends to minimize problems or refuse to acknowledge problems altogether.

VA has failed to embrace transparency, as evidenced by the 115 outstanding deliverable requests dating back more than two years that this Committee continues to wait for. VA has failed to engage

their clinician workforce as partners, as evidenced by the numerous whistleblowers who have come forward to share their stories of retribution and reprisal and many more who continue to call our office, yet, understandably, are reluctant to come forward publicly.

Our veterans deserve a VA that works for them, not one that refuses to work at all. Improvement and innovation are necessary, but neither can thrive in a bureaucratic vacuum. And with any vacuum, nature fills it with whatever is available, and in this case it is questionable care, falsified performance and abuse of employees.

During this morning's hearing, we are going to discuss how the Department, and by extension, how our nation's veterans can move forward from this summer of scandal and create the VA Health Care System our veterans deserve by leveraging the best practices used by non-VA providers and private sector health care organizations.

On our witness panel today we have two Malcolm Baldrige National Quality Award winners, a former VA physician, two high-performing VA academic affiliates, and a national advocacy organization representing more than 5,000 hospitals, health care networks, and care providers. Though VA or though VA's organization and patient population may have certain demographic qualities, there are valuable lessons to be learned from health care standard bearers and leaders that, if heeded, could vastly and rapidly improve the care that our veterans receive.

As I stated, during the hearing at the very beginning of this intense Committee oversight process, the Department got to where it is today due to a perfect storm; a perfect storm believing its own rhetoric and trusting its status quo as a sacred cow that was immune from criticism and internal revolt. VA cannot continue business as usual. The status quo is unacceptable. It is time for a change, change that embraces both new ideas and proven practices.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

And with that, I would yield to the ranking member for his opening comments.

OPENING STATEMENT OF HON. MICHAEL MICHAUD, RANKING MINORITY MEMBER

Mr. MICHAUD. Thank you very much, Mr. Chairman, and good morning.

I appreciate that we are continuing to gather valuable information about what works and what doesn't work in the Department of Veterans Affairs Health Care System. This information is guiding our efforts to reform the Department and ensure that our veterans receive quality, safe, timely health care where and when they need it. I am looking forward to the testimony that we are going to hear this morning from our panelists on best practices in the private sector. I believe that we should always strive to do better, and I think that we can learn and get some good ideas in areas where private sector health care providers have had great successes in either tackling or outright avoiding many of the problems that we are confronting today in the Department of Veterans' Affairs.

One area where I think we need to hear more from the private sector is related to scheduling and patient medical records. Clearly, the scheduling practices and technology within the department are not working. The system can be manipulated. There is no standardization and patients are not getting seen in a timely fashion and I would be interested in hearing about some of the scheduling models of various private sector organizations-uses. Getting patients seen right away before their medical conditions are allowed to worsen absolutely must be one of our first priorities.

Also, the Department has clearly struggled to anticipate and plan accordingly for a surge of veterans seeking to access the health care system as we continue winding down the wars. I would like to hear how other health facilities have developed strategic plans and are tailored to the current and anticipated needs of their specific population. I believe that in order for us to maintain progress on things like the wait list, the backlog, the VA needs to do a better job of looking a few years down the line, figuring out what regional and local veterans population needs will be and plan accordingly.

We should also keep in mind the VA provides a number of specialty services for our veterans that just can't be found in the private sector. Despite the many problems throughout the VA system, it remains a system best suited to meet our veterans' health care needs across the entire episode of care.

As we all know, our veterans generally have greater health care concerns and are older than the general population. The VA has developed a bench of medical professionals who are trained to treat the specific—to service specific needs of veterans better than most. That includes issues like prosthetics, spinal cord injury, and inpatient mental illness services. Also, a higher number of medical professionals in our country, more than 60 percent, trained at the VA medical facilities. I want to be clear: I am not looking at talking about privatizing VA care, I am talking strengthening the health care system that is uniquely suited to serve the needs of our veterans with best practices that are working in the private sector.

And I would like to thank the panelists once again who are here this morning. I look forward to hearing your testimony today. I think we can learn a lot from the private sector and look forward to the question and answer.

And with that, Mr. Chairman, I yield back the balance of my time.

[THE PREPARED STATEMENT OF HON. MICHAEL MICHAUD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much to the ranking member and to the panel. Members will be coming in and out all morning. There are other hearings and markups that are taking place on the Hill this morning, so expect a little movement from up here at the dias and we apologize for that.

Members joining us today on our first panel is Mr. Richard Umbdenstock, the President and Chief Executive Officer of the American Hospital Association; Dr. Monte Brown, the Vice President and Secretary of Duke University Health System and the Associate Dean of Veterans Affairs for the Duke University School of

Medicine; Mr. Daniel Evans, Jr., the President and Chief Executive Officer of Indiana University Health; Dr. Rulon Stacey, Executive Officer of Fairview Health Services; and Mr. Quint Studer, the founder of the Studer Group, which I should let you know is based in Pensacola, Florida, where thousands live like millions wish they could.

So it is great to have all of you here today and Mr. Umbdenstock, you have five minutes for your opening statement. Thank you, sir.

STATEMENT OF RICHARD J. UMBDENSTOCK

Mr. UMBDENSTOCK. Thank you, Chairman Miller, and Ranking Member Michaud and Members of the Committee. I am Richard Umbdenstock, the President and CEO of the American Hospital Association and I appreciate the opportunity to speak on behalf of our 5,000 member hospitals, health systems and other health care organizations. For decades, the VA has been there for our veterans in times of need and it does extraordinary work under very challenging circumstances for a growing and complex patient population. The nation's private sector hospitals have a longstanding history of collaboration with the VA and stand ready to assist them and our veterans as they seek solutions to today's challenges.

Health care delivery is most effective when it is tailored to the unique needs of patients and the community; it is not a one-size-fits-all enterprise. All hospitals are committed to providing the right care at the right time and the right setting. Many hospitals are borrowing process improvement programs like the Baldrige criteria for performance excellence, the Lean process and Six Sigma for manufacturing, all to optimize the patient experience, lower costs and improve overall quality.

Each hospital is unique, so leadership must select the method that it believes will work best for its organization; however, quality improvement efforts generally involve five steps: Identify target areas for improvement; then determine what processes can be modified to improve outcomes; then develop and execute effective strategies for improving quality; track the performance and outcomes, and disseminate the results to spur broader quality improvement. Successful health care providers have cultures that set clear, measurable and actionable goals, communicate them clearly and make sure that they are understood by the employees, as the chairman noted in his opening comments. They measure the results and share them widely. They embrace clinicians as partners. They use standardized nomenclature and processes and they undertake multiple incremental changes revising and adjusting as they go.

Nationally, hospitals are harnessing the power of collaboration to dramatically improve the quality and safety of patient care. The AHA's Health Research and Educational Trust administers the largest hospital engagement Network under the HHS Partnership for Patients. In the first two years of that program, participating hospitals in that Hospital Engagement Network reduced early elective deliveries by 57 percent, pressure ulcers by 26 percent, central line associated bloodstream infections by NICUs by 23 percent, ventilator-associated pneumonia NICUs by 13 percent and across

all units by 34 percent, and hospital readmissions within 30 days for heart failure by 13 percent. HHS estimates that the HEN program as a whole has prevented nearly 15,000 deaths, avoided nearly 560,000 patient injuries and saved almost $4 billion dollars.

These lessons in collaboration are valuable models for development and dissemination of operational best practices. Other witnesses can speak more directly about what has worked in their organizations, but I can share a few principles around scheduling. For primary care, the Institute for Health Care Improvement recommends an opening scheduling system in which physicians begin the day with more than half of their slots available. Same-day appointments are made regardless of the type of care needed. Open-access scheduling may be ideal in the private care setting, but it is not always feasible.

In specialized care, for example, capacity is more limited and testing and consultations may be needed before appointments can be scheduled. To be successful, open-access scheduling requires understanding and measuring patient flow so capacity problems can be identified quickly and resolved at the appropriate point. Ongoing monitoring of continuous improvements necessary, and staffing is also critical.

AHA applauds Congress in its speedy action in passing legislation to allow veterans to more easily secure care from civilian providers. As you resolve the differences between the House and Senate bills, we urge you to adopt several specific principles to ease veterans access. First, retain and strengthen language that would enable hospitals to continue to contract directly with their local VA facilities, rather than going through a manage-care director—contractor, excuse me. Second, to facilitate veterans access we must avoid barriers, such as pre-clearance permission to utilize civilian providers, so that veterans who meet the criteria can be seen by a physician or a hospital of their choice close to home. Third, Congress must provide adequate reimbursement rates for non-VA providers, and we support the House payment language. And finally, the AHA urges conferees [sic] to insert language to establish and implement a system of prompt payment for claims from non-VA providers, similar to the Medicare Program.

In conclusion, the VA does extraordinary work under very difficult circumstances. I am confident the system's current operational challenges can be overcome and that in the interim, private sector hospitals can help. Thank you very much.

[THE PREPARED STATEMENT OF RICHARD UMBDENSTOCK APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Dr. Brown.

STATEMENT OF MONTE D. BROWN

Dr. BROWN. Good morning. Thank you for allowing me to speak today for something that I have been passionate about for 30 years: the care of our veterans. I am currently the Vice President Secretary of the Duke University Health Care System and Associate Dean for the VA Affairs for the Duke University School of Medi-

cine, so I am intimately involved in the issues that the VA faces today.

My past involvement of the VA includes medical training, six years as an employee at the Palo Alto VA where I served in many different roles, including the associate chief of staff of inventory care and the assistant chief of the medical service. My administrative career was a very unusual one in that it began as a battlefield promotion during the earthquake of 1989 where I was suddenly thrust into the role of evacuating the Palo Alto VA four months after medical training. My greatest professional accomplishment also includes the VA, as it was the creation of the Menlo Park Willow Clinic. This is the only clinic that I know of today where a county health system, the VA and two private hospitals came together for the benefit of all the parties, mainly the patients. They said it couldn't be done, but it lasted 20 years.

I am proud of the overall improvement of the quality of care of the VA system over the years and I am proud to say that my brother and stepfather continue to receive care in the VA system. My mother insisted today that I tell you how appreciative she is of the care that they are receiving or I wouldn't be allowed home.

The CHAIRMAN. Let the record reflect that you delivered that message.

Dr. BROWN. So my goal here today is to improve the system, rather than be critical. We should not forget that the VA is doing many things well, and in some cases, doing it better than the private sector.

The VA has tremendous VA research awards, the VA mail pharmacist system, the teleradiology program, the medication monitoring by nonphysicians and the use of non-face-to-face encounters by the VAs are great examples.

What the VA lacks that the private sector benefits from is flexibility. The VA has so prescribed the programs and centralized the big three of IT, H.R., and local contracting that the local entities can no longer maximize the use of their resources and make rapid adjustments to meet the needs of their patients. There is no one-size-fits-all approach, just look at the population density of our veterans by county. What works in Boston won't work in rural North Carolina where you may not even find good Internet access.

From the perspective of those who live it every day, the problems are only getting worse. First, contracting: The regionalization of contracting continues to be the single-most frequent complaint I hear both internally and externally. With the exception of the purchase of bulk supply, centralization of contracting by the VA has only created a large layer of inefficiency and unnecessary rules.

I want to highlight one example that is pertinent to the current issues of the patient access that you are undertaking today: the leasing of space. Current local management can only approve a lease up to $300,000, even if the medical center can only provide one room per provider, which is very inefficient and has a growing population. It would take them years to lease space under the current rules.

One quick way to improve access would be to more broadly define the use of sharing agreements with the academic affiliate to include use of academic excess. If it were allowed today, Duke could

offer the VA over 40 examine rooms with an existing building within weeks to months, not years; a collaborative effort.

Second is information systems. Weil the VA has an excellent centralized clinical information system, the VA and the private sector trends differ in two ways. First, the private sector trend is toward purchasing EMRs, rather than continuing to invest in what has now become a commodity, rather than a differentiator. We all need to have electronic record.

Second, the VA has divorced IS from the clinical operations by segregating it into a separate reporting structure. Simple things like having computers and scanners or updating outdated telephone switches to improve customer service are no longer within the purview of the local director. The VA should return deployment decisions back to the local entities. I can't imagine telling a CEO of a private hospital they can't purchase a new PC.

Third is the H.R., the private sector mantra is that we need all clinicians working at the top of their license. One example where this may not be happening is the Patient Aligned Care Team model where the VA RN-to-provider staff ratio is three to four times that in the private sector. The VA needs to maximize the use of RNPs, physician assistants and physicians by providing the appropriate non-clinical support staff so the clinicians can practice at the top of their license.

I believe that the VA needs a fundamental cultural change in the hours of operation. I don't know of a private clinic that closes at 4:30 p.m. Extending to 5:00 p.m. would add five million visits without any capital investments by the Government. The VA should also review and consolidate all mandatory annual training for providers which reportedly takes a full week per year, thus decreasing provider productivity. The VA could also clarify that it is legal for the full and part-time providers to perform services at non-VA facilities while on their VA tour. This would allow the VA providers to provide procedural access without increasing fixed facility costs. I do want to mention, since it will impact the future leadership of the VA that the current VA pay system limits the VA's ability to attract and retain the best physician leaders, as physicians actually can take a pay increase if they take on important administrative responsibilities like the chief of staff position.

In closing, we should remember the VA and the private sector each have their own strengths and weaknesses. Only a thoughtful, flexible, and accountable, patient and family-centered approach will deliver the care our veterans deserve. It is time to entertain bold ideas rather than protectionalism and incrementalism. Thank you.

[THE PREPARED STATEMENT OF MONTE D. BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

And, Mr. Evans, welcome. You are recognized.

STATEMENT OF DANIEL F. EVANS, JR.

Mr. EVANS. Thank you, Mr. Chairman, and special thanks to the Congresswoman from Indiana where we have numerous facilities in her district and we appreciate being here today on behalf of Hoosiers and especially Hoosiers in her district.

First of all, I adopt, by reference, everything that Dr. Brown and Mr. Umbdenstock said as if I said it myself and that will shorten my comments just a little bit. At the present time, I am actually Chair of the Health and Quality Committee of the Hospital Association in Indiana which deals with the HEN and the Partnership for Patients Project and I can tell you that private hospitals that fully incorporate the Partnership for Patients idea will be those that are the most efficient and provide the highest quality care.

IU Health is Indiana's largest and most comprehensive academic health system and one of the busiest health systems in the United States. We have a unique partnership with the IU School of Medicine, the nation's second largest medical school, and as such, have frequent interactions with the education facilities of the VA.

Like the VA system, the IU Health system is both complex and diverse. Our patients range from those with basic primary care needs in rural and urban areas to those with the most complex or severe ailments imaginable. It is not easy to change any large and complex health organization, whether it is IU Health or the VA, but I would like to respond specifically to the comments that the ranking member made about scheduling and get those into the record

To that end, IU Health has been part of a system wide strategic plan effort, meaning assessment of what the core customer, the patient, needs. We at an aggressive, but achievable goal of 25 percent efficiency over the—efficiency improvement over the next four to five years. What that means is that without spending any additional money on bricks and mortar, we will be able to treat more people. That is a private sector idea, been around a long time and I will remark on it in just a second.

So, therefore, we have established an office of transformation to change the way that the work is done throughout our organization. A key tool in implementing this transformation is the Lean process, which Rich referred to a moment ago. But where did we go to train our senior staff, including me? We went to DOW—Eli Lilly and Subaru, all of whom are located in Indiana and we had all of our senior leaders mandatorily attend their Lean training. These are places that have succeeded and failed in implementing Lean and we learned a heck of a lot—I won't call any of them out, they all did a fantastic job—but they were all impressed that we were trying to transform ourselves to be more like them than the other way around and warned us that this would be difficult, that this journey is not easy because it requires a change in culture.

If I were to say one thing is the key attribute to that change in culture, it would be focus on one thing. We only have one customer in health care and it is the patient. That is it. There are no other customers in health care. I will leave this hearing in a few minutes and go to Arlington National Cemetery where by complete coincidence, my father-in-law will be buried. If he were alive, he would tell you that he knows the people who have benefitted from VA care from his generation. He also is aware of people from subsequent generations, of which there are many more, who could benefit more from a different kind of VA than he had when he was a young man.

With the assistance of outside consultants, which specialize in Lean transformation, we have successfully implemented Lean. We have done hundreds of rapid improvement events, all of which have led to higher patient satisfaction and reduction in things like 30-day readmission rates and the things that Rich mentioned. But specifically with regard to same-day appointments—I think I have a slide on that—it beats the heck out of me why someone can't make an appointment the same way I made my airplane ticket and boarding pass to get here in the last 24 hours. I just don't understand it.

So we have been experimenting within IU Health and this is the output. What you see is the self-service page for our smallest hospital, by the way, in White County, Indiana, Monticello, where the County Board of Economic Development came to us and said to us, can you help us improve the health care in White County, Indiana—too much off time. In other words, privates or just ordinary people are just spending too much time of off work to get to, obviously, to the doctor. This is a part of a Lean process.

Now we have essentially a zero wait time. People make their appointments at their convenience. Remember what I said about Lean, it is about the patients not about us. So the thing that Rich referred to about physicians and us are going to have vacancies on our daily schedule, you can't make same-day appointments if you overbook the plane, right? So that is the cultural change. People have to accept that. So that won't work unless you have things like EMR and things like that and so forth

So our academic affiliates, that is the VA—we are very proud of our affiliation, we are committed, as you are, to ensure our nation's veterans receive the care they deserve. IU Health stands ready to work with this Committee to succeeded in achieving that goal. Thank you.

The CHAIRMAN. Thank you very much, and please pass along our condolences and thanks to the family you will be joining out at Arlington today for your father-in-law's service.

Mr. EVANS. Thank you. I can't tell my mother, but I can tell my mother-in-law, so thanks.

The CHAIRMAN. Thank you.

Dr. Stacey, you are recognized.

STATEMENT OF RULON STACEY

Dr. STACEY. Thank you. Good morning.

My name is Rulon Stacey. I am President and Chief Executive Officer of Fairview Health Services, an integrated, academic health system, based in Minneapolis, Minnesota, serving more than 600,000 people each year. I am also honored to currently serve as the Chair of Board overseers of the Malcolm Baldrige National Quality Award, the world's leading performance excellence criteria. The Baldrige Award was created by an act of Congress 25 years ago to improve America's performance in its competitive standing in the world.

Thank you Chairman Miller, Ranking Member Michaud, Members of the Committee, for this opportunity to speak with you today.

I, myself, am honored to be a veteran of the United States Air Force. That background gives me an enhanced interest on the topic under consideration today. I also bring my perspective from nearly 30 years of health care administration experience. I have worked in a variety of public health care systems in rural, suburban and urban markets. Based on this diverse background, I would suggest that while the issues faced by the VA today are significant, they present you with problems similar in nature to the issues each of our systems are facing, specifically how do we increase access and quality in light of the limited resources.

Like my health system and others in the country, Congress is wrestling with how to deliver the care our veterans deserve without breaking the bank. As the American Hospital Association has suggested, health care needs are unique and health care needs to be tailored to the individual; however, the processes by which we can improve clinical outcomes are not unique. The challenge, I would suggest is to find proven improvement methodologies that cross care settings that can benefit any health care organization, including the VA.

To this end, we are fortunate in the United States to have the world's finest process to address these issues. The Malcolm Baldrige Performance Excellence Program located at the National Institute of Standards and Technology in the Department of Commerce is a public/private partnership that defines, promotes and recognizes performance excellence in United States organizations. Some organizations choose to pursue the actual Baldrige Award which carries the presidential seal and award recipients then share their best practices with others. Best of all, the program is up and running and available to help the VA right now at no additional cost.

The program initially revolutionized manufacturing in the United States and is now having the same effect on health care. In 38 hospitals that were Baldrige Award finalists, the overall risk adjusted mortality rate was 7 and a half percent lower; the patient's safety index, more than 8 percent better; and risk-adjusted complication index, 1.3 percent better than in 3,000 peer hospitals. Using a simple extrapolation, a comparable improvement in mortality in U.S. hospitals would save more than 54,000 lives and nearly $2 billion dollars annually.

As a recipient of the Baldrige Award at a prior organization, I experienced firsthand the power of the Baldrige Performance Excellence Program. Using the program as an improvement roadmap, we improved patient satisfaction for ten consecutive years. Our risk adjusted mortality rate improved to arrange among the top 10 percent nationally. Additionally, by improving staff motivation and empowering the staff to be innovative, we were able to decrease employee turnover from 25 percent to less than 5 percent and we achieved national rankings in the top 10 person for physician loyalty. While driving these improvements, we also created efficiencies, freeing up resources and other abilities to invest in our clinical care.

This process works and it is instantly available. It works because engages physicians and nurses and staff in identifying improvement opportunities and then engages them in duplicating best

practices, so each and every patient we serve receives the best care possible.

On a national level, our health care providers have much to learn from one another. In fact, the VA, in the past has led the industry in identifying sharing best practice research. The precursor to the National Surgical Quality Improvement Program, the nation's leading surgical best practice tool, came from VA research and best practice hearing. I know that the American Hospital Associations and organizations like mine throughout the country stand ready to help revitalize this process and lend any assistance we can to search for leading-edge ideas on how to improve quality while reducing costs.

Those services at Fairview, where we serve annually, 5.8 million patient encounters and 1.5 million clinic visits, allow us to be able to interact with you, interact with the American Hospital Association, identify best practices, and share them across the country as we mutually find the alternative that will best meet our needs. Thank you.

[THE PREPARED STATEMENT OF RULON STACEY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Doctor.

Mr. Studer, you are recognized.

STATEMENT OF QUINTON D. STUDER

Mr. STUDER. Well, thank you.

My name is Quint Studer. I am the founder of the Studer Group. I am hearing impaired. I am completely deaf on my right side. I hear just a little bit on my left side. So if I miss anything, I apologize. Many people ask me questions about hearing impaired and normally it is how do you get to be hearing impaired? It is not a bad option sometimes.

One of the things I have looked at—and I am not going to repeat these distinguished gentlemen, they said great, great comments, but I would be real careful not to fall into terminally uniqueness and where I see most health care falls into trouble is when they come up and think they are so unique that there can't be a standardized approach to performance improvement.

Autonomy does not create high performance. Standardization and frequency creates high performance, and normally when I look at—we do a lot of research at Studer Group. I started out at—I don't have a master's degree in health care administration or an MBA—I started out at a 35-bed hospital and then I went to a larger inner-city hospital in Chicago, where we were hospital of the year; then I went to a large hospital in Florida, where we were hospital of the year; and then we formed the Studer Group. We work with over 900 health care systems in the United States. We also work in Saudi Arabia, Canada, and we work in Australia, so we allegation understand the capitated payment system and how that works, because I think there is not more money, but there can be more efficiency and more effectiveness and that is where we come from.

We go into a health care system and if the first thing we tell them is you need to spend more, we probably won't work with have

many. We have to talk to them about how do you better utilize your resources? The mission statement at the Studer Group is to make health care better, for patients to receive care, employees to work, and physician to practice medicine.

So while we all have different approaches, if I went to the doctor and Rulon went to the doctor—and we are fortunate enough to work with Rulon and Danny over the years—certainly I would have some differences, but there would be a lot of standardized processes that would happen also. We find the difficulty is not that people can't identify best practices; it is people can't implement best practices.

Thomas Edison says that, you know, a vision without execution is hallucination. That is usually what we get. Ralph Waldo Emerson says that people like to be settled, but it is only by unsettling them is there any real hope. And I thank you because you are unsettling some things right now, but you are unsettling things because you want things to be better, and with that, there is hope. There is hope that people have better access, better care, and so on.

A couple points as I wrap up in these last two minutes is the employee, and that is who I want to talk about in the next minute. Research basically shows that if you leave out the most important person in the VA system, you won't reach the patient, and that is the employee. I happen to believe that most employees who get up every day with great purpose. My grandson is in a burn center right now from an accident this summer at the University of Wisconsin Hospital System. I happen to believe that every day when those nurses, doctors, occupational therapists, physical therapists go into his room, they want nothing but the better care for Cooper Kennedy. I believe the VA is same way. I think you have a number of probably wonderful employees, and what we find is that if you don't get the employee with you by capturing their heart and mind, you will never be able to execute, no matter what process and improvement you work.

I don't know if the VA does an employee engagement diagnostic, but that is where I would start. I would start finding out what do your employees feel. They will fell you exactly who your better leaders are; who could use some skill development; what works; what doesn't work. Because employee engagement connects to mortality. No longer is it just about employee satisfaction; it is about employee engagement.

The University of Alabama Birmingham study on employee engagement shows that if you want to improve patient safety and process improvement, you have to have high employee engagement or else you are wasting your money; you are wasting your resources because you have to capture the hearts and minds of your employees.

We have done a number of studies—and I will wrap up with our studies—we have done more studies on this than anybody else in the industry. Our studies show high-performing organizations have some commonalities. Sure, they have uniqueness, whether they are in Minnesota, Indiana or North Carolina, but they have a lot the same. Number one, they are led by relentless leaders and that

means they are relentless to achieve measurable outcomes, as Richard said.

Number two, they have a good evaluation system. There is no subjectivity; it is an objective evaluation system. Sort of like in Pensacola when a pilot lands on a ship, they have objective measurement on how well he does; it is not subjective.

The third thing is they invest in middle-management training. Nobody feels more pressure than that middle manager and most of our middle managers are promoted from within with little skill development.

Number four, they connect with the employees. They make sure that the employee understands what is happening.

And lastly, they connect to the why. People don't need purpose leads and there is no better purpose than I can think of right now than to make sure that our veterans get the very best in health care, so by connecting that to the why, people comply, but if we don't connect back to the why, people don't comply. Thank you very much.

The CHAIRMAN. Thank you very much for your testimony. We will do a single round of questions and then Members, if you have additional questions, I am sure that the panel would be willing to take them.

Concurrent with your testimony this morning, the Acting Secretary Sloan Gibson is over in the Senate testifying before the Senate VA Committee. I got a copy of the news release that they have sent out on the secretary's testimony and basically it boils down to the Department needing an additional $17.8 billion dollars in additional resources for the remainder of 2014 through 2017, and so what VA is saying is we need more money and we need more space. I'd like to ask if you would give us a brief synopsis of if you think that that will solve the problem.

Mr. Umbdenstock.

Mr. UMBDENSTOCK. Well, we certainly understand that the VA didn't find itself in this situation overnight and it is going to take some work to get it where it needs to be. We certainly ready to survey our members—I have offered this to the acting secretary in person—to do whatever we can with our reach. We communicate daily with the 5,000 private sector hospitals and health systems to find out what capacity they might have to Dr. Brown's comment about being able to provide it much more quickly, than on a capital investment basis, so we stand ready to do that, if that would be of help.

The CHAIRMAN. Dr. Brown.

Dr. BROWN. Not having seen a breakdown of that, I can't tell you——

The CHAIRMAN. I haven't seen it either.

Dr. BROWN [continuing]. The likelihood, but I think that, you know, one of the things, as I pointed out, there are things that they can do to increase, quote "space capacity without building new space." But, in fact, I think the VA should predominately be looking at leasing space.

If you look at the VA's data from 2012, only 10 percent of VA space is leased. I would venture to guess that that is 30—that ours is 40 percent or more is leased space. You can then flex based on

your patient needs of when and where you need it, so if a lot of that money is in actual outpatient facilities, I would probability, if it were in the private sector, being looking to lease that space. But space alone won't do it. You need the providers to go along with it.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. To paraphrase Quint, this is an area where you can't do it alone. Right out my window at 10th and Senate in downtown Indianapolis, I can see four hospitals. I can see the VA, Riley Children's Hospital, University Hospital, Methodist Hospital—five—and Eskenazi, the public hospital, five hospitals. None of those hospitals is full every day, none, and I don't know how many hundreds of thousand of square feet we have in outpatient facilities that we have in the same area. But there has got to be a way in an era of scarce resources to flex in a way that takes advantage of all the resources that are available.

To Dr. Brown's point, we have the same thing available. So one of the advantages to Lean for us is by becoming more efficient and cutting out waste and focusing only on the customer, we don't need as much bricks and mortar as we thought we did. So we are building new buildings now that are actually smaller on a square foot basis per patient encounter than they were before, because we are simply using the space more efficiently.

So, again, like Dr. Brown, I haven't read what the acting secretary had to say, but my guess is that if they leased more space or if they collaborated with a local providers—one last story and I will be quiet.

My last conversation—I was in southern West Virginia, which is not rural North Carolina, but it is pretty close to it—I happened to run into a physical therapist. I said to him, "Tomorrow at this time, I will be before a certain Committee of Congress, what would you like me to tell them?"

He said, "Tell them my patients have to drive 120 miles roundtrip from Greenbrier County, West Virginia, to Beckley, West Virginia, to get physical therapy."

Think about that. How many physical therapists are there in Lewisburg, White Sulfur Springs, that are just as competent as those in Beckley? I don't know, but that was his point, so now I have discharged that duty to him.

The CHAIRMAN. Thank you.

Dr. Stacey.

Dr. STACEY. You know, I, too, don't know the specifics of the request. I know if I went to my board with a huge request, my board would require that I show to them that I had a process in place across the system where we shared data. We were able to prove to them showing data that we were using the best practice, that that best practice was being driven throughout the organization and that we had evidence-based criteria that would show that we had the best opportunities for our patients and our staff and then they would consider spending more money if we were using it the best.

The CHAIRMAN. Quint.

Mr. STUDER. Yeah, we do something the same thing. I don't live in that world. You know, we work in a world where people know they are not going to get more resources; they are probably going

to get less. If people think they are going to get more resources, they actually don't look at improving efficiency and effectiveness because they think somebody is just going to give them more resources.

So, first of all, people have to know they might not get them, so how do you make what you have work the best? I look at things like how much hospital-acquired pneumonia do you have; how many falls do you have; how many infections do you have? These are all things that can be eliminated and reduced by implementing standardized practices and that is really where you get your efficiency and effectiveness.

I would also look at things like employee turnover, because employee turnover at VA Voluntary Hospital Association has shown that your turnover has a huge impact on your, again, efficiency and effectiveness, so that is where I would go first. I would go to look at your current measurement, what can be taken out, and so on.

I agree with Dan. There is a lot of flexibility of even using different types of people. A friend of mine, Steve, had severe headaches and he called the Mayo Clinic in Jacksonville—he lives in Pensacola—they recommended he go there and he called up and they said we can get you in tomorrow. And he was shocked that they could get him in tomorrow, and they said, well, we are going to have a nurse practitioner who specializes in headaches see you first, but the doctor will be there.

So I think there are all sorts of standardized best practices that you could implement prior to just throwing money and dollars at a problem.

The CHAIRMAN. Thank you very much.

One of the things that we have heard in testimony and we have been trying to gather from VA is how much does it cost for a patient to see VA? They cannot define that for us, and we have had experts on this committee. Dr. Wenstrup has tried to get that answer. Dr. Benishek has too. VA cannot tell us. The panel of patients that a VA doc sees is 1200. The average patient load at VA per a day is about eight and in the private sector, it is our understanding that it is considerably more than that.

So I think the efficiencies that VA needs to be looking at and needs to be surveying is part of the solution as well. If more money is needed, we understand that, but as has already been outlined, I think, by the panel, VA has got to show how they are going to use that money. What they have done so far is to continually ask for more, get large increases every year and there has been no desire on their part to deliver health care in a timelier fashion, more efficiently, and better for the veteran.

Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

You know, several—I know we haven't heard from physician groups, but what many physician groups have told me is that there is a looming shortage of physicians in our country across, whether it is private sector or Government health care, and I want to know if you would concur with that, that we face a serious shortage.

And I have talked to my local Kaiser person who has opened up a clinic not too far from me and he says, you know, we are especially in the empire of California, Southern California, facing a

shortage of behavioral health people, and I know that that has been a real struggle not VA, as far as delivering mental health services. I know that they have been trying to drive efficiencies through telehealth, so I want you to know that Dina Titus, myself and Mr. O'Rourke have offered a bill which would fund 2,000 more medical residencies at VA hospitals.

I want to know if you think that would make a difference, not only for the VA, but for the total supply of doctors, including the four-year members, starting with Mr. Umbdenstock.

Mr. UMBDENSTOCK. Umbdenstock, yes. Thank you.

Yes, the American Hospital Association is on record supporting the increase in graduate medical education or residency slots. They have been held constant for a long time.

And we do face a shortage, but it is not just a shortage; it is a distribution of specialties as well. Clearly we need to make a better case for medical students to choose primary care residencies. We have a particular problem in the primary care area, so we would certainly want to favor that and then we have to think about how we can encourage people to practice in underserved areas. And we know that people typically serve in areas where they typically receive their training, so we want to see those residencies strategically placed to encourage that distribution.

You mentioned behavioral health. That is a huge problem across the entire health care system. It has largely been underfunded and I would say ignored in recent years and to the VA's credit, but others as well, I think in the last five years or so, everybody has figured out that you have to integrate behavioral health and primary care into one practice and see that patient who has multiple conditions at the same time. So that is one approach that is being used.

And finally, it is not all about physicians. We can do, I think, a lot more with the skills of nurse practitioners and physician assistants and others in a team-based approach, saving that physician's expertise for that true clinical—clinically ambiguous issue where that skill and expertise is needed and utilize others a lot more effectively.

Mr. TAKANO. I appreciate it.

If we can go down the line quickly.

Dr. BROWN. I am going to echo some of the things that it is not a physician shortage; it is a provider shortage, and the VA needs to utilize that workforce. As of last week, there were 776 job postings for physicians in the VA and there were 78 PA and RNPs. The VA pays well for the nurse practitioners and the physicians, but the PAs, they are not able to attract because the salaries are really too low.

So this is really a workforce issue, and I would actually say that in order to get the workforce up and going faster—I am going to get myself in trouble—the better dollar for investment is actually in the nurse practitioners and PAs and more training there first because the time for training is shorter.

Mr. TAKANO. So you disagree with what the AMA and others are saying that we are not facing a shortage in this country?

Dr. BROWN. No. We have shortages, and especially, like they said, by specialty, but if you are going to put dollars and try to get a faster impact to the provider shortage to the VA—remember a

PA, the training varies, but from two years to four years. A nurse practitioner start from nursing is five years and a doctor is eight years.

Mr. TAKANO. Well, thank you.

Go ahead, sir.

Mr. EVANS. We have got hospitals all over the state of Indiana, so we have residency programs all over. We do need to expand residency funding. It has been frozen, I think, since the Balance Budget Act of 1996—is that right—so it is a whole generation.

In the meantime, the population has aged incredibly, so the specialties that are needed have changed, not to mention the primary care needs.

Mr. TAKANO. Excuse me. Is the Government—I mean I heard that 90 percent of the residencies are funded by the Federal Government or actually almost a hundred percent, right? Ninety percent by Medicare?

Mr. EVANS. We all have caps and we have to fund over the cap, so I don't know about——

Mr. TAKANO. I see.

Dr. BROWN. So below the cap is funded by the Government and then the provider itself does any other positions above that cap.

Mr. EVANS. And I believe that we are funded only for the pure salary and we have to come up with——

Mr. TAKANO. There is supplemental that you have to——

Mr. EVANS. Yeah, there is more.

Dr. BROWN. There is IME and GME, so at Duke we have 900 residents and fellows; 400 are funded by the Government; the rest are funded by the Department, so the University; and a hundred are funded by the VA. That is kind of the breakdown.

Mr. EVANS. So what that means is that the clinical operations have to subsidize the expanded residencies and in this day and age where we are being reduced in reimbursement, that is more challenging to do.

But one idea for you—I tried this during the Affordable Care Act. It didn't get very far, so maybe we will get further. Now, one of the problems is debt and where do they do their residencies and for what. So if you have got two or three hundred thousand dollars in debt, you are not going to do a residency in a specialty that is not going to help you deal with that reality. The lines don't cross now on income and debt until you are middle aged.

So what would you do if you had to make—so I tried to do this with Senator Snowe and Senator Bye and it didn't get anyplace, but you have to give tax credits to get people to go to places they don't want to go. You do it for all other industries, don't you? We don't—we, society, does it for all sorts of other industries, but why we don't do it to get primary care docs in underserved areas, I don't really understand, but we don't do it in an aggressive way.

Now, number two—I need a number two—run residency programs where you want people to stay. There is a high correlation between where one does one's residency and where they end up practicing medicine. So we have a very successful residency program in Muncie, Indiana. Not the site of a big University. Not the site of a major community hospital, although we have a hospital there, it is not a big academic hospital, and it is highly successful.

It keeps about half the residents that it trains in Indiana—pretty good ratio—and we need those residents—or we need those permanent docs in places like Muncie. Thank you.

Mr. TAKANO. Mr. Chairman, I——

The CHAIRMAN. No, continue.

Mr. TAKANO. Okay, thank you.

Go ahead.

Dr. STACEY. I would—the answer to your question is yes, that there is a—we are in the midst of a significant decrease in the number of physicians available in the United States and it is an issue that we are going to have to address.

My personal argument would be that as we address the shortage of physicians, there is a huge downstream; the cost of that. As the supply decreases, helping us with the graduate medical education funding today will help defer that down the line. But we have a—the model that Quint talked about earlier, I think is significant. We have a clinic in Eden Prairie that adopted a team-based approach where we try to use everybody at their highest license. We know that there is no panacea out there. We want to make sure that the nurse practitioners are functioning to the highest level that the nurse practitioners can; the physicians to the highest level that the physicians can, and so on, work in a team-based approach and address those needs.

And for us, it is reduced wait times. It has enhanced the delivery to patients and I think it is a model from which I think the VA could benefit.

Mr. STUDER. Thank you.

Did you mention Kaiser?

Mr. TAKANO. I just mentioned as someone in my community had just opened—we have a shortage generally, but Kaiser——

Mr. STUDER. In the health care system?

Mr. TAKANO. Yes.

Mr. STUDER. We are fortunate enough to have been working with Kaiser for many, many years. In fact, the research that I will give you is from Kaiser.

I have a new book that I am working on. The working title is for doctors. It is called, "Who moved by future?" Instead of who moved my cheese, because that is exactly what is happening to physicians. They are now in an environment that they weren't trained for and it is very, very difficult.

Sixty-five percent of physicians look back and say I'm not sure that I want to do this anywhere, so I think step one is let's make sure that we retain the physicians we have because if we don't—years ago, 20 years ago, it is the same thing you heard on nursing, you know, people couldn't find nurses, and then we made it a better place for nurses to work and that is not an issue right now, nursing, as it is with physicians.

In our work with Kaiser—Kaiser has found out that if they visit a physician every month with some basic questions: Do you have what you need to provide excellent care to your patients? It is either a yes, what are we doing right? Or it is a no, what can we do better?

When they visit a physician and have that conversation once a month, the physician satisfaction is pat over the 80th percentile. If

they do it every quarter, it drops down around 70. If they do it every six months, it is around 55. If they do it once a year, it is really around 50.

So the question is: What systems and places can we put with the current doctors in the VA system and so on to make sure that they are feeling good about what they are doing and so on; however, I go back to why fix an old problem with old solutions?

And I go back to what Rulon just said here. I have skin cancer. It was recently removed by a nurse practitioner. I thought the care was great. I think there are some wonderful nurse practitioners and physician assistants.

We were brought over to China to look at their health care system, telemedicine. So I think there is a lot of better solutions than just saying how do we get more docs. I think that is part of it, but I think we can be much more flexible in looking at the talent we have in the system to handle that situation. But I, again, don't know how you measure physician satisfaction in the VA system. How can you come up with a treatment plan if we have never diagnosed the problem?

So we measure physician engagement currently in the VA system because I think they will give us some pretty good insights on what we can do to make it better. Thank you.

Mr. TAKANO. Thank you.

The CHAIRMAN. Dr. Benishek, you are recognized for five minutes.

Mr. BENISHEK. Thank you, Mr. Chairman.

Well, Mr. Studer, you bring up a really good point. You know, I am a doctor. I am a general surgeon and I worked at the VA for 20 years.

Mr. STUDER. Can I come up to you to hear? Can I come your way?

Mr. BENISHEK. Yeah, yeah, sure.

Mr. STUDER. I don't hear well.

Mr. BENISHEK. Well, the point that you brought up about physician engagement is a serious one because in talking to physicians and myself being a VA physician, they feel they have no input whatsoever and that the processes that they are dealing with come from above and they don't have any input.

Do you have any suggestions? And for the rest of the panel as well, how do we get more efficiency out of the physicians there? What are the processes that you all use, other than like what Mr. Studer has stated to make sure that physicians' input is taken into account by management?

Mr. Studer, could you please start?

Mr. STUDER. I will now pass along, because I know that they worked hard on this. Health care systems that are led by physicians normally outperform those that don't.

Mr. BENISHEK. Right.

Mr. STUDER. And the reason is because people all want to know where is the physician on this, because the physician, even if they are not even in an official leadership position, are seen as a leader in every health care system, and if they see that the physician is doing certain behavior, everybody follows it. When we research physicians, they basically want input because they don't want to be

hostage in a situation that they are working in and that is how they can feel at times.

So I think, one, where are you at now? How do we make this a better environment for you to work in? Physicians aren't asking for more money; it is normally more efficiency, more effectiveness, a better work environment; you know, that is what they are looking for, and then the input. You know, nobody knows the health care system better than a doctor, so doctors, basically, when you ask them what satisfies them, it is give me an opportunity to provide excellent care for my patients and then give me input into the decision-making around here and, again, if you are not asking them—you know, one of the things—you know, employee engagement—physician engagement starts out, you can almost improve it just by asking them, and, again, I don't know how the VA is currently measuring employee engagement.

Do they have a system in place?

Mr. BENISHEK. Well, it is not very pretty. The physicians that we have talked to at the VA are very unhappy.

Dr. Brown, do you have an opinion there?

Dr. BROWN. Yeah, I think the VA does do physician engagement. The question is: What action is taken on them? They do student engagement, actually, and they have very good process and because there is external review by the residency programs to then act on it, those things actually get acted on in realtime, otherwise we lose our accreditation.

At Duke, we actually do employee engagement, not just physician engagement, and my salary is tied to that.

Mr. BENISHEK. Right.

Anyone else has an opinion there?

Mr. EVANS. We do the same thing and my salary is tied to it, as well. That causes the focus of the mind, and I agree with what has been said here. Physicians have to do this, not corporate CEOs. Our job is to create the atmosphere in which that can occur, and then as Quint said, assiduously, relentlessly, measure it, and then you know.

And if you only meet with physicians every six or 12 months, right, Quint, it can never improve.

Mr. STUDER. Right.

Mr. EVANS. And if you meet with them frequently but never do anything they suggest, it will actually go down. I think this is a problem for the learned professions in general as we kind of lose control of our daily lives that we rebel by saying that we don't have any control and then it actually becomes a case.

Mr. BENISHEK. Dr. Brown, let me ask you this: As I understand from your written statement that you had consulted with a visit about ten years ago on how to apply private sector analytics to the VA system. Can you expect that they take up any of your suggestions or tell me more about what that was.

Dr. BROWN. Yes, I called myself the reluctant consultant, that I actually like to, I would rather spend money and teach employees rather than having consultants who then walk away. So I agreed to consult to actually Indiana, Michigan, Detroit, Ann Arbor, about using dialysis as a model of how the VA could then use business

analytics to decide should they insource it? Outsource it? Especially since the VA pays for travel.

So the good news is Indiana was already the model and was as good as the private sector. The good news is we taught then the VA employees at the VISN how to do these analytics. And by the time I actually issued the report the other two VAs had actually adopted what Indiana had done.

Mr. BENISHEK. So we had a good experience. I am just about out of time. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank the panelists for being here. I think we can all agree that the culture in the VA has to change. And you have all testified towards what a culture should look like. It should be patient centered; it should be a culture of continuous improvement; transparency; data driven decision making; teamwork, where the team is honored for improvements and individuals within the team are honored for improvements. So my question, I think it is an important question but it is a broader question. What should this committee in its oversight responsibilities do to, what should we be looking for? And I think primarily in the short term, I am looking at. I know we have a longer term issue here. But what should we be looking for as an oversight committee in the short term to determine that there is real change taking place within the VA? And I ask the panel, anybody could——

Dr. STACEY. Well I would suggest that, we talked earlier about a strategic plan. And the reason for a strategic plan is you identify where you want to go and then set objectives to get there. If I were on this committee I would want to know what are the measurable objectives that are going to be implemented immediately, and what is the report out? Employee satisfaction is one of those. How are we going to measure the engagement of our employees? My board wants that data every year. And I have to give it to them, and my salary too is tied to that. Physician satisfaction. What are our strategic objectives, and then what is the report out to Congress on the measurable objectives? And set the goals, set those targets with the specific targets related to those outcomes and then expect feedback. And we do it, they will be able to do it. I am sure it is just a process that will make you and the American people feel more comfortable with where we are going.

Ms. BROWNLEY. But I feel like, I do know if the rest of the members here feel like, that in large part the VA has done a lot of the things that you are suggesting that they do. But the outcomes that we are looking for are not necessarily there. And so, you know, what is it that we need to be looking for that is going to be those sort of real levers within the VA that indicates to us that real change is taking place?

Mr. EVANS. I asked the CEO of our Monticello Hospital that question this morning. I said if I were to say one thing about your same day appointments and your improvement in service, what was the standardization that you used? And she said NCQA Level 2 Primary Medical Home Certification, period. Those are measure-

ment tools that tell you whether or not you have got there to do the job. So there are plenty of those measurement tools out there.

I know very little about the overarching statute. I tried to read it the other day. I am a lawyer, an attorney, but I had not read the U.S. Code in some years, I think since I took the bar exam. It seemed really complicated. So these, this kid in West Virginia, who is a P.T., when he says to me, they have got to drive 120 miles away, the way I read the rules was that was almost mandatory. Meaning you had to go through a process to access care. So if you had these standards you might find, either doing a Baldrige process or a Lean process or both, where the waste was. Because waste is defined as something of no value to the patient. That is red. It is on your flowchart, your value stream. And I daresay that if you put a chart up in this room and ask the Acting Secretary to pick a hypothetical patient from point A to point Z who had skin cancer, what would the value stream show? How much of it is red? How much of it is green? Green is very simple. Green is, only has value to the patient. Paperwork has no value to the patient. So you see we were stunned, I cannot speak for my colleagues but I bet they were too. Stunned at how much red was in our value streams and posed by us, not by the government. Please go to Point A to fill out the paperwork, and then go to Point M to turn in the paperwork. And you put that in a value stream.

Where it was most dramatic was the nurses in our pediatric hospital NICUs. Who suddenly realized that their value stream imperfections caused the baby to get home to its parents. And they were very emotional about that. So back to Quint's comments about the purpose of the work, the purpose of the work is to get the baby back home to the parents, not to fill out a bunch of paperwork.

So there are specific metrics. I would, if you want to improve wait times for primary care physicians, and you want to improve the health of veterans, you had better have a primary care home. If you do not have it, it is not going to work.

Ms. BROWNLEY. My time is up.

The CHAIRMAN. Thank you, Ms. Brownley. Dr. Huelskamp, if you would hold for just one second? We have another question from Mr. Lamborn. He just wants to follow up very quickly on a question that was asked just a few minutes. Mr. Lamborn?

Mr. LAMBORN. And then thank you both. Dr. Brown, if you could just finish what Dr. Benishek had been asking you and then you ran out of time? But you said you did a study on the VA versus the private sector, and incentives and results and outcomes? What was, what could VA be doing to better match, at least in productivity terms, the private sector?

Dr. BROWN. So my specific aiming goal of that engagement was to actually teach the VA how to do their own work, because I did not want to be a long term consultant. I like staying at home. But I knew the VA and I knew the private sector. So I actually gave them what I thought were the tools so they could actually make their own decisions. And I think that is what we need to help the VA do, is have more people who understand what the private sector is within the VA and then doing the analysis.

So there, you know, to me they basically adopted the policies of how they could run their own internal practices of dialysis. And

this is not difficult where, how you use the number, what type of employees, RN versus techs. So they had a best practice within the VA in their own VISN, but they had not shared that learning across the VISN. And that just by sunlighting it they then saw what the best practice was. What they did not do then is to say, to take some risks politically about how they then could utilize the external world and saying is it better to outsource this dialysis if that person is driving 200 miles or 100 miles? Because we pay, the VA pays for travel for these patients, and for the customer convenience, and the pay. So they did not adopt at that time. VA has now changed some of its practices, ten years later, about doing their own dialysis, owning their own dialysis. But I do not think they actually analyzed it from a is it better to keep it from within or outsource it as well as we could.

Mr. LAMBORN. And then finally you have mentioned, and two others have mentioned, that your salary is tied to certain, like employee engagement, or other factors. In other words, you are not just paid a salary and that is it? You are paid and then you have to produce something on top of that, right?

Dr. BROWN. Top management all the way down to management at Duke has a system of metrics that was tied to the overall system. We have our own unit metrics, and we have personalized metrics both short and long——

Mr. LAMBORN. Is that something the VA could learn from as well?

Dr. BROWN. Yes——

Mr. LAMBORN. Adding incentives to salaries?

Dr. BROWN. I think the VA should do that. But I would actually argue that currently the VA has metriced themselves to death. They have metric fatigue. There are 500 metrics and measures and so you cannot pay attention to the biggest ones. So the issue is that if you are looking for change, look at your leadership. Without leaders you will not get the change.

Mr. LAMBORN. Okay, thank you very much. Thank you, Representative Huelskamp. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Dr. Huelskamp, you are recognized for five minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I would expect a few more acre feet to come down the Arkansas River by being nice to my colleague from the west. But I appreciate the testimony. And one common theme I have heard from a number of you is putting the needs and the desires of the patient first. And coming from a very rural area, that patient is usually lost. I just had a case of a gentleman that would like a shingles vaccination like he had received last year that was available at the local CBOC. They said rules have changed, you now have to drive five hours one way to get a shingles vaccination. But there is a hospital 31 miles down the road that would take care of that, but the VA cannot quite figure out how to work in that system.

So Mr. Umbdenstock, and your name is almost as difficult as mine to pronounce——

Mr. UMBDENSTOCK. You nailed it.

Dr. HUELSKAMP [continuing]. Maybe that is why you have not gotten as many questions. But can you describe how we can work

together better with our local hospitals? I have about 70 community hospitals. And it is a royal pain for them to actually work with our veterans and give them a chance to come in there because of the paperwork and the nightmare that comes from the VA system. So if you could expound on that I would appreciate you doing that.

Mr. UMBDENSTOCK. Thank you. And thank you for correctly pronouncing my name. It was nicely done. The reality is that there are a lot of community hospitals today who have very good working relationships with local VA hospitals. And it seems to be that it has been able to be worked out at the local level. And so we want to see that continue and actually expand. So there are a couple of things to think about.

One is, you know, do they have the capacity and ability? And most of my members, as I mentioned to the chairman on the way into the room, are saying how can we help? So I am taking that as a real positive, not just of intent but they feel they have the capacity. Number two, make it easy for them to contract. There are plenty of them that have direct contracts. We can figure out what makes that work. There are some of them now going through third party contractors. We find that it can work but we find that burdensome and not the preferred way. And if they cannot make decisions locally on, as was mentioned earlier, areas of priority to them that they can fix today through that kind of cooperation then the whole system is not going to work. So I say let us put fewer barriers in place, not more barriers, and figure out what those best relationships show by way of how they are set up, how they function, and how they are accountable. And what is it that we have to demonstrate as a provider contractor back to the VA?

Dr. HUELSKAMP. A couple of things on that. Then are you seeing different results and ability to work with the VA depending on what VISN they are in? Are you hearing any of that difference?

Mr. UMBDENSTOCK. Definitely as we have talked to our members, and we have been holding calls over the past month, six weeks, to get more information on this, if you have seen one, you have seen one, for sure.

Dr. HUELSKAMP. Yes.

Mr. UMBDENSTOCK. And they do seem to operate very differently. You know, our systems operate differently across our membership, too. But not when they are under one organizational control system.

Dr. HUELSKAMP. You know, in my particular congressional district there are four different VISNs and all of them are a long ways away, at the main facility. And they are not close. And the VA's response is, well, we will pay for travel. By the way they changed that, we will pay for travel in the shortest distance possible, which might be down the dirt road rather than the interstate which raises a little concern. But trying to figure out how they can work better, because your members, my community hospitals, they want to participate in the system and they are not allowed to participate. It is incredible paperwork.

One of the possible avenues was the Project ARCH program, which looks like the VA is going to cancel. Do you have any thoughts on that? Some places it seems it might have worked. But

it seems an enormous load of paperwork compared to other systems that our hospitals participate in.

Mr. UMBDENSTOCK. Yes, one of our colleagues who actually serves on the AHA board at the moment from Caribou, Maine testified about two weeks ago on their experience with the ARCH program and are extremely favorable and would like to see it continue. So that type of really local knitting together can really be useful.

Dr. HUELSKAMP. Yes, and one thing that we cannot forget that it is the family, as well. You say, oh yes, the VA will pay under certain circumstances to drive, but you have got to have a driver. You have got to have family that has got to take a, as many of our veterans that are returning now are younger and younger they have got to take a day or two off of work literally from my district to drive to Wichita, Kansas. A young man, young in terms of about 50 years old, he was told that he had to drive three round trips in ten days for a service that he could have gotten in his local hospital but the VA would not approve it. And so he had to take off basically three full days of work. And we can figure that out. We should be able to by giving veterans a choice in keeping their needs in mind first of all. So with that I will yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Huelskamp.

Mr. STUDER. Congressman Miller.

The CHAIRMAN. Yes.

Mr. STUDER. Can I make a comment?

The CHAIRMAN. Yes, you may.

Mr. STUDER. Thank you. And I will go, metrics, I think you brought up, ma'am, what are the key metrics. We work, this is what we do, you know, we have got Cleveland Clinic down to seven. And I think what happens is we get to the point here we metric ourselves, we paralyze ourselves with so many metrics. So while we need all those metrics, what are the key element metrics? You know, things I would look at I think Rulon brought up, which are patient experience, your employee engagement, what is your physician engagement. Then if you are looking at access it is what percentage of patients can get in to a doctor within so many time, how many left without being treated? I mean, when you have people that actually show up and then leave. So I think you pick five to seven good metrics you can agree on and that becomes what you say your dashboard.

Your comment, I think also there is probably some VA hospitals that work very, very well with the private hospitals. The Heath brothers in their research on change, when change is hard, there is a book out called Switch that does pretty well right now. And they basically say you can study where it does not work but you will not learn much. You can go in and study that has got a free lunch that drops out and you might not learn much. But study that child with a free lunch that does well. So I think there is also again, I do not want to measure this thing to death, but I bet you there are some real bright spots and the Heath brothers say——

Dr. BROWN. I will offer that, to come to Duke and the Durham VA. We have a great relationship. The fee basis system works. We get authorized. I can tell you who the fee basis authorizing person is. We get the authorization number, we put it into our system, the patient then, communication. What the VA does not do well is then

pay. I actually think this system of direct contact is better than the PC3 system so the ARCH system. Remember, you do not need a contract for the fee basis or now called the non-VA care system. But I would actually hope that the VA looks differently that it is not just hospitals. Remember outpatient care. It is CVS, it is Walgreens, it is all these. They can do it cheaper, so why are we not thinking big picture, big change, not little change?

Mr. STUDER. And that is what I would mention. You find your bright spots. You study them. In my book Straight A Leadership I have a whole chapter on moving best practices. And what is called is find your bright spots then figure out how to scale them and move them.

My last question I would ask the committee to think about in this conversation is we did a workshop for health care boards. And one of the board members, and we work with a lot of rural hospitals, one of the board members said what if your goal is to stay independent? Because there is a lot of mergers. And the, James Orlikoff and Renee Kaufmann who were on the panel, not me, said well is that your goal? Or is your goal to provide the best care for the patient? So the real goal is not how do you create a better VA. That is part of it. But that is a symptom. The real question is how do you provide the best care for veterans? And then they should go to the facility or the location that provides that best care. Thank you.

The CHAIRMAN. Thank you. And I am trying to get some real time data as we are going through and listening to the Secretary's testimony. And Quint, I want, you do not need to react, but I just want you to think about this and maybe we will talk about it a little bit later. And Dr. Brown, this kind of keys off on what you just said a second ago. But the Secretary made this comment. "The greatest risk to VA health care is to spend money on providing dollars for purchased care without addressing the longstanding issues of lack of dollars for VA." So both of you can think about that just a little bit.

Ms. Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you very much. I appreciate you all being here today and I wanted to address my comments to the discussion of collaboration and moving things along. I was impressed to find an article in the Boston Globe, and I do not know if you any of you have seen it, but it is about data driven scheduling predicts patient no-shows. One of the most incredible issues that we have heard about is the 50 percent no-shows. And it does not help that the VA is working off a 1985 scheduling program, apparently. And there is more than a few questions around here, I am a new member, but hundreds of millions of dollars have been appropriated. But I was intrigued by this article and I will give it to the chair for the record. They actually analyzed the patients that are least likely to show up and compare them to the patients that are most likely to show up. And use that information in the scheduling process. And so that rather than just treating all patients similarly. I guess I just want to ask generally, are there these types of innovations that are going on? And are there, you know, can the VA learn from that and do a better job? Because it seems to me the greatest waste right now is physicians in their offices, practitioners, and I appre-

ciate the comments on nurse practitioners and PAs, in their offices ready to see patients. But because of this scheduling fiasco they are not showing.

Mr. EVANS. If you applied Lean, and said what is the problem? What is the question? The question would be we have a 40 to 50 percent no-show rate in a particular kind of clinic. Dermatology, which is famous for no-show rates by the way. Then you would say what is the desired state? Well, what is it? No no-shows. And then you go through the why, you would measure it, you would have a rapid improvement event to see if it worked, you would measure the outcomes. If it did not work you would not try that again. You would try something else. But that would be a Lean process. That would be a specific tool.

The Baldrige award goes to people that do things like that well. So I think what we have done in this country is we have trained millions of people to not show up. Because when they do show up, they wait. It is the only industry that still has waiting rooms, ours. So the example that I showed you of Monticello, Indiana, we have replicated that in LaFayette, Indiana, which is a much bigger community. And the waiting rooms in LaFayette have nobody in them. They are empty because they are not waiting. So now they show up, right? So that was part of a rapid improvement event that came out of a Lean process that we did this value stream to determine what was waste. And we discovered that regular things that we did were wasteful to the core customer, the patient. So what remedy did the patient have? They do not show up. Or worse yet, I think Quint referred to it, they show up and then they walk out. They leave without receiving care, like in ERs. But the tool that we used anyway was Lean to achieve that. And back to what Rich said, we had to convince docs that empty time on their schedule so that you could deal with the ebb and flow of real live people. And the younger veterans that someone referred to have jobs. So they are more likely to not be able to show up. So do we want to punish them? So that is the whole purpose of that Lean process and a measurable outcome would be——

Ms. KUSTER. Reducing no-shows?

Mr. EVANS [continuing]. Yes, no-shows.

Ms. KUSTER. And Dr. Brown.

Dr. BROWN. So I am not sure what, I am not familiar with the article. But I am not sure if you are also referring to the previous testimony a week or two ago about 50 percent no-show in the psychiatry service. I think that is not common in the other practices of the VA. And I would argue that it is not a scheduling problem then. If they have behavioral health issues it may be that they need a home visit, not actually a patient visit, them coming to us, because there are other things going on. So it is not, I think what the article may be referring to is actually how we are looking at overbooking. Should you overbook by five or ten percent? That is not really the issue. My experience in looking at the why people no-show, the number one is that we did not actually communicate to them an appointment that they actually could keep. The second is the length of time between you give the appointment, I mean you give them the appointment and when it is actually scheduled for.

So if you are scheduling nine months out, I cannot tell you in nine months if I can come or that I will remember. So I think that——

Ms. KUSTER. And particularly if there is not a reminder. That was part of the issue.

Dr. BROWN. Right. The VA does have that. But again, that is 50 percent I think was specific to a psychiatry practice, not the usual VA practice.

Ms. KUSTER. All right. My time is up. Thank you.

Mr. STUDER. What we have found when we go into an organization one of the things of course we have to demonstrate is how we are going to prove our worth. And one of the things we always look at is the no-show rate and it is usually much higher than they think. Then you have to say was it a no-show rate because the patient does not show up, or is it a no-show rate because the doctor does not show up? Or the doctor cancels their practice? So you have to again do this diagnose before you treat.

However, we do find that there is some simple things you can do that will reduce no-show rate and we guarantee it by 70 percent no matter what it is. And that truly is you have to remind the patient. A human being reminding them is better than a machine. And explain to them where their appointment is, how to get there, where to park, how long it is going to take, and then tell them why it is a medical necessity. So we teach something called Aid It. Part of it is explanation. Because when a patient has something explained to them, why it is important, what to do, we find no show rates can drop by 70 percent. And we start off by having people make those phone calls when the patient is not showing up, and then pretty soon financially it makes sense if you need to to have somebody do it because your productivity improves so much.

Ms. KUSTER. Okay. Thank you very much. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. Ms. Walorski, you are recognized for five minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman, for holding this hearing today. And I would like to extend a special welcome to Mr. Dan Evans from IU and a fellow Hoosier. And I just wanted to say that I am grateful for the services that IU Health provides in my district in Goshen, La Porte, Starke County, and we are grateful for your service there.

Mr. Evans, can you speak to this issue of leadership in a multibillion dollar facility as large as the VA is? And I guess, you know, what we have heard continually on this committee in all these hearings is this constant proclamation that says it is leadership, it takes leadership. You guys have all talked about it today. But given that Indiana has done such a phenomenal job, IU has as well, and I am proud of the IU system in Indiana and the standard that you have set. But can you just speak to, as we look at, even some of the things the chairman just read about, you know, we have an Acting Secretary, we have a soon-to-be Secretary could be vetted, could be the next person selected. Can you just speak to what does that, what is the issue with leadership in a facility this large?

Mr. EVANS. That is a big question.

Mrs. WALORSKI. I know.

Mr. EVANS. That is a really big question. And any of the gentlemen here could answer it just as well if not better than I.

First of all, I work in the building where I was born. The people that I see everyday are my friends and neighbors, literally. So it is difficult for me to relate to someone who is a journeyman manager and may be managing a facility where he could be gone in a while. So the first thing I think is demonstrable passion about the work. And you do not have to be a resident CEO, you can be a journeyman administrator to do that. So here was my measure when I first became CEO of IU Health, and I learned a little bit of this from Quint and his colleagues, is if I went to a meeting and the word patient was not mentioned in the first five or ten minutes, I just figured I was at the wrong meeting. So who is the keeper of the flame in a big institution? It is the CEO, the Superintendent, the General Director, the Chair of the Committee, the President of the United States, the Secretary. That is the person.

So you have got to engage people in the core work. And if the boss is not engaged in the core work, then it is never going to happen. You will always have lousy employee engagement. The docs will never believe what you have to say. And I want to manage up Quint a little bit. Quint and his organization have done an excellent job of teaching people how to be better leaders but I do not think, Quint, you have made any leaders that did not already have the passion in them. So I think it is that you have to walk the talk. And it is as simple as that.

And then what happens in our place anyway is people talk about it. I am always amazed, I am sure my colleagues feel the same way, amazed how the smallest action by the CEO is magnified throughout the system, negatively or positively. It is hard to magnify focus on the patient negatively, the purpose of the work negatively. So the comments about the people driving 120 miles round trip; the comment about the VA saying, oh, do not worry, we pay for your time; that is just horse stuff, you know? Time is important, even to people who have got plenty of it. So if you are focused on the patient you are not going to require somebody to do something like that.

Mrs. WALORSKI. And just a real quick question on the Lean program, and I am fascinated by the Lean program as well. And I know that you mentioned Eli Lilly and Subaru as being companies that were involved in that. When you first looked into that concept of Lean, from the time that you started checking out to what you consider an institution that has been greatly affected now by Lean, which is the IU Health System, how much time elapsed in there? What kind of a timeline was that?

Mr. EVANS. It is a minimum of three years for us to get to an operational stage. First of all, like many of the facilities here we are gigantic.

Mrs. WALORSKI. Mm-hmm.

Mr. EVANS. And to get something, at the VA it would be just huge. But it is a common tool. And the first, and we start at the top, not the bottom.

Mrs. WALORSKI. Mm-hmm.

Mr. EVANS. So it was me and my direct reports who went to Subaru, Dow AgroSciences, and Lilly, and sat down with, in fact,

we sat down with people who had failed as well as people who had succeeded.

Mrs. WALORSKI. Mm-hmm.

Mr. EVANS. And so it took a year just for us. Secondly, a footnote to that, it means that I had to become Lean trained myself. By the way, I think I was an ER orderly. That was the job that I pretended I was in order to get my own certification. But that took a while.

And then the second key is put your best people in charge and do not make it a project. So spending more money, it could be that, I do not know if you need to spend more money because like Dr. Stacey said, no one is sitting around here offering ways to give health systems more money.

Mrs. WALORSKI. Mm-hmm.

Mr. EVANS. I do not know why you would give anybody in the health industry more money because we have already eaten everything that we have been given. We need to use what we have already got more efficiently. But we did employ funds to the Lean effort and made it permanent.

Mrs. WALORSKI. I appreciate it. And I, again, am grateful for the work that you do in our district as well. So thank you very much for your presence today. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. Mr. Walz, you are recognized for five minutes.

Mr. WALZ. Well, thank you, Chairman. Thank all of you for bringing your expertise here and choosing to put that expertise towards helping our veterans. And Dr. Evans was getting at improving the entire health care system. I think we love the false choices. They make neater sound bytes. And so it is public versus private, and then that is the argument. It is much more complex. And the good news is there is much more solutions in that. So I want to applaud each of you for just clear testimony.

Dr. Brown, just within a few seconds of, just very clear, how you focused on it, and talk about clinicians practicing at the top of their license. We have had some hearings where I have asked the folks who are sitting here when is the last time you saw a patient? And they cannot tell me. And they are obviously talented doctors, now they are in administration positions. And then the longer hours, just that small thing.

VA does a lot of things well. Building brick and mortar hospitals is not one of them. And they want to engineer the dang thing. Heck, they want to carry the bricks to do it. And that is wrong. So I appreciate that.

And I also want to bring, I represent Southern Minnesota and I drive by Dr. Stacey's hospital every Monday, and I have the Mayo Clinic in my office. I want to bring all of you when they talk scope of practice, so I will sit down with the nurse anesthetist and anesthesiologist, you can work out that whole feud for me on scope of practice. But you are hitting on an important point. And do not get me wrong, I somewhat facetiously say that. But it is a tough issue. But it is one we are all going to have to address, both in the private sector and the public sector.

I am going to come back on this, this issue of leadership. And I am going to go to you, Dr. Stacey, on this Baldrige issue. It is

ironic. Yesterday we lost James MacGregor Burns, and transactional versus transformational leaders, and some of the things that we have grown up on. The Secretary sat right where you were, Mr. Evans, and said she is going to achieve ISO 9001 certification. Now the thing is I thought about this in full disclosure, and my doctoral work education deals with Baldrige so I am more facility with Baldrige in working on that. ISO 9001, you can help me Dr. Stacey, focuses on defects more than it focuses on results and strategy. And it seems to me, I have seen this happen in organizations, the process of achieving 9001 can become an end rather than a means to patient care. And if there was ever an organization in a world that lends itself to getting sucked into the process over the outcome, it would be that. If you had, Dr. Stacey, using the rest of the time, should they be doing 9001? I do not want you to go towards Baldrige——

Dr. STACEY. Why do I feel set up?

Mr. WALZ. No, but I want you, I want them to pick the right thing for the right reasons and get the outcome that we need, not just to come back and here display a 9001 certificate and we get the same results. So help me understand.

Dr. STACEY. So I will offer my opinion on the topic. I think the most important thing is process. Process that identifies the problems, evaluates the opportunities to improve, and measures that improvement. And then shows the people who are responsible the objective improvements proving by data how we improve and where we are going. We as taxpayers should be able to see that and understand that, and I agree with that.

We did an evaluation in my organization years ago and looked at the different alternatives for process improvement. We looked at ISO 9000. It was 9000 then, it is 9001 now. We looked at Baldrige. We looked at a number of different alternatives. Like you I personally believe that the performance excellence criteria as outlined in the Malcolm Baldrige National Quality Award, because it identifies the opportunities for improvement and then uses Lean or Six Sigma, the specific alternatives to help address the problems that it finds is the best. But I will say I know ISO 9001 well enough to know that it is better than nothing. It is, see that pejorative and I did not mean it to. It is, it is a process. And it is a system for improvement. And if they are pursuing that it is a different alternative than I came up with, but it is an alternative I personally think, especially since Congress approved Baldrige there is reason to look at Baldrige.

Mr. WALZ. I wished I would have asked why they came up with that decision. Because it wonders to me if it almost, you know, and I, again, I am the VA's staunchest supporter but their harshest critic. I do not know why they came up with it.

Mr. UMBDENSTOCK. I cannot speak to that either, and I cannot give you numbers. But I can tell you that in conversation with my members of 5,000 hospitals in this country many of them select Baldrige, many of them select ISO 9000. And I think to underscore the central point that Rulon was making, that the issue is get on to a framework that brings the process out clearly and can align everybody in support of that process——

Mr. WALZ. I agree. I did not want to discourage them from it because it seemed like a positive step.

Mr. UMBDENSTOCK [continuing]. Rather than one brand or the other.

Dr. STACEY. It is a positive step.

Mr. STUDER. Yes, if I could comment on that? Because as a company we deal with people that use all of them. And what John Cotter will tell you from Harvard, there is a 70 percent failure rate, and the Heath brothers will tell you there is an 80 percent failure rate in change. So when we look at them, here is what we see, the ones that work and the ones that do not work. You have to have the right process but if you do not tie it in to how you are going to manage the objective or the amount of accountability, it does not matter. So if I am a leader and you are telling me I need to use a better selection process you still should hold me accountable then for turnover, not did I put the process in place. So one that is measuring the outcome.

Number two, making sure that the leaders have the skill to implement the process. And that does not mean I know the process. That means I can connect my employees to why this will make things better. And once somebody connects into why, once you capture the heart, in fact the Heath brothers will tell you people change because either their mind tells them to change or their heart tells them to change, and about 75 percent of the time it is their heart that tells them to change. So I think process improvement will not work as a stand alone. I think it just has to be part of an operational structure.

Mr. WALZ. Good advice. I yield back.

The CHAIRMAN. Dr. Wenstrup, you are recognized for five minutes.

Dr. WENSTRUP. Thank you, Mr. Chairman, and gentlemen, it is a pleasure to have you here today. You know, as we look back on some of the other testimony that we have had where we were initially relying on those within the VA for solutions I found it very interesting because the head, basically, had never been in private practice, never been in a private hospital setting, never had to be in the black. So the set of solutions to keep the doors open was completely different for them, and I think we have an opportunity to make some changes here.

When I started in practice I had two employees and I wrote the checks and paid all the bills and bought the insurance, and later joined a larger orthopaedic group with 20-some doctors, operations chairman. And so when we looked at how to improve we looked at how do we serve more patients in a timely fashion with greater quality. And I can tell you probably the last thing that we really looked at was how do we spend more money and how do we utilize more space. It was finding better solutions than that. Unless we were looking at physician extenders, or another medical assistant, someone that can improve the timeliness of your clinic to allow you to be more productive and proficient. That is really what we were after. And we would look at things like are doctors too bogged down with administrative duties. And I am in the military as well, and DoD has that same set of problems.

But you know that being said, we talked a little bit before about the cost per patient. And the VA just measures RVUs, and that is how they measure their productivity, which certainly is subject to change. But they do not look at the cost per RVU. And so when I hear that we are saying, well, we need to spend more money. How do you know what you are really spending money on if you send a patient out, I am talking about? Because you do not know what you are spending per RVU. Medicare does, they know what they are spending per RVU. And so that is totally lost in the whole system right now. And I know a young veteran who now lives in Hawaii, and he volunteers at the VA there. And he said that they fly patients from Samoa to Hawaii just for their annual physical and put them up for a few days. Now what does that cost per RVU? And would you ever take a look at that and say that this makes sense? Obviously not. And I would like your opinion on what would be the problem of having somebody be considered a VA doctor that is not in the walls of the VA? In other words, I might be a provider for United health care, Blue Cross Blue Shield. I could be a provider for the VA. And I could actually be on Samoa seeing these patients. Can I get your opinion on that concept? Any of you?

Dr. BROWN. Do you want me? Actually that was actually what I recommended, and to not say anything there actually it is happening today, but the providers, the medical directors out there and the different units are not sure if they should be encouraging this or not. I say, absolutely. So there are places today where VA people on VA time that are being paid under VA, you know, rates are actually practicing in private sector. When the capacity of the VA gets too high and they cannot do their surgeries or endoscopy, they go use the local facilities. So why are we not encouraging it? That is best practice. Let us do more of it. So I absolutely think it can be done. But the rules are unclear. So people in the VA are a little bit hesitant to then go and do it big time.

Dr. WENSTRUP. But do you not think it is more difficult if you really do not know what you are spending per RVU to begin with?

Dr. BROWN. Oh, absolutely. And the VA is in an unusual situation. They say they know what their costs are. But the reality is just like in my family one day they use their Medicare benefits, the next day they may use another benefit that is from their previous employer. So they do not know the true cost of care. So I do not actually think the VA currently can be looking at using panel size. That actually, you know, I could have a thousand people on my panel but they only show up once a year, versus somebody else who shows up every week. So I am not sure that is the right way to measure it. I actually would recommend that the VA, rather than doing their own fee basis payment, use the Medicare intermediaries to pay it. Then we could collect all the data, everything they are fee basing out, and what they are getting in their Medicare data, and then merge that with the VA data, and we would know the true cost of taking care of these patients.

Dr. WENSTRUP. If I can get your opinion on one other thing? I think back to when I started in practice, and I had about 20 new patients a month. And I went to my two employees and I said I will bonus you a dollar for every patient over 20 we see each month. And suddenly they are saying, hey, so and so just called,

can you stay a little longer and see one more? And a year later I am writing fifty dollar checks, which was a big deal to them. You know, going from 20 to 70. What kind of incentives can we put within the VA system to promote that type of productivity?

Dr. BROWN. Currently within the rules I do not know that they have that flexibility to do it. Especially, there are more flexibility in the physician Title 38 positions but not then, you still need the OR tech to stay, the, you know, anesthesia people, you need everybody to stay if you want to do that extra surgery. So there are private sectors who do that. To say, okay, if you take on the extra case then you do this. Right now it is just overtime. And there is not the incentive. You know, everything in the VA, as I pointed out, you know, kind of slows down or shuts down around 4:30. That would not happen in most other private sectors. And——

Mr. EVANS. So if you could flip it, if the VA measured the productivity rather than the expense, you would have the heart before the mind. Right now it is just an expense. That is why we all sort of hesitated when you asked that question. There is no way to incent——

Dr. BROWN. Right now.

Mr. EVANS. They are just, yes, they are just spending more.

Dr. BROWN. Without changing the culture.

Mr. EVANS. If we add another surgery it is just going to cost us more.

Dr. WENSTRUP. And the bottom line comes down to making the patient an asset rather than a liability.

Mr. EVANS. Core customer.

Mr. STUDER. With that, research shows that only one in five physicians feel they get adequate feedback on their own performance. One of the things we look at is a provider feedback system because the RVUs is just one slice. So an organization has to say what is important. If access is important that should be part of the feedback for the payment system. If clinical quality is important. These are the types of things where I think, and you know you need that balance feedback system. Because I believe physicians want to do a good job. I think they want to do the best job. But we really do not have, maybe we think there are not many very good feedback systems. That is why we pushed something called a provider feedback system which allows the physician to have input into how am I going to get the feedback, when am I going to get the feedback. And we even weight it. So we tell them weight for the doctor what you feel is the most important. If RVUs is, then put that. But if it is not, maybe it is something else. So I think putting in better feedback systems is only fair for the physician. And we capture the physician because now they have input and they have skin in the game.

Dr. WENSTRUP. Excellent input. I appreciate it. I yield back.

The CHAIRMAN. Dr. Ruiz, you are recognized for five minutes.

Mr. RUIZ. Thank you very much, Mr. Chairman. This is one helluva of a panel. We have the all-star team here and I really appreciate the comments, and I appreciate your minds. And I appreciate you caring for our veterans and all of the work that you have done to improve health care. One of the things that is very striking here for me is to really look at a system. And I remember working

with my father at a packing house in Thermal or Coachella, and every system has a product, and every system has the outcome. And the product of a health care system is the health and wellness of our veterans. It is producing healthy, productive veterans. And we measure our health care system through effectiveness, how well are we doing that, and efficiency, how much resources are we expending per unit volume of the product. And so clearly we need to make sure that we go back to our basics and really focus on the outcome of the VA health care system, which are our veterans. And I repeat it over and over and over again, that we need to change the culture from an institutional based culture where we value and put our focus on either administrators, on physicians, on providers, and switch and transform that into a veteran centered health care system. So and we all talk about that and it seems like we are all in agreement with that.

So my question is drawing upon your expertise is what are three practical, pragmatic, problem solving things that we can do, that the VA can do, to change that culture into a veteran centered, high quality culture within the VA health care system?

Dr. STACEY. I would argue that it centers on your measurement tools to begin with. And if you, if we are focused on veterans then what is the outcome we want? We want to meet the needs of veterans. How do we measure that? How do we know if those veterans' needs are being met? Do we do customer satisfaction engagement? How are the employees—that is one thing is we could measure that. The second thing is with that data we engage the employees in meeting those criteria. It is all a part of a system where we know what we want to achieve, that is meeting the needs of the veterans. And then we engage the employees in meeting that goal. We measure how well the employees are engaged in meeting that role. And then how they participate with the physicians, how the physicians and the employees are meaningfully engaged. I think there is a wide range of opportunities for us to first engage the employees, who then engage the physicians, who collectively provide the best care ever.

Mr. RUIZ. Thank you. So I understand a physician centered survey questionnaire that has teeth to it. Something that like in the physician practice, the Press Ganey where your salary could be determined based on your patient satisfaction on your bedside manner. And I think that would be a very, something to look into.

Mr. Studer.

Mr. STUDER. Yes, I think what you have to do in every organization is flip the organizational chart upside down. And once the veterans are the key point, then you measure how they feel. Then I go to what Rulon said, I believe then you, the most important person is the person who touches the veteran. And that person has to be your most engaged. What we do in organizations is pretty much hold the managers accountable for the employee engagement piece. And it is amazing what happens when the manager finds out, and the questions are not ridiculous, they are do you know what is expected of you? Do you get feedback on how well you are doing? Do you have the tools and equipment you need to do the job? It is basic performance questions that every manager and every leader should want their employees to field. So if I measured just two

things it would be that patient experience and that employee engagement, particularly the front line employee.

Mr. RUIZ. Wonderful. One of the things I did when I went back home in an underserved area where I grew up was to conduct some community centered forums to get qualitative data that we can then put some numbers and metrics based on what they said that their experiences are with a lack of health care. And one of the things that they said is we do not have enough physicians. So we looked at the full-time equivalent physician per population ratio. We found in my area we have one to 9,000 and the recommended number is one to 2,000 in the United States. So would looking at a physician per veteran ratio per VISN or per health VA system, would that give us good measures as to the need for more providers in that area? Mr. Umbdenstock?

Mr. UMBDENSTOCK. You know, I would like to try to stream together a comments that have been made throughout the morning and put this on a business basis. If this was a company that any of us owned of any size, and it was not performing the way it needed to, and the operators of that company were coming back to the owner looking for more resources, we would sit down and craft a strategic plan that said what are the critical few things we have to address and straighten out? How do we measure those things? How do we then communicate those things to everybody in the organization, and how do we hold people at each level accountable for that? Incent them, as was raised over here by the gentleman. Incent them, but only incent them on those critical few measures. And start to get some progress around those measures.

At the same time you are asking your customer, in this case the veteran, do these measures, do these make sense to you as the customer? I am not sure that physicians per thousand is going to make sense to them so much as how that translates into their access to the system. So you will start to put things into patient friendly terms and you refine that over time.

But at the moment if this business is kind of stuck in the water where it is, what it needs now is some direction, some priorities, and some momentum, and then build from there.

One side comment, and Dr. Brown mentioned this earlier, but we had a meeting previously scheduled before the whole scheduling issue came up around the VA. It got cancelled due to a snowstorm this winter. We met subsequently right as this was breaking. We were with senior leaders of the various VISNs and quality directors. And I was stunned when they shared that they had some 600 or 800 measures that they track and produce within the system. That is not the critical few. I mean, that is somebody someplace saying, you know, I would really like to know more about this. Well that is terrific for that person. But that is not an organizational priority. So you really have to boil it down. Get it down to the basics. Get everybody aligned and directed. A Baldrige framework can help do that so that everybody in the organization knows how they contribute to those critical few. And get some progress, get some momentum.

Mr. RUIZ. Thank you very much. You know, this is a breath of fresh air to be solutions based rather than hammering on the same problems that we know exist. And I appreciate you being here.

I just in closing, I want to give you my condolences, sir, Mr. Evans, you, and your mother-in-law, and your family. And Mr. Studer, your grandson Cooper Kennedy, from working in a burn center before, I will be praying for him. And you know, make sure that they have enough procedural sedation and analgesia during his wound care, especially for pediatrics.

Mr. STUDER. Thank you.

Mr. RUIZ. I yield back my time.

The CHAIRMAN. Thank you, doctor. Mr. Coffman, you are recognized for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman. When we, first of all I want to thank you all for your time in coming here and helping us find solutions to fix the Veterans Health Administration. But when we talk about metrics I think one of the big concerns I have is I would think that you all could tell me or know how much it costs to do a given procedure in your hospital, I mean at least within a range. And I do not think we have any idea within the VA system how much it costs in any given facility and how much it comparatively costs. I know I see outcomes data in terms of, oh, infectious diseases, and morbidity, and things like that, mortality. But I do not see the data in terms of cost and some kind of valuation. And so I wonder if you all could address that issue?

Mr. UMBDENSTOCK. Certainly. I have to be totally honest with you, we are only starting to get better at that in health care.

Mr. COFFMAN. Okay.

Mr. UMBDENSTOCK. We have performed, we have been paid on and performed to more of what I call a wholesale form of business enterprise, not a retail. And so cost per unit and true cost accounting systems definitely exist in health care but I would not say they are widespread. I would say they are now starting to grow. So it is not just in this particular sector, it is something that we are grappling with across health care. See if my colleagues agree with me on that.

Dr. BROWN. I would say the three institutions I have worked at in the private sector, you know, Stanford partners and Duke, we all have that data and we analyze it all the way down to the variation by provider, what is the cost per provider for providing the same case, to then see where they could learn from each other. So I think the data is there available. You know, we at Duke also have a hundred performance, even just for Duke itself, have a hundred performance services people who are operations improvement. So they go in there at the CEO's direction and say what is the performance standard or labor standard for a phlebotomist? What is the performance standard for a respiratory therapist? I mean, you cannot use our same standard because your operation systems, your space, everything is different. You need it to be specific to your area and how things work. But having a performance services group is a very important part of health care now.

Mr. COFFMAN. Mr. Evans.

Mr. EVANS. I echo both the comments. Ten or 12 years ago we did not much know what our costs were. We knew what our charges were.

Mr. COFFMAN. Mm-hmm.

Mr. EVANS. We were excellent at charges, superb. But we were not so good at costs. Part of it I think is our 501(c)(3) nature, or the accounting principles, while we use gap accounting that is just a tool to measure what we tell is in there. So we have, to improve our productivity, which I mentioned in my testimony, we had to figure out what our costs were. And that was a journey as well. It was not as easy as I thought it would be. Part of that is the artificiality of how we allocate expenses among our various units. Because health care, we have got thousands of business units. Maybe tens of thousand, I am not really sure. And then acute care hospitals and critical access hospitals, tertiary and quaternary hospitals, so how do you allocate that? So we had, but it was not until we had a grip on what our costs were that we really could do this improvement process.

Mr. COFFMAN. Dr. Stacey.

Dr. STACEY. At the risk of sending accolades to any of my competitors, I was meeting with the CEO of Health Partners Health System in Minneapolis and that is a fully integrated system that has both insurance, it is like Kaiser as was brought up earlier. And I believe that that is where we are going as an industry. I believe that that level of interaction is what our future is. And their ability to calculate the cost per patient, per encounter is crucial. And it is something that we are learning. I do not think as an industry we are as far along as we need to be. I think it is something that we can all work together because that, sure as shooting, is where we are going to go. And if we cannot manage that the rest is just window dressing.

Mr. COFFMAN. Mr. Studer.

Mr. STUDER. Well I think what you are finding is with the fact that there is, at least in the private sector, limited access to revenue now. You have to look at being, how do you measure, and I think measuring cost is where everybody is at. And I think the public, whether not for profit or for profit health care systems, are facing some of the same challenges the VA has. This is something that I do not think anyone has declared victory in.

Mr. COFFMAN. Because it is interesting, and I have not seen the report that apparently the President's nominee to be Secretary of Veterans Affairs has determined, has mentioned, is testifying before the Senate Veterans' Affairs Committee today, and putting forward a request for more resources. I do not know what the break down for those resources, what the break down is. But I think the mere fact that we do not know what the costs are——

Mr. STUDER. Right.

Mr. COFFMAN [continuing]. For doing given procedures makes it really difficult to say, I mean, can we wring out more efficiencies in the system in fact? If they are way, way out of line with their counterparts in the private sector in both for profit and not for profit, inpatient facilities as an example, I mean, we have no idea. And yet we are asked to put more resources into the system. And I think that is problematic.

Mr. STUDER. Right. It is like driving a car without a dashboard.

Mr. COFFMAN. Yes. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. Mr. O'Rourke, you are recognized for five minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman. The chairman last week convened an excellent panel comprised of, we had Sergeant Renschler, who had returned from War with Post Traumatic Stress Disorder, Traumatic Brain Injury. He was joined by the parents of three young returning servicemembers who had similar conditions, all of whom took their lives. And the parents showed great courage in sharing their stories of having to deal with the VA, what the experiences were like for their children, and even for them after their children had taken their lives. Trying to get medical records, trying to see somebody, trying to frankly be treated with the dignity and respect that their sons had earned. But beyond focusing our attention on the true and total cost of War, and the deficiencies within the VHA, they came to the table with some recommendations and some potential solutions. And the parents of Daniel Somers, Dr. and Jean Somers, proposed that perhaps the VHA should become a center of excellence for War-related injuries, both mental and physical. And kind of following some of Dr. Wenstrup's questions about could we expand capacity by having doctors serve veterans in the community; and Dr. Brown, some of your comments about the rules are not clear about how we do this; could we more clearly and cleanly define what the VA does or can do very well, and limit the VHA to doing that? And then make it very clear that these other procedures and conditions and issues will be treated in the community? I would love to get, Dr. Brown, your thoughts, and then anyone else on the panel who would like to share their thoughts on this?

Dr. BROWN. I think obviously you bring up a big long term question, is what is the future of the VA? I remember when I started my career back in the eighties everybody said, well, are we going to be here existing, you know, ten or 20 years from now. And everybody kind of worried about it. So I do not know. One of my rules is whatever you predict, you will be wrong. You know, we look at a five-year planning horizon. Where will we be in five years? You can see the declining population.

The private sector, in my opinions, does not do a great job with the injuries that are being sustained in our current conflicts. They are very specialized in certain areas. You know, you can name the top five institutions. So I think the VA has to continue to invest in the research and the prevention of these issues. There is a lot of actually research where people are trying to predict who might get Post Traumatic Stress Disorder and should not then go into the battlefield. I mean, that is really where the key, where the VA can play a current role now. I think there could be better collaboration of private and public, even in these centers of excellence that you are talking about. They do not have to be islands. That is not a core competency of Duke, but there are other private sector places that actually they could be doing this jointly together probably and learning from each other. Because I think there are great learning lessons. Think about what we are seeing in the football injuries.

Mr. O'ROURKE. Right.

Dr. BROWN. You know, are there correlations to this?

Mr. O'ROURKE. And I wonder if anyone else would like to comment on whether the VA should confine itself to treating, doing the necessary research on, and maybe preventing these conditions that

are essentially War-related, and leave other medical attention and care to the private sector? Mr. Evans?

Mr. EVANS. Bulls-eye. What I meant to say was when I look out my window I see all this capacity. I see five hospitals, all of which have empty beds, empty outpatient centers at that moment. And I wonder why the VA does the things that they do, if there is capacity across the street, and if they could stop doing it. So that is another Lean principle. You just stop doing something. It is not achieving the goal.

So what you just referred to, the witnesses last week, that is we would call VOC, voice of the customer. And that is the loudest voice in the room. So when we hear the voice of the customer, we consider those our orders. So if you have got a customer saying become an expert at TBI, wow. Wow. That, my office also overlooks the NCAA. There is a partnership there someplace. We keep Duke as a great brain injury center. We keep getting grants from various places to study brain injury. It has become the thing with neuroimaging in particular. So why cannot the VA be the place to go for TBI?

Mr. O'ROURKE. Mr. Umbdenstock, do you have a comment?

Mr. UMBDENSTOCK. The flip side of that is that whatever you might decide as the VA to stop doing, the private sector needs some lead time to understand what they are going to be picking up and what the unique needs of these particular patients and individuals are. Because so few people ever have just one condition when they present anymore. And certainly if they have a highly complex condition it is not going to be the same as our, there is no average patient, but a typical patient coming in from a community based setting. So we need time to understand what it is we will be picking up in that as much as possible.

Dr. BROWN. I will give you one data point that I know of just from my specific thing. The fee basis people that tell me that they are calling all the patients, veterans, over a certain time period, 70 percent of those people are deciding to stay within the VA and 30 percent are deciding to fee basis, and that is where I have been working with them. So there are customers, the voice of the customer, who prefer the VA. We do not know yet the total cost of care. But my gut tells me the VA could do a good job. It may not be in every place around the country. So I think it is going to end up being a hybrid. I do not think it is going to be an all or nothing phenomenon. And I think that the data should make the decision.

Mr. O'ROURKE. Thank you.

Mr. STUDER. I think what you are bringing up is excellent. I think you have to be good at those things where you are going to have the most demand. And I think the question continues to ask, I ask you, is your goal to have a strong VA, or is your goal to provide the best care for veterans? And if the number one goal is to provide the best care for veterans then the location where they can get the best care is where they should be. It should not depend on what the title is. And for most people I talk to access is vital right now. So of course that would probably provide better access.

Dr. STACEY. And if I might just add one thing. A year and a half ago my nephew came back from Afghanistan. He was a Marine in Afghanistan. And when he went to Afghanistan we all feared the

worst. And he came home with PTSD. And we realized that the worst was not what we thought it could be, that this was the worst. And it is an ongoing, I appreciate hearing you say what can we do? What unique nature do we have that we can take care of to take care of people like my nephew? I just hope we remember those things. The national surgical quality program is in place today because the VA had the best access to surgery and training and they shared that with everybody. There are things like that that we can take advantage of.

Mr. O'ROURKE. Thank you. Thank you all for your answers. Mr. Chair, I yield back.

The CHAIRMAN. Thank you. Dr. Roe, you are recognized for five minutes.

Dr. ROE. I thank the chairman, and I certainly thank the panel for being here. And you have made a lot of great comments. The lenses I will always view the VA through is in the examining room, patient to doctor. That is how I will view it. And I look at the private for profit, not for profit hospitals, versus the VA system, and Mr. Evans and those of us that have lived in the private world all these years, you know, you start your fiscal year, you do not know what your revenue will be. You think you know what it will be based on previous years, but you really do not know what it will be at the start of the year. Just the opposite for the VA, they know exactly what their revenue is going to be, exactly how much money they have budgeted because we provide that for them. They come up here, present a budget, we approve it, pass it, and write the checks. So there is a different motivation. And I look at what Dr. Wenstrup and Dr. Ruiz both were mentioning, there is a difference when you are an employed physicians at a VA, a certain expectation, versus an employer, which is what I was, working for myself. I had a totally different motivation to get up and go to work everyday. And it did not stop at 4:30, and it did not start at 8:00. It started at 6:00 or 6:30 in the morning, and it finished when I got finished, whenever the time was that day. And if I did not finish that day I might finish the next afternoon, 36 hours later. That was a different motivation and model than you see at the VA right now. And I think with all this testimony I have heard, I have been here five and a half years, and you see this as a symptom. And I do not know whether you can change the VA or not. I do not know whether it can be done or not.

I certainly agree with Dr. Wenstrup. I was a, have VA hospital a mile from where I live at home. I saw, because they did not have a gynecologist, an OB/GYN doctor most of the time, I saw a lot of VA, I served as a VA doctor in the private sector. It worked fine. And I think many things, I am a veteran, I could easily go to the VA, or I could go to the private sector. I choose to go to the private sector because I can afford to and there are other needy veterans who cannot so I do not want to get in the way of someone who would need that. So they limit the number of people they see based on a lot of reasons. Scheduling, number of patients that can be seen, number of doctors, providers they have, and so on. A lot of different reasons. And Mr. Evans and Dr. Stacey know in the private sector we have to serve everybody. You keep your emergency room, you cannot say, well, we are overbooked. You have to take

whoever comes in the door. And that is a completely different philosophy, I think, than you see at the VA.

I have heard a lot of good ideas here today. Whether we can actually incorporate them, and one bad idea I have heard is let us just, and I have not heard it yet, but it is let us just throw some more money at it. Money is finite. And we ought to look at the resources we have, and can we better use them within the VA? I think we can. I think good, smart people can do that. And I know you all provide the 30,000-foot level. The level I work at, as I say, is in the patient's room or the operating room. And you have to have systems here that allow me at my level to do my job the most efficiently I can. And right now I do not think that occurs at the VA. I have worked in a VA. I trained at one, most physicians have. And it is a different model than the private sector. So that may in and of itself stop it. And I want to hear your views on that, from any of you on the panel that would like to comment.

Dr. BROWN. I will say I am actually in the weeds on all those things, too. I actually designed the space, the exam room. But the most troubling thing I heard out of there is you do not know if it can, believe that it actually could be done no matter what. So if that is the case, do we not have to prove that it actually will work and do a pilot somewhere that something different that is, if you look for innovation in industries it usually does not come from the big monolithic, you know, organization. It is the skunk works, the, you know, a new start up or something. So should we take a center and totally turn it upside down, change every policy and procedure, and let it be managed under a different set of paradigm, and then prove that it could be done, and then take that through the rest of the VA? Rather than trying to change the entire VA at once?

Dr. ROE. I think that makes a lot of sense. I think one of the things that will help the VA get better is competition. I think having veterans who can opt out, as you said 30 percent, I think, of veterans do. Many veterans like to be served at the VA, and they should have that choice. I agree with that completely. And many veterans get great care at the VA. I want to make that, and it is not all bad. And I mean, the Veterans Hospital provides a lot of great care for veterans and they do some things better than anybody else I think in the world, as Mr. O'Rourke mentioned.

So I think they need to do what they do well. I think things like taking care of high blood pressure, Type II diabetes, things that we do everyday that is just ho-hum in the private sector can be taken care of well outside and relieve these long waiting lines, and so forth. So yes, I like your idea of taking a VA center and say, hey, let us try these new things. I totally agree with that. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much to the panelists. We are very grateful for you coming today. Just a couple real quick short, short questions. VA has told us that one of the biggest barriers that they have and that is time consuming, is the credentialing and privileging process for their physicians. And my question is, to those of you that are, I suspect Mr. Evans, Dr. Brown, in particular, Dr. Stacey, do you agree with that? What is the average time it takes to credential somebody, and get them hired?

Dr. BROWN. In the VA it is not just the credentialing, it is then the security stuff and the fingerprinting, and all the rest. But it is, you know, four to five months.

I think there are two different processes that members need to understand. There is the credentialing, where I actually call back to your medical school, I check your——

The CHAIRMAN. No, I have that.

Dr. BROWN. Right.

The CHAIRMAN. I am sorry. I am talking, because this is what VA will tell us. They will say the biggest problem, basically is looking to see their medical licenses, and they will talk about the different states they have to go through, and all this. And that should be quick.

Dr. BROWN. Yes. And I would actually say that we could actually do a better job of sharing that information. So within health systems we only have now one office that checks the credentials for all of our hospitals. Each of the hospitals have to have a separate privileging board that gives privileges. But credentialing is centralized.

The CHAIRMAN. How long does that process take?

Dr. BROWN. I could not say off the top of my head.

Dr. STACEY. The process can take a month or more to get all the data——

The CHAIRMAN. Yes, but VA, and that is what I am saying. I am fine with that. VA says it takes them eight months. All right?

Dr. BROWN. And they duplicate what we do. Because most of the VA docs are actually also our docs. Could we actually share this and do this together?

Dr. STACEY. But we have that data. Yes——

Mr. UMBDENSTOCK. There is a nonprofit organization here at the national level that has a uniform practitioner database where you keep all your credentials up to date yourself and then you decide who they send it to. So it does not all have to be done by individual organizations either. There are options.

The CHAIRMAN. Again, I think VA is doing it the way they did it in 1944. And we have got to change the process. And so, we have also heard from VA that when one veteran patient, in particular it happens in Northwest Florida because people come from the North down to the beaches for the summertime, and they are considered a new patient when they come into the VA system again, year after year after year. And so Mr. Evans, quickly to you, if you go from one facility to the other within Indiana, are they considered a new patient?

Mr. EVANS. Our vision as a system is one standard of care, everyplace, all the time. So that somebody in Goshen, Indiana, which is on the Michigan border, or somebody in Paoli, Indiana, which is down near Louisville, receives the same standard of high quality care. At the root of that is data. So in practice we are not 100 percent there. Our electronic medical records do not talk to each other all the time. But that is our goal. And in reality we are probably 75 percent there, meaning that that website I showed you, I can go there, I should have done it, I can get on it and put in my own name and it would tell you every place I have received care within IU Health, and I could make an appointment, and then I could co-

ordinate with the pharmacy, and the doc, and so forth. But the root of that is the electronic medical record. And the industry is still on a journey with that.

But as the other panelists have said, the VA has been a leader in some of these areas.

Dr. BROWN. That being one.

Mr. EVANS. That being one. So why the heck it is not completely integrated, I do not really understand.

Dr. BROWN. Well within the VA it is not actually one single unified record. You still have to request it through a web if you are actually going from Wisconsin to Florida. If you are within the VISN you get it. From a CMS, you know, system within the private sector, if you are seen within the same tax id'd organization within two years you are not a new patient. You know. So it is the difference between is that a workload unit? Because you do not have to redo everything within two years. So I am not sure they would be considered a new patient within the same VISN.

The CHAIRMAN. Well, and I was not talking about the same VISN. I was talking about people coming from the North into a totally new VISN.

Dr. BROWN. Right.

The CHAIRMAN. It still does not make sense. It should be one health care system for everybody that is out there. And then real quickly, as we close, VA is surging, obviously from the time that we brought this forward on our hearing in April 9th, they have said they have reached out to everybody that they can think of in order to talk about the issues. And so my question is, very simply, yes or no, and you have already said that they have reached out to you. So Dr. Brown, have they reached out to you?

Dr. BROWN. No, but I am an Indian. I am not a bigwig. They would not. I mean, I have reached out and talked to my own, I talk to my local VA every week. But not any higher than that.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Well the Superintendent of our VA, whatever his title is, I talked to him this morning.

The CHAIRMAN. About.

Mr. EVANS. About this hearing and about our collaboration. Our COO——

The CHAIRMAN. But prior to that did——

Mr. EVANS. Yes. Yes.

The CHAIRMAN. Okay.

Mr. EVANS. Well, one of the reasons is we provide most of the specialty——

The CHAIRMAN. Yes. Dr. Stacey.

Mr. EVANS [continuing]. Medical school.

Dr. STACEY. Yes.

The CHAIRMAN. Mr. Studer.

Mr. STUDER. No.

The CHAIRMAN. Okay. Very good. Any other questions? I ask that all members would have five legislative days with which to revise and extend their remarks.

Again, we are grateful. We hope that we can invite you back to talk with us. And this hearing is adjourned.

[Whereupon, at 12:16 p.m., the committee was adjourned.]

APPENDIX

Prepared Statement of Jeff Miller, Chairman

Good morning. The Committee will come to order.

Welcome to today's Full Committee oversight hearing entitled, "Creating Efficiency through Comparison: An Evaluation of Private Sector Best Practices and the VA Health Care System."

Over the last eight weeks, the Committee has held ten Full Committee oversight hearings, encompassing just over thirty-five hours of testimony.

At these hearings, we have heard from VA leaders and a diverse collection of expert witnesses about the many and varied access, accountability, integrity, and data reliability failures that are plaguing the Department of Veterans Affairs (VA) health care and benefits systems.

In their testimony this morning, the American Hospital Association states that:

"Successful organizations have cultures that: set clear, measureable and actionable goals and ensure they are communicated to and understood by all employees; embrace transparency . . . [and] . . . engage their clinicians as partners, not employees . . . "

By this measure—which I believe is a fair one—the VA health care organization as we know it today cannot be considered a successful organization.

VA has failed to set and embrace clear, measurable, and actionable access and accountability goals as evidenced by a recent Administration report which stated that VA's fourteen-day scheduling standard was " . . . arbitrary, ill-defined, and misunderstood . . . " and VA's culture " . . . tends to minimize problems or refuse to acknowledge problems altogether."

VA has failed to embrace transparency as evidenced by the one-hundred and fifteen outstanding deliverables requests dating back more than two years that this Committee continues to wait for.

And, VA has failed to engage their clinician workforce as partners as evidenced by the numerous whistleblowers who have come forward to share their stories of retribution and reprisal and the many more who continue to call our offices yet, understandably, are reluctant to come forward publicly.

Our veterans deserve a VA that works for them; not one that refuses to work at all.

Improvement and innovation are necessary but neither can thrive in a bureaucratic vacuum.

And as with any vacuum, nature fills it with whatever is available and, in this case, it is questionable care, falsified performance, and abuse of employees.

During this morning's hearing, we will discuss how the Department—and, by extension, our nation's veterans—can move forward from this summer of scandal and create the VA health care system our veterans deserve by leveraging the best practices used by non-VA providers and private sector health care organizations.

On today's witness panel we have two Malcolm Baldridge National Quality Award winners; a former VA physician; two high-performing VA academic affiliates; and, a national advocacy organization representing more than five-thousand hospitals, health care systems, networks, and care providers.

Though VA's organization and patient population may have certain demographic qualities, there are valuable lessons to be learned from health care standard-bearers and leaders that, if heeded, could vastly and rapidly improve the care our veterans receive.

As I (the Chairman) stated during a hearing at the very beginning of this intense Committee oversight process, the Department got where it is today due to a perfect storm of believing its own rhetoric and trusting its status quo as a sacred cow immune from criticism and internal revolt.

VA cannot continue business as usual.

The status quo is unacceptable.

It is time for change—change that embraces both new ideas and proven practices.

Prepared Statement of Michael Michaud, Ranking Member

Good Morning, and thank you Mr. Chairman for holding this hearing today.

I appreciate that we continue to gather invaluable information about what works and what doesn't work in our VA health care system.

This information is guiding our efforts to reform the VA and ensure our veterans receive quality, safe, timely health care—where and when they need it.

I'm looking forward to the testimony we'll hear this morning from our panelists on best practices in the private sector.

I believe that we should always strive to do better.

And I think we can learn and get some good ideas in areas where private health care providers have had great success, and either tackling, or outright avoiding, many of the problems we are confronting today in the VA.

One area where I think we need to hear more from the private sector is related to scheduling and patient medical records.

Clearly, the scheduling practices—and technology—within the VA system are not working. The system can be manipulated, there is no standardization, and patients aren't getting seen in a timely fashion. I would be interested to hear about some of the scheduling models various private sector organizations use. Getting patients seen right away—before their medical conditions are allowed to worsen—absolutely must be one of our first priorities.

Also, the VA has clearly struggled to anticipate and plan accordingly for the surge of veterans seeking to access the health care system as we continue winding down two wars. I would like to hear how other health facilities have developed strategic plans that are tailored to the current and anticipated needs of their specific populations.

I believe that, in order for us to maintain progress on things like the wait list backlog, and to ensure individual VA facilities have the resources they need to treat their patients in an acceptable amount of time, the VA needs to do a better job of looking a few years down the line, figuring out what regional and local veteran population medical needs will be, and planning accordingly.

We also should keep in mind, as we hear these best practices, the VA is the health care system best-suited to meet the needs of our veterans. It provides a number of specialty services for our veterans that just can't be found in the private sector.

Despite the many problems throughout the VA system, it remains the system best-suited to meet our veterans' health needs across their entire episode of care.

As we all know, our veterans generally have greater health concerns and are older than the general population.

The VA has developed a bench of medical professionals who are trained to treat the service-specific needs of veterans better than most. That includes issues like prosthetics, spinal cord injury treatment and in-patient mental health services.

Also, a high number of medical professionals in our country—more than 60 percent—train at VA medical facilities.

I want to be clear: we are not talking about privatizing VA care. We are talking about strengthening a health care system that is uniquely suited to serve the needs of our veterans with best practices that are working in the private sector.

I'd like to thank the panelists who are joining us today, and I look forward to hearing today's testimony.

Thank you Mr. Chairman, I yield back.

Prepared Statement of Hon. Corrine Brown

Thank you, Mr. Chairman and Mr. Ranking Member for calling this hearing today.

The VA has been under the microscope for its practices over the last few months. We all know how big the VA is and the many issues that accompany treating veterans for their many and individual health issues that come with serving in the military and deploying overseas.

The VA operates 1,700 sites of care, and conducts approximately 85 million appointments each year, which comes to 236,000 health care appointments each day.

My regional VISN, the VA Sunshine health care network serves more patients than most health care systems. With eight VA Medical Centers in Florida, Georgia and Puerto Rico and over 55 clinics serving over 1.6 million veterans, veterans are getting the best in the world.

Over 2,312 physicians and 5,310 nurses are serving the 546,874 veterans who made nearly 8 million visits to the facilities in our region. Of the total 25,133 VA employees, one-third are veterans.

In 2013, 37,221 women received health care services at VA hospitals and clinics in Florida, South Georgia and the Caribbean—more than any other VA health care network nationwide. This means that more than 75% of women Veterans enrolled for VA health care in VISN 8 were seen by providers in 2013.

I look forward to hearing the testimony of the witnesses today and am interested in how they think they could adapt their policies to the unique circumstances the VA deals with every day.

Prepared Statement of Richard J. Umbdenstock

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to testify on operational best practices from the private health care sector and their applicability to the Department of Veterans Affairs (VA) health system.

The goal of every hospital in America, including VA hospitals, is to ensure patients get the right care at the right time, in the right setting. For decades, the VA has been there for our veterans in times of need, and it does extraordinary work under very challenging circumstances for a growing and complex patient population. VA patients are generally older and sicker with more limited resources, in many cases requiring greater care coordination. The VA also is the definitive source of care for the treatment of conditions related to the occupational health risks associated with military service; for example traumatic brain injury, polytrauma, spinal injury and post-traumatic stress disorder. In addition, the VA is a leading expert on helping patients who require prostheses navigate life post-amputation. The nation's hospitals have a long-standing history of collaboration with the VA and stand ready to assist them, and our veterans, in any way they can as they seek solutions to today's challenges.

As others on the panel will demonstrate, health care delivery is most effective when it is tailored to the unique needs of patients and the community. What works for one type of health care provider in one setting or one location, may not work for another because health care is not a one-size-fits-all enterprise.

Our testimony focuses on two areas:

- Lessons learned from hospitals' continuous efforts to improve operational efficiency and quality, including demonstrated best practices from the private sector; and
- The AHA's advice to the committee regarding a final agreement on legislation to speed veterans' access to health care through the private sector.

A Culture of Continuous Improvement

Hospitals are on a never-ending journey of quality improvement—employing new technologies and techniques and research on what works, as well as continuously training new workers to meet the needs of patients and improve operations. While hospitals are at different points on their quality path, all hospitals are committed to safety, improving clinical quality outcomes and the patient experience.

Varying Approaches To Improvement

Hospitals employ various approaches and models to improve quality. Many hospitals are using process improvement programs with roots in manufacturing to optimize the patient experience, lower costs and improve overall quality. Examples of these models include the Baldrige Criteria for Performance Excellence, Lean, Six Sigma and the Plan-Do-Study-Act (PDSA) approach. The Baldrige Criteria are an organizing framework that facilitates organization-wide alignment around improvement goals and supports the development and continuous strengthening of a culture of improvement. The criteria focus on seven critical aspects of managing and performing as an organization: leadership; strategic planning; customer focus; measurement, analysis, and knowledge management; workforce focus; operations focus; and results. Health care is the dominant sector utilizing and being recognized in the Baldrige process. Lean, based on the Toyota Production System, is a process improvement methodology that aims to increase efficiency and productivity while reducing costs and waste. Six Sigma is another approach to improving quality that was developed by engineers at Motorola for use in improving the quality of the company's products and services. It uses statistics to identify defects and a variety of techniques to try to identify the sources of those defects and the potential changes that could be made to reduce or eliminate them. The PDSA approach is a four-step cycle to carry out a change, such as a process improvement or a modified work flow. Under the model, providers develop a plan to test a change (Plan), execute the test (Do), observe and learn from the results (Study), and determine potential modifications (Act).

Because each hospital is unique, leadership must select the method that it believes will work best for its organization. However, quality improvement efforts generally involve five steps:

1. Identify target areas for improvement;
2. Determine what processes can be modified to improve outcomes;
3. Develop and execute effective strategies to improve quality;
4. Track performance and outcomes; and
5. Disseminate results to spur broad quality improvement.

For improvement efforts to be sustained, the organization's culture must be aligned. Successful organizations have cultures that: set clear, measureable and actionable goals and ensure they are communicated to and understood by all employees; embrace transparency—results measured and shared widely; engage their clinicians as partners, not employees; standardize language and processes across the organization; and focus on multiple, incremental changes to ensure processes and systems are rethought, revised and tweaked to continue achieving a precise execution. Top-performing organizations also recognize their successes, both as individuals and teams, and encourage active and ongoing feedback. Any member of any team—from a clinician to an environmental services worker—should be empowered to speak up when they believe something could be improved.

Lessons From Hospitals' Patient Safety and Quality Efforts

While hospitals have typically looked to other industries for operational performance improvement strategies, they also are harnessing the power of collaboration to dramatically improve the quality and safety of patient care. Hospitals are working together, as well as with quality-focused organizations, states, payers and others, to improve patient safety and reduce adverse events. By forging effective strategies and sharing what they have learned, hospital leaders have spurred notable improvements in care delivery and patient outcomes at the national, state and regional levels. These efforts have led to better quality and patient safety, as well as reduced health care costs, but more work is yet to be done.

The AHA/Health Research & Educational Trust (HRET) administers one of 26 Hospital Engagement Networks (HENs) under the Department of Health and Human Services' (HHS) Partnership for Patients campaign. The AHA/HRET HEN, the largest in the nation, is comprised of 31 participating states and U.S. territories and more than 1,500 hospitals. The AHA/HRET HEN has accelerated improvement nationally, and patients are benefiting every day from the spread and implementation of best practices. Among other quality and patient safety improvements, in the first two years of the program, participating hospitals reduced:

- Early elective deliveries (which can increase complications) by 57 percent;
- Pressure ulcers by 26 percent;
- Central line-associated bloodstream infections in intensive care units by 23 percent,
- Ventilator-associated pneumonia in the intensive care unit by 13 percent and across all units by 34 percent; and
- Readmissions within 30 days for heart failure patients by 13 percent.

HHS estimates that the HEN program has contributed to preventing nearly 15,000 deaths, avoided 560,000 patient injuries, and saved approximately $4 billion. The program has helped the hospital field develop the infrastructure, expertise and organizational culture to support further quality improvements for years to come. These lessons in collaboration could also prove valuable for development and dissemination of operational best practices.

SPECIFIC OPERATIONAL ISSUES CONFRONTING THE VA

Internal audits and this committee's investigations have revealed systemic problems in the VA's scheduling system and patients' ability to access care in a timely manner. While the other witnesses at this hearing can speak more directly to what has worked for their organizations, I can share a few principles around scheduling and backlog reduction, specifically.

Patient Scheduling. Health care providers utilize a variety of options to ensure the efficient flow of patient care. In the primary care or ambulatory hospital settings, one of the key components in ensuring patients receive the care they need in a timely manner is effective scheduling.

There are three access models for patient scheduling in the primary care and ambulatory setting:

- In the traditional model, the schedule is completely booked in advance; same-day urgent care is either deflected or scheduled on top of existing appointments.

- In a carve-out model, appointment slots are either booked in advance or held for same-day urgent care; same-day non-urgent requests are deflected into the future.
- In the advanced or "open access" model, there is true same-day capacity: The majority of appointment slots are open for patients who call that day for routine, urgent or preventive visits.

Because health care is not a one-size-fits-all enterprise, each organization determines which scheduling model offers the best fit for its patients' needs. health care organizations should analyze the needs of patients as a group, for example their condition, age and gender breakdown.

For primary care, the Institute for health care Improvement recommends an open scheduling system in which physicians begin the day with more than half of their slots available. Same-day appointments are made regardless of the type of care needed. New patients and physicals are also seen on the same day. Schedulers use a standard slot size—15 minutes, for example—and simply combine slots to make time for longer visits. Depending on scale, an organization can do a hybrid or carve-out model of open scheduling. While open access scheduling may be the ideal in the primary care setting, it is not appropriate for every care setting, particularly specialized care where capacity is more limited and testing and consultations may be needed before appointments can be scheduled. Nor is it easily realized; according to a November 2013 Commonwealth Fund report, only 48 percent of U.S. adults surveyed reported being able to secure a same-day or next-day appointment to see a physician or nurse.

Understanding and measurement of patient flow through the system is critical to successfully implementing open access scheduling. Measurement enables capacity problems to be identified quickly and resolved at the appropriate point in the system. As with any process, ongoing monitoring and continuous improvement is necessary.

It also is critical to consider resource availability and alignment when selecting a scheduling system. One systematic electronic health record, such as the VA has, allows for consistent data collection. But staffing is also critical. Many organizations find it helpful to create "care teams" with the appropriate mix of caregivers needed to meet patient demand.

As with most systems, communication is key to ensuring any scheduling system's continued success. Agreement among all staff is required before proceeding with the new scheduling process, and ongoing meetings and status check-ups should occur among staff on the new scheduling process. Communication also should be structured to identify gaps in the scheduling process and pinpoint areas for improvement.

Education for staff and patients is also key. Staff should be provided with education on the open scheduling concept, and training should be tailored to each position along the process. New patient orientation should explain the open scheduling concept.

Backlog Reduction. Even a well-functioning system can sometimes result in backlog when demand is high or staffing is not optimal. To reduce and eliminate backlog, facilities must first measure it, then create and use a reduction plan.

Often in primary care, the backlog consists of patients waiting for physicals, new patient visits or follow-ups. In specialty care, the backlog includes patients waiting for an initial consult with the specialist, or awaiting a timely return visit.

The Institute for health care Improvement's Backlog Reduction Worksheet provides a step-by-step process to calculate backlog by each provider in a given practice.

The Importance of Staff. Another way to improve efficiency is to ensure that staff turnover is kept at a minimum. The right mix of health care professionals, as well as support staff, is needed to build an efficient team and to maintain positive morale. An inappropriately staffed team is an inefficient team. Overburdened staff are under not only an enormous amount of physical strain, but emotional strain as well. Health care is about people, and staff are emotionally invested in their mission and their patients. Conversely, overstaffing can lead to inefficiency and higher costs as well. The key is to maintain optimal staffing levels with minimal turnover.

Ensuring Veterans' Access Through the Private Sector

America's hospitals stand ready to offer assistance to ensure our veterans get the care that they need and deserve. As Congress continues its work to resolve differences between H.R. 4810, the "Veteran Access to Care Act of 2014," and H.R. 3230, the "Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014," we have urged the conferees to adopt specific language in the final agreement to ensure veterans are able to more easily obtain care from civilian providers.

Minimizing Burden for Veterans and Providers

First, the AHA urges Congress to retain and strengthen language in both the House and Senate bills that would enable hospitals to maintain the ability to contract directly with their local VA facilities rather than requiring hospitals to go through a managed care contractor. Many hospitals have ongoing and cooperative relationships with their local VA facilities, which can be built upon to enable our veterans to readily secure needed care. Allowing hospitals to contract directly with the VA allows hospitals to meet the needs of their local veteran community and provides the quickest route for veterans to be seen by a primary care provider. While some hospitals participate in the Patient Centered Coordinated Care (PC3) program, civilian hospitals should not be forced into this model in order to provide care that veterans need.

We also encourage the committee to minimize any additional administrative burden placed on hospitals opting to contract with the VA by exempting hospitals for the limited duration of the final legislation from any federal contractor or subcontractor obligations imposed by the Department of Labor's Office of Federal Contract Compliance Programs (OFCCP).

The obligations OFCCP imposes on federal contractors, which could be applied to hospitals that contract with the VA, will only add to hospitals' costs and frustration without enhancing protections against discrimination. Hospitals already are subject to myriad anti-discrimination laws and regulations, including anti-discrimination regulations that are appropriately enforced by many federal, state and local agencies. Subjecting hospitals to additional paperwork burdens and the costs associated with OFCCP regulations would divert financial resources from patient care, and may, as a result, inhibit hospitals' ability to improve access and deliver high-quality, timely and efficient care to veterans with significant unmet health care needs as the legislation intends.

Additionally, to facilitate veterans' access to needed health care, it is imperative that any barriers, such as "pre-clearance" permission to utilize civilian health care providers, be avoided so that veterans who meet the criteria (more than 40 miles from the nearest VA facility or unable to receive an appointment in the allotted time span) can be seen by a physician or in a hospital of their choice near their place of residence.

Your commitment to work with hospitals and other health care providers to streamline burdensome regulations will benefit both veterans and caregivers by enabling health care professionals to spend more time with patients and less time on bureaucratic paperwork.

Providing Adequate and Prompt Reimbursement

The AHA further encourages conferees to provide adequate reimbursement rates for non-VA providers. Under the Senate bill, payment for care provided by a non-VA facility could not exceed Medicare rates; the House bill would pay non-VA providers who are not under an existing VA contract at a rate set by the VA, Tricare, or Medicare, whichever is greatest. We support the House language and urge conferees to include this language in its final conference agreement.

Finally, the AHA urges conferees to insert language to establish and implement a system for prompt payment of claims from non-VA providers, similar to the Medicare program. Currently, there is no binding prompt pay language in either bill.

CONCLUSION

The Department of Veterans Affairs health system does extraordinary work under very difficult circumstances for a growing and complex patient population. While the system faces operational challenges, I am confident these can be overcome through the sharing of best practices and technology solutions with the private sector, along with additional access to civilian caregivers.

The AHA applauds Congress for the speed with which it has moved to allow veterans to more easily secure care from civilian providers. And we urge Congress to move expeditiously to resolve differences between the House and Senate bills. We look forward to working with our VA colleagues, Congress and the Administration to ensure our veterans receive the care they need when they need it.

July 16, 2014 Monte D. Brown, MD

Good Morning Ladies and Gentlemen and thank you for allowing me to speak about something that I am passionate about and has been continuously part of my life for over 30 years- the care of our Veterans.

I have no personal conflicts to declare but as you know I am employed by Duke University Health System which does work with the Veterans Administration and other federal agencies. I also consulted to one VISN over ten years ago on how to apply private sector business analytics in the VA system using inpatient and outpatient dialysis services as the example.

Before I begin my assigned task of talking about where the VA might benefit by more closely aligning with the trends in the private sector, I would first like to say that I am proud of the overall improvement in the quality of care in the VA system over the years and I am happy to say that my brother and step father continue to receive care in the VA system. In addition, my mother insisted that I take the time to make sure you all knew how appreciative she is for the care that the VA provides for her family.

So as you can see from both my professional experience listed on my biography that was provided prior to the meeting and my personal experience, I am deeply committed to the care of our Veterans. I understand the issues Veterans face in choosing whether to use their VA, Medicare, or private benefits from both the provider and patient side; so while my comments may be difficult to hear and more specific than your other witnesses here today, my comments should always be interpreted as an attempt to continuously improve the system rather than to criticize it.

We should not forget that the VA is doing many things well and in many cases are doing it better than the private sector.

Things are definitely improving and much of this can be attributed to the fact that the pay scale of VA physicians and nurses is now competitive in most specialties so the VA can now attract and retain the best clinical physicians and nurses. Work still needs to be done for other VA positions to achieve the best efficiency and outcomes.

The VA Career Research awards continue to be the standard that allows the VA to attract and mentor new talent and improve the care of patients for issues that are most important to Veterans.

Medication monitoring by non-physicians and use of non-face to face encounters by the VA are well ahead of many private sector systems of care.

The VA mail pharmacy system and National TeleRadiology programs are great models that need to continue to evolve.

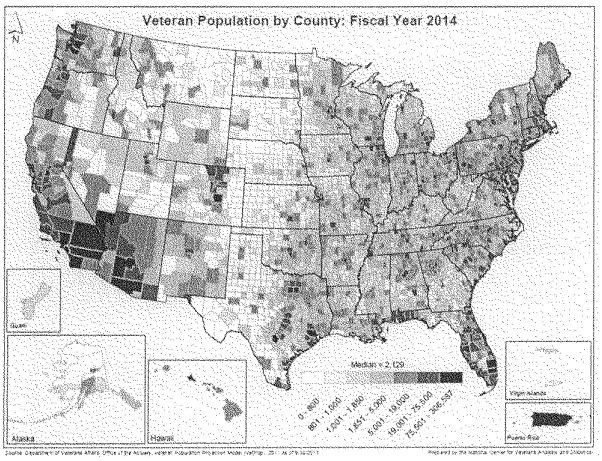
These are just a few of the examples where the private sector should learn from the VA experience.

On the flip side; the key to success that the private sector benefits from, and that the VA does not enjoy, could best be described as flexibility, flexibility, and flexibility.

On the clinical side both the private sector and the VA are striving to achieve standardization of best practice through evidence based medicine, but this always includes local clinical judgment by the one with **all** of the facts- in this case the provider. This is not happening on the administrative side of the VA where the local administration is not allowed to use its judgment to adapt to the local environment.

The VA has so centralized the "big three" of IT, HR, and contracting that the local entities cannot maximize their use of local resources or make rapid changes to meet the needs of the rapidly changing health care environment.

Having been a part of several large health care systems over the years, including the VA, a county, Stanford University Hospital, Partners Healthcare System, and now Duke Medicine; I can tell you that how you manage and how best to deliver care needs to be different in different parts of the country. One system does not fit all. This is clearly demonstrated by just looking at the population density of our Veterans by county as displayed below.



Despite blue ribbon panels and being listed as key strategic priorities by VA leadership, the IT, HR, and contracting policies and procedures, as well as their interpretation and execution of these directives, are getting worse from the perspective of those who live it every day.

Contracting:

The regionalization of contracting continues to be the single most frequent complaint I hear from those who deal with the VA. While the rationale that contracting would be improved by having "centralized experts" in contracting involved; nothing could be further from the truth. With the exception of bulk supplies, by regionalizing contracting, the VA has placed a huge barrier between those who understand the exact services needed and the prioritizing of those services with no improvement in cost, service or outcome. Some examples of issues:

1) High turnover of contracting positions
2) New contracts take years to accomplish.
3) Contracting officers at not always familiar with regulations.
4) Existing contracts are often extended time after time for short periods of time over years as the authority for longer contracts has expired; leading to increased administrative costs on both sides.
5) Request for even simple things like redline changes have been denied causing increased administrative costs.
6) The academic affiliate is the one who has to track contract timelines and ensure lapses in services do not occur. (i.e. when contracts are set to expire, often times contracts have to be urgently signed so that Veteran care is not interrupted leaving the clinicians in limbo as to whether they can continue to schedule care; thus causing delays in care).
7) Contracts with wrong vendor, tax id, or even wrong services in contracts (i.e. radiology terminology in a lab contract)
8) Standard VA clinical contracts have been interpreted as contingent upon federal budgets placing clinicians in ethical dilemmas.
9) New IT restrictions regarding IT security and co-mingling of data has caused us to eliminate lab contracts; so specialized labs that were previously done within 24 hours are now shipped off site, which can lead to delays in diagnosis and care; further increasing costs.
10) VA can only approve up to $300,000 locally for a lease. For various reasons VA facilities are unable to give the minimum number of exam rooms (2 per provider) that they need to be efficient. Large contracts can

take years thus limiting the size of a new clinic to a less efficient configuration or location.

11) VA contracting often has to go to the lowest "reasonable" cost, which is often interpreted as the lost cost. The lowest cost is not always the best for the organization as it can lead change orders/amendments etc. Rarely is the criteria established to equally weight cost and other priorities including operational efficiency.

The VA should review and revise its contracting policies and procedures to give local entity control of existing procedures and new ones to give them much greater latitude. One rapid improvement would be to more broadly define the use of sharing agreements with the academic affiliate to include sharing of excess academic resources with the VA at fair market costs. Currently VA sharing authority is limited to excess VA resources. For example if the academic affiliate has excess space can this be shared with the VA under a sharing agreement? If so we could quickly improve VA access.

Information Systems;

While the VA has an excellent centralized standardized clinical information system (IS); where the VA and the private sector differ is that the VA has divorced IS from the clinical operations by segregating it into a separate reporting structure; whereas the private sector is placing more and more emphasis on the strategic nature of IS and thus its management and decision making process is integrated into the fabric of every decision.

The VA has swung the pendulum too far to where the organization is now less responsive to the needs of the organization and the priorities are not always aligned. Having computers to open new clinics, updating outdated phone switches to improve customer service are no longer within the purview of the local director. Furthermore, the VA has stipulated that new computers and IT equipment cannot be approved locally unless it is included in the budget for new space. This has resulted in some cases where providers have to share outdated equipment or complete clinical notes after hours.

There is nothing you can do in healthcare that does not involve IT.

How do you hold local officials accountable for the outcomes when they don't control the deployment of one of its most critical assets? In the private sector, even when resources are centralized there is a single point of accountability locally that is

accountable to local management and budgets are jointly agreed upon based on the strategy of the organization and local conditions.

HR

HR Issues are not unique to the VA but are significant. Most providers working in the VA would disagree with the recent focus that many positions in the VA have been overpaid as they were misclassified. They would argue that the VA does not pay enough for support staff and that the classification system is the problem. This is supported by the construct of Patient Align Care Team where it appears that the VA is using RNs to perform non RN duties in its clinics.

Other significant HR issues

a. Too long to recruit and on board positions.
b. Job descriptions and pay band revisions are back logged, thus current position descriptions may not accurately account of the level of skill required including computer skills.
c. Market adjustments need to be more flexible and reviewed annually to keep pace with market demand. Example echo tech techs and PA
d. Retention pay being limited to only one year at a time is not a sustainable way to retain employees.
e. Excessive mandatory annual training leading to lost productivity.
f. Rules do not always make best practice. I.e. $147K limit on fee basis cap for contractors gives management less flexibility and increases costs.
g. Except in nursing, time keeping rules make it difficult to flex full time employee staffing to meet unpredictable needs. You don't always know your workload a week in advance. One simple solution is to allow flex time for full time employees in much the same way that the VA does for part time employees.
h. Providers are not authorized partial day leave from the VA to handle personal issues such as their own health. Instead, providers must take a full day of leave to simply attend their own annual physical causing an incentive not to return to work that day to see patients.
i. Local Senior Management Pay. The current VA pay scale for physician leadership limits the VA's ability to attract and retain the best physician leaders. For example, the Chief of Staff (COS) position at our most complex VA medical centers has a cap of $275,000. This is one of the most important

roles within the VA structure. As you can see from the attached VA pay table, anyone with any service level experience or any clinician other than a primary care or non-invasive specialist would have to take a pay cut to become the COS. If you want good outcomes we need to hire good leaders with experience and let them lead.

j. The salaries are even more out of touch with the market for Director/Hospital President or CEO, Associate Director/Hospital Vice President or COO; thus the VA cannot compete with the private sector.

DEPARTMENT OF VETERANS AFFAIRS Veterans Health Administration Title 38, U.S.C. Sec. 7431,

Physician and Dentist Annual Pay Ranges

PAY TABLE 5 – CHIEF OF STAFF MINIMUM	MAXIMUM		COVERAGE
TIER 1	$150,000	$275,000	Complexity Level 1a and 1b Facilities
TIER 2	$145,000	$255,000	Complexity Level 1c and 2 Facilities
TIER 3	$140,000	$235,000	Complexity Level 3 Facilities or Facilities with no designation level

Other private sector trends that the VA might want to explore include the following:

1) Quality/Performance Services

Organizations that have been most successful in making quality the top priority have quality reporting to the top of the organization. Performance services also reporting directly to the Secretary would mean that the data would be presented in an unbiased way to upper management. The same could be done at the local entity level where there appears to be inconsistency of where quality reports.

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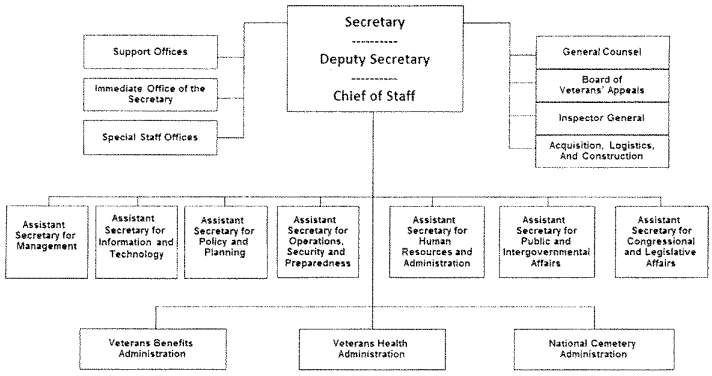


2) Everyone practicing to the top of their license:
    a. Example: In the VA Patient Aligned Care Team (PACT), a primary care provider (physician, nurse practitioner, or physician's assistant) leads an inter professional teamlet in care delivery. The VA "teamlet" includes a registered nurse as care manager, a health technician or licensed practical nurse (LPN), and a medical clerk. This RN/provider ration is 3 to 4 times the private sector ratio.
        i) Is the fact that the medical clerk VA job descriptions are not up to date and have therefore been downgraded meant that RNs are really doing clerical work? If the administrative staff were working to their full "license" would you need an RN for every provider? This is an expensive model and not typical of a private primary care practice.
        ii) What percentage of the RN duties really requires an RN, are they practicing at the top of their license?
        iii) Has the VA fully empowered the use of PA and RNP to meet the workforce needs of the VA in this model?

b. Role of Registered Nurse Practitioners and Physician Assistants in work force needs. The private sector is rapidly moving in this direction in order to meet its workforce needs. Since patient preference and satisfaction surveys have shown that patients not only are satisfied but often prefer a non-physician as their primary contact; Duke has set an initial goal in its primary care clinics to achieve an equal mix as part of its team approach. Has the VA done everything they can 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. Example why are some primary care jobs listed for RNP, others as PA and why are they under two different systems of pays?

3) Expanded Hours:
   a. Clinics: Why is it that the VA still lists its primary duty hours as 8 am to 4:30 pm. By merely expanding to 5:00 pm across the entire VA system just think about the productivity gain vs the fixed costs that the VA has. It could add capacity for 5 million more outpatient visits to the 86M that were provided in 2013. So why hasn't this been done? Just ask the local leadership about the issues they face in accomplishing this.
   b. Urgent Care: A huge national trend is the use of urgent care. This is being delivered by a combination of traditional providers, focused for profit urgent care companies, and non-traditional providers like pharmacies. The VA should explore urgent care centers, collaborations with other providers of urgent care to avoid ED visits at the VA or the private sector that they end up paying for. This fiscal analysis should include any potential cost savings for avoided travel pay. Is it cheaper to have private pharmacies deliver the annual flu shots?
4) Matching Workload to Need
   a. In the private sector an annual budget determines baseline staffing needs based on the current and projected year needs; and flex budgets are established to account for fluctuations in volume during the year. In the VA the resources lag by two years.
   b. On the day to day physician staffing VA, you can use flex time for part time physicians but this is not available for full time providers. The VA should extend flex time to full time providers and possibly even other staff.

5) Conversion from Inpatient to Outpatient: Facility Implications

	Owned Assets			Leased Assets		Land	Facility
	Buildings	Historic Buildings*	Square Footage	Leases	Square Footage	Acres	Replacement Value**
VHA	5,439	1,878	145,588,523	1,636	14,776,785	15,733	$103,495,166,889
VBA	22	0	767,032	212	4,512,700	0	$461,796,934
NCA	404	121	1,008,266	4	19,716	19,454	$894,580,302
Staff Offices	8	1	1,696,608	90	2,166,182	165	$808,386,508
Grand Total	5,873	2,000	149,060,429	1,942	21,475,383	35,352	$105,659,930,633

Frank Bell FY 2102 Office of Construction and Facilities Management

Both the VA and private sector are moving to the outpatient but the VA continues to maintain outdated and underutilized inpatient facilities often driven by politics rather than what is best for patient care. Based on the table above from 2012 and the projected decline in the Veteran population; it would appear that the VA might want to reconsider its strategy regarding building and owning new space verses developer owned and operated space which would give more flexibility in the future and possibly allow for greater collaboration with the private sector. The VA should consider a BRAC like process where the future locations and services are based on current and forecasted patient needs. (Currently I understand that any reduction in inpatient beds must go to VA Central Office and any closures must go to Congress, causing delays in decisions.) Modernization of the type of facilities to meet the current delivery model would result in better care of the patient in their communities as resources could be redirected to support the services that are actually needed. I.e. why maintain an outdated or underutilized inpatient facility? This results in the inability to adequately maintain the existing buildings, even at our flagship facilities; and limits the VA's ability to expand its access sites. The VA would then be able to make rational decisions to rent most outpatient space while owning inpatient and outpatient facilities where the work load and expertise will continue to be needed long into the future. Long term facility determination should include ability to attract and retain providers, not just work load.

6) Consumerism

The VA has the opportunity to continue to be the market leader in this area regarding quality and access. Making real time access data available to Veterans rather than implementing more reporting and compliance metrics could be an alternative method to assure that reported access measures were accurate; as the Veterans themselves would let you know in real time if the data was inconsistent with their experience.

But consumerism is not always the best way to solve a problem, as often the data itself is not enough to make an informed decision. An example is that it appears that in recent draft language the VA would be required to inform patients of the training and certification of the surgeon prior to surgery. This appears to be an attempt to make sure that only qualified providers are performing specialized surgery. In this case, it is the Medical Staff who should be accountable for only granting privilege to the appropriate providers; not trying to make the patient decide what is the appropriate training.

7) Management Contracts;

The Private sector makes much greater use of management contracts. This can range from management of a particular service like EVS or food service to management of entire hospitals or systems without a change in ownership. In North Carolina, Carolinas Healthcare Systems employs the management while staff remains employed by the local entity of over 20 hospitals.

For years, county leaders have found it much more efficient to outsource the management of their county facility to either a local or national expert in hospital management. This can take many forms. Should the VA consider similar models?

Since there would be no cost savings in consolidation of purchasing the savings would have to come from elimination of duplications, improved coordination of care for Veterans using both their private sector and VA benefits. Local management would be incentivized to find more cost effective sharing of resources and would likely improve care by elimination of services that are rarely used. (I.e. it is hard to maintain competency if the task is rarely done). Expensive equipment or services would not need to be duplicated. Management costs could be reduced.

8) VA utilization of other Government Services and Contracts

The VA does not have a core competency in the revenue cycle and thus continues to struggle with the ability to process non VA care claims. The VA is the only "payer" where we have to drop the claim to paper and include a copy of the medical record with the claim. This copy is a duplicate of what we send the Durham VA for clinical care purposes. Our days in accounts receivable is much higher than private sector payers and is often an obstacle to convincing private physicians to take VA patients. Since we receive an authorization number that is specific to that Veteran and the specific medical condition, and the authorization is time limited by the "valid dates"; why doesn't the VA just utilize the same contractors as CMS to process these claims? It can then be automated like all our other claims and would reduce costs for all parties.

9) VA collaboration with the community including academic affiliates

The VA would benefit with new policies and procedures that would allow the VA to benefit from shared resources.

For example:

A) Many part time VA providers also provide care at their academic affiliate or other local community hospital. Yet the VA has their own credentialing office where the provider's medical license, educational background check etc. must all be duplicated. While JCAHO requires separate privileging committees, the administrative functions could be done more cost effectively if there was better sharing. The same goes for annual training in HIPAA, infection control, etc. that is similar between most facilities.

B) Often the rate limiting resource is OR time, not VA physicians. Rather than building more ORs in VA facilities the VA should encourage through enhanced authority the use of private facilities by VA employed providers where appropriate to meet patient's needs. This can be more cost effective than simply outsourcing the care through non VA care service.

C) The VA should evaluate its recent use of a third party for non-VA care coordination. Simply using CMS as listed above could be more effective and restore the relationship between the VA providers and the community.

10) Standardized Quality Metrics

The country is overrun with every agency and insurance company trying to establish its own set of quality metrics. The same is true of the VA where they have reached metric fatigue. The VA and CMS should agree upon the same set of standard and same methodology so we can do national comparisons. For example if Medicare defines 30 day readmission to include readmission to any hospital, not just the index system, the VA should use the same definition and thus must use a combination of private sector and VA data.

11) Management Structure:

With the changing landscape of healthcare from inpatient to outpatient and the improvements in technology, the VA should once again reexamine its management organization from top to bottom including VACO, VISNs, and the Assist, Associate and Director Positions.

A March 27, 2012 **Veterans Health Administration** *Audit of Management Control Structures for Veterans Integrated Service Network Offices stated that* "VHA established the VISN offices to improve access to medical care and ensure the efficient provision of timely, quality care to our Nation's veterans. In 1995, VHA submitted a plan to Congress called *Vision for Change* that restructured VHA field operations into VISNs. VHA estimated that 22 VISN offices could operate annually at a cost of about $26.7 million or for approximately $9.3 million less than the cost at that time to operate 4 medical regions. VHA specifically decentralized its budgetary, planning, and decision making functions to the VISN offices in an effort to promote accountability and improve oversight of daily facility operations.

In FY 2011, VA's information systems reported that the VISN offices spent about $202.5 million for the salaries and benefits of 1,495 staff and their related expenses. Based on data in VA's automated information systems, VHA's 21 VISN offices expended about $164.9 million during FY 2010 to support their own operations. VA's Personnel and Accounting Integrated Data (PAID) system showed the VISN offices expended about $124.9 million for the salaries and benefits of 1,098 staff. VA's Financial Management System (FMS) showed the offices expended an additional

$40.0 million, excluding centralized purchases on travel, rent, utilities, equipment, supplies, and services."

*The report concluded that "***VHA** lacked adequate management controls and needed to improve the quality of VISN office data to oversee and evaluate the effectiveness of VISN staff and organizational structures. First, despite improvements, VHA lacked assurance that its performance management system allowed the effective monitoring, evaluation, and comparison of VISN office performance. Second, VHA had not adequately monitored and managed the growth in the offices' organizational structures and staffing. These lapses occurred because VHA focused on the performance of its healthcare facilities and allowed VISN offices to operate autonomously. Consequently, VHA could not adequately justify the VISN offices' organizational structures and staffing levels and ensure that they provided optimal oversight, facilitated improved healthcare facility performance, and reflected the effective stewardship of VA funds."

In the private sector, the independent audit team would be required to do a follow up audit and report to the board to assure that management's corrective actions were completed. I was unable to find such a follow up audit.

While I am not able to find a comparable comparison on the growth of VACO during the same period it appears that VACO positions seem to have grown disproportionately to the services delivered to Veterans. Should the VA review all VACO programs, policies, and directives to see if they are appropriate for modern management? Should VACO review all of its programs to see if older programs have been superseded by other programs, and which ones are actually evidence based, or might best be administered at the local level rather than centrally?

An alternative structure would be to return to the original intent of the VISN or to simply make the major medical center in each VISN accountable for the VISN strategy and metrics so that the majority of the resources are totally aligned with the best outcome for the region and performance for all directors in the VISN heavily weighted to the whole VISN outcome rather than the individual medical center performance.

Selected Veterans Health Administration Characteristics: FY2002 to FY2013					Calculated
Fiscal Year	**TOTAL ENROLLEES[1]**	**OUTPATIENT VISITS[2]**	**INPATIENT ADMISSIONS**		**visits/veteran/yr.**
	(in millions)	(in millions)	(in thousands)		
2002	6.8	46.5	564.7		6.8
2003	7.1	49.8	567.3		7.0
2004	7.3	54.0	589.8		7.4
2005	7.7	57.5	585.8		7.5
2006	7.9	59.1	568.9		7.5
2007	7.8	62.3	589.0		8.0
2008	7.8	67.7	641.4		8.6
2009	8.1	74.9	662.0		9.3
2010	8.3	80.2	682.3		9.7
2011	8.6	79.8	692.1		9.3
2012	8.8	83.6	703.5		9.5
2013	8.9	86.4	694.7		9.7
[1] Includes non-enrolled Veteran patients.					
[2] Includes fee visits.					
Source: Department of Veterans Affairs, Veteran Health Administration Office of Policy and Planning					
Prepared by the National Center for Veterans Analysis and Statistics.					

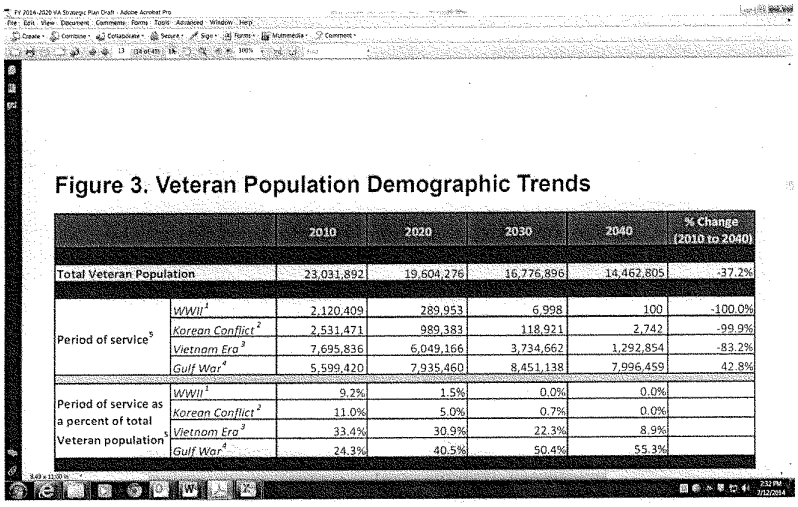


Figure 3. Veteran Population Demographic Trends

		2010	2020	2030	2040	% Change (2010 to 2040)
Total Veteran Population		23,031,892	19,604,276	16,776,896	14,462,805	-37.2%
Period of service[5]	WWII[1]	2,120,409	289,953	6,998	100	-100.0%
	Korean Conflict[2]	2,531,471	989,383	118,921	2,742	-99.9%
	Vietnam Era[3]	7,695,836	6,049,166	3,734,662	1,292,854	-83.2%
	Gulf War[4]	5,599,420	7,935,460	8,451,138	7,996,459	42.8%
Period of service as a percent of total Veteran population[5]	WWII[1]	9.2%	1.5%	0.0%	0.0%	
	Korean Conflict[2]	11.0%	5.0%	0.7%	0.0%	
	Vietnam Era[3]	33.4%	30.9%	22.3%	8.9%	
	Gulf War[4]	24.3%	40.5%	50.4%	55.3%	

Testimony of Daniel F. Evans, Jr.
Chief Executive Officer, Indiana University Health
Before the U.S. House of Representatives Committee on Veterans' Affairs

Creating Efficiency through Comparison: An Evaluation of Private Sector Best Practices and the VA Health Care System

July 16, 2014

Good Morning. On behalf of Indiana University (IU) Health, thank you for your focus on improving access to health care services for our nation's veterans. IU Health is committed to honor their service by continuing to work with our VA partners in Indiana to meet the health care needs of those men and women who have served our country in the armed services.

IU Health is Indiana's largest and most comprehensive academic health system, and one of the busiest health systems in the United States. IU Health has nearly 30,000 team members in more than 20 hospitals and health centers throughout our state. IU Health is one of Indiana's largest safety net hospitals, providing nearly $183 million in free or reduced-cost care, benefitting over 139,000 patients.

IU Health also has a unique partnership with the Indiana University School of Medicine (IUSM), the nation's second largest medical school and a national leader in medical education and research. IU School of Medicine residents rotate between our system and the Roudebush VA medical center in Indianapolis.

Like the VA system, the IU Health system is both complex and diverse. Our system spans the state and includes an academic health center, one of the nation's preeminent children's hospitals, and 12 other community and critical access hospitals. Our patients range from those with basic primary care needs to those with most complex or severe ailments imaginable.

It is not easy to change any large and complex health organization, whether it is IU Health or the VA health system. However, we at IU Health firmly believe that systematic changes are necessary. Those who pay for and receive our services are increasingly – and rightfully – demanding accessible, high quality and more affordable care.

To that end, as part of IU Health's recent system-wide strategic planning effort, we have set the very aggressive but achievable goal of improving productivity by 25 percent over the next five years. We know we must invest in our strengths while simultaneously finding ways to eliminate the waste and inefficiencies in many of our processes in order to bring enhanced value to our patients.

IU Health has established a system-level Office of Transformation to change the way work is done throughout our organization. A key tool in implementing this transformation is the ***Lean*** process improvement methodology, which is used widely in other industries but is only more recently being adopted by healthcare systems. With the assistance of the widely respected firm, Simpler, which specializes in Lean transformation, we have successfully launched Lean initiatives in all of our hospitals,

as well as in our employed physician group. These projects are empowering our team members to re-shape their daily work, and have already led to an estimated $10 million in savings and improved outcomes. For example, one of our hospitals successfully reduced its 30-day readmission rate by 38 percent using more consistent patient education.

We know that people increasingly expect to get their healthcare in the same way they get most other services today – quickly and conveniently. They want to be able to schedule appointments online, take advantage of evening or weekend appointments, and use video visits for primary care appointments. These are not radical concepts, except perhaps in our industry!

Responding to the needs of our patients, IU Heath now offers same day appointments to patients seeking primary care services. Patients are given one number to call to schedule an appointment with an IU Health primary care provider either that same day or the following day. And, patients now also have access to online scheduling, including same day appointments. To fulfill our commitment to improved access, we are changing the way that we work. We have worked with our primary care providers to offer extended hours at their offices to accommodate evening or weekend appointments. We now include "access" as a component of our compensation model for primary care providers to advance the system's overall goal of improving our patients' ability to access our providers *at their convenience*. Participating physicians have standardized the appointment types that they offer and set aside time in each day to be available for same day service. We centralized scheduling to enable our team to balance a patient's preference to be seen by his own provider with his need to be seen quickly in order to drive the best overall outcome.

IU Health will continue to look for creative ways to enhance patient access by increasing the number of venues where we provide care, the way we schedule patient visits, and how we leverage technologies like telemedicine to help our patients and care teams stay connected.

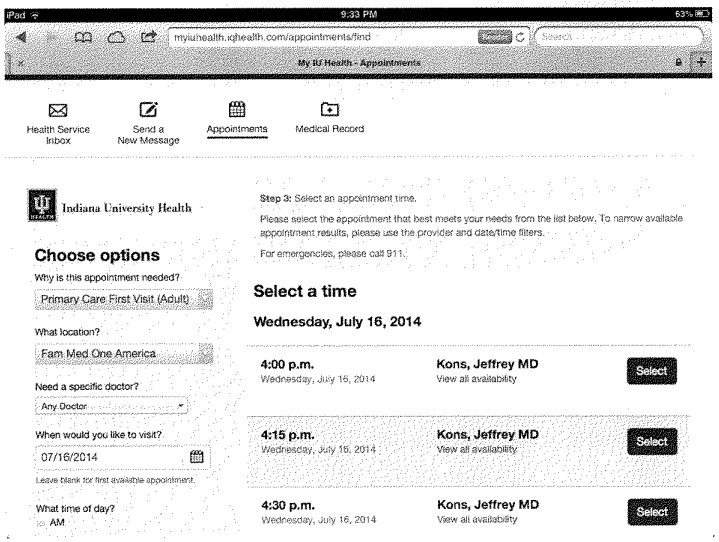
The VA academic affiliates – schools of medicine and their associated clinical group practices – have been long standing partners with the VA in accomplishing its statutory mission. IU Health is honored to be a VA partner through a variety of means, including providing contracted specialty services to our VA partner at the Roudebush medical center in Indianapolis. We would respectfully recommend to the Committee that they expand contracting with health systems such as IU Health to increase access for veterans to the world-renowned healthcare services available to the American public.

Thank you again for allowing IU Health the opportunity to testify on these important issues. We are committed as you are to ensure our nation's veterans receive the care they deserve when they need it most. IU Health stands ready to work with this Committee and our VA partners to meet these demands today and in the future.

DANIEL EVANS, J.

Same-Day Access

Self Service Scheduling



Prepared Statement of Rulon F. Stacey

I appreciate the opportunity to speak to you today both on behalf of Fairview Health Services, an integrated, academic health system based in Minneapolis, Minnesota serving more than 600,000 people each year, and the Malcolm Baldrige National Quality Award, the world's leading performance excellence criteria created by an act of Congress 25 years ago to improve America's performance and its competitive standing in the world.

I myself am honored to be a veteran of the United States Air Force. That background gives me an enhanced interest on the topic under consideration today. I also bring my perspective from nearly 30 years of health care administration experience. I've worked in a variety of private health care systems in rural, suburban and urban markets. Based on this diverse background, I would suggest that while the issues faced by the VA today are significant, they present you with a problem similar in nature to the issues each of our systems are facing. Specifically, how do we increase access and quality in light of limited resources? Like my health system and others in the country, Congress is wrestling with how to deliver the care our veterans deserve without breaking the bank.

As the American Hospital Association has suggested, health care needs are unique and health care needs to be tailored to the individual. However, the processes by which we can improve clinical outcomes are not unique. The challenge, I would suggest, is to find proven improvement methodologies that cross care settings that can benefit any health organization, including the VA.

Malcolm Baldrige Performance Excellence Program

To this end, we are fortunate in the United States to have the world's finest process to address these issues. The Malcolm Baldrige Performance Excellence Program, located at the National Institute of Standards and Technology in the Department of Commerce, is a public-private partnership that defines, promotes and recognizes performance excellence in U.S. organizations. Some organizations choose to pursue the actual Baldrige Award, which carries the Presidential seal, and award recipients then share their best practices with others. Best of all, the program is up and running and available to help right now at no additional cost to the VA.

The program initially revolutionized manufacturing in the United States, and it is now having the same effect on health care. In 38 hospitals that were Baldrige award finalists, the overall risk-adjusted mortality rate was 7.57 percent lower, the patient safety index was 8.17 percent better, and risk-adjusted complications index was 1.3 percent better than in 3,000 peer hospitals.

Using a simple extrapolation, a comparable improvement in mortality for all U.S. hospitals would save more than 54,000 lives and 1.78 billion dollars in health care costs annually.

Results achieved by Baldrige Award recipients include the following:

Health Care Outcomes And Patient Safety

- 24 percent reduction in risk-adjusted mortality rate over 3 years (Advocate Good Samaritan Hospital, Indiana); 23 percent reduction in overall mortality rate over 2 years (Heartland Health, Missouri); 25 percent reduction in overall mortality rate over 5 years (Robert Wood Johnson University Hospital Hamilton, New Jersey); and 20 percent reduction in overall mortality rate over 2 years (Bronson Methodist Hospital, Michigan)
- 33 percent reduction in harm events per 1,000 patients over 3 years through a "zero-defect, no-excuses" approach to health care outcomes (Henry Ford Health System, Michigan)
- 1 percent or better hospital-acquired infection rate over 3 years (Schneck Medical Center, Indiana); zero central-line-associated blood stream infections since 2010 and zero catheter-associated urinary tract infections and adverse events involving incompatible blood since 2008 (Sutter Davis Hospital, California); No central line-associated blood stream infections in the intensive care unit for two years (North Mississippi Medical Center)

Patient Satisfaction

- Top 10 percent nationally for patient satisfaction and engagement as defined by the Hospital Consumer Assessment of health care Provider and Systems (HCAHPS), as well as a four-year record of meeting CMS benchmarks for overall hospital ratings of and measures of customers' willingness to recommend the hospital to others. (Sutter Davis Hospital)
- 725 percent improvement in medical-group patient satisfaction with urgent care and 100 percent improvement in overall medical-group patient satisfaction over 5 years (Sharp health care, California)

- Weighted patient satisfaction results at or above the Press Ganey Associates 90th percentile since 2008 (North Mississippi Health System)
- Better-than-top-decile patient satisfaction ratings for outpatient, emergency, ambulatory surgery, and convenient care (Advocate Good Samaritan Hospital, Illinois)

Efficiency and Cost Reduction

- Decrease in Emergency Department average door-to-doctor time from 45 minutes in 2008 to 22 minutes in 2012, well below the California benchmark of 58 minutes. (Sutter Davis Hospital)
- Best 25 percent in the state for adjusted cost per discharge (Sutter Davis Hospital, California)
- Decreases of 50 percent in costly emergency room and urgent care visits, 65 percent in specialty care, 36 percent in primary care visits, and 54 percent in hospital admissions due to increased same-day access to care (South Central Foundation, Alaska)
- Despite its location in what has been called "the nation's epicenter of poverty," the only health care organization in Mississippi or Alabama with a Standard & Poor's (S&P) AA credit rating, which it has held for the past 18 years. (North Mississippi Health System)
- Average charge $2,000 lower than that of its main competitor and $7,000 lower than the average charge in the metropolitan area, while achieving a profit per discharge higher than the top 10 percent of U.S. hospitals (Poudre Valley Health System, now University of Colorado Health)
- Nearly 28 percent overall improvement in length of stay over 3 years (Poudre Valley Health System); nearly 16 percent overall improvement in length of stay over 4 years (AtlantiCare)

Workforce Engagement

- Employee satisfaction and engagement scores that are better than the top 10 percent in a national survey database. (Sutter Davis Hospital)
- Employee retention rate at or above 90 percent since fiscal year 2009, exceeding the Bureau of Labor Statistics' benchmark for health care organizations by 10 percent. (North Mississippi Health System)
- A culture that emphasizes "people first" among its critical success factors. Based on a "servant-leadership" philosophy, managers model the organization's values and build trust with employees, sustaining an empowered, accountable, and high-performing workforce. (North Mississippi Health System)
- Ranking in the national top 10 percent of similar organizations for physician loyalty; names on of the "Top 100 Best Places to Work" (Poudre Valley Health System, now University of Colorado Health)
- Clinical Integration Program that rewards physicians for achieving superior clinical, service, and efficiency outcomes (Advocate Good Samaritan Hospital, Illinois)
- Nearly 47 percent improvement in physician satisfaction over 3 years (AtlantiCare, New Jersey); 20 percent improvement over 2 years (Bronson Methodist Hospital); 99 percent overall physician satisfaction (North Mississippi Medical Center)
- Decreases in employee vacancy rates: 68 percent decrease over 3 years (Robert Wood Johnson University Hospital Hamilton); nearly 31 percent decrease over 2 years (North Mississippi Medical Center); 34 percent decrease over 5 years (Mercy Health System); 33 percent decrease over 4 years (AtlantiCare, New Jersey)

As a recipient of the Baldrige Award at a previous organization, I experienced first-hand the power of the Baldrige Performance Excellence Program. Using the program as an improvement roadmap, we improved patient satisfaction for ten straight years. Our risk adjusted mortality rate improved to rank among the top 10 percent nationally. Additionally, by improving staff motivation and empowering the staff to be innovative we were able to decrease employee turnover from 25 percent to less than 5 percent, and we achieved national rankings in the top 10 percent for physician loyalty. While driving these improvements, we also created efficiencies, freeing up resources to further reinvest in our clinical care and services.

This process works and is instantly available. It works because it engages physicians, nurses and other staff in identifying improvement opportunities and then engages them in duplicating best practices so each and every patient we serve receives the best possible care. Best practices can come from within our organization or from others in the industry.

What Providers Can Learn from One Another: Examples from Fairview Health Services

On the national level, health care providers have much to learn from one another. In fact, the VA has, in the past, lead the industry in identifying and sharing best practice research. The precursor to the National Surgical Quality Improvement Program, the nation's leading surgical best practice improvement program, came from VA research and best practice sharing. I know that the American Hospital Association and organizations like mine throughout the country stand ready to help revitalize this process and lend any assistance we can as we search for leading-edge ideas on how to improve quality and access while reducing costs.

These processes have also helped us at Fairview Health Services, where we annually have more than 5.8 million outpatient encounters, 1.5 million clinic visits, 72,000 inpatient admissions and 9,000 births. And we continue to driving many quality improvements from which I believe other organizations can learn. Some examples:

- In just one of our Emergency Departments, the care team cut the average time spent waiting between registration and seeing the doctor by more than half—from 58 minutes to less than 28 minutes.
- In May 2010, we launched an ambitious effort to change how we deliver primary care to improve quality outcomes and the patient experience while reducing the total cost of care. By more fully leveraging the multidisciplinary team and the date now available to us through the electronic health record, we've moved the dial on all three metrics. In fact, just this week 32 of our clinics were recognized statewide for clinical quality results.
- A Tel-Assurance program that has been in place less than a year has already has helped cut in half the 30-day hospital readmission rate for participating patients compared to a baseline population—from 13 percent to 6.5 percent. The program was initially launched for select patient populations, and we're now spreading it to others.
- To meet the needs of adult patients with complex, chronic conditions who have physical, psychological or social barriers that make leaving their home challenging, we recently expanded our Complex Care Clinic to provide more home-base care. We found that meeting with patients in their homes does more than provide them access. It provides an opportunity to more rapidly build relationships and trust and to identify barriers to their health and well-being that may not be readily evident in the clinic setting.
- A multidisciplinary team at Fairview believed reducing injuries to mothers and babies during delivery was a worthy mission and set out in 2008 to reduce those injuries to zero—and they are making great progress. For example, birth injuries at our children's hospital were already rare, but this work reduced them by another 70 percent. Our work to drive birth injuries to zero is often cited as a national best practice.
- To specifically better meet the needs of the seniors we care for, we are bringing more health care directly into our senior resident communities. Services include mobile X-rays and fracture casting, in-house vision and hearing check-ups and online medical record services accessible by residents and their families. We're learning that one person's convenience is another person's lifesaver.

I share these examples to emphasize that health care organizations can achieve dramatic improvements when we identify improvement opportunities—both small and large, take steps to address the opportunities, measure the results and then spread what works. I also share them to reinforce that health systems across the country are driving improvements and that providers have a lot to share and learn from another. That's what methodologies like the Baldrige Performance Excellence Program teach us. We are fortunate to have such a resource available to us, and I hope more health care organizations take advantage of what it can do to improve care and reduce costs.

The United States Congress expects people like me to find ways to deliver even higher quality care while further reducing costs. And, you are right to do so. By using proven methodologies and sharing best practices across the industry, our nation's health care system can improve and better serve the people who count on us each day to care for them and their loved ones.

Prepared Statement of Quinton Studer

Chairman Miller, Ranking Member Michaud and Committee Members:

Thank you for the opportunity to address the Committee today on best practices from the private sector.

Health care organizations, both large and small have found that standardizing operations along with standardizing clinical care practices lead to both efficiencies and improved outcomes.

Successful operators in the private sector know they must reduce tolerance for variance, whether it is within a specific department, across departments or across facilities within a division. Further, once a best practice is identified (by measurable outcomes) the path must be opened for it to be scaled across an organization.

These successful leadership teams also recognize that this begins with workforce engagement as studies have shown that a more highly engaged workforce creates both a safer work and a safer care environment. Higher engagement traditionally leads to fewer workarounds which drives safety and, in turn, clinical outcomes.

The path to standardization begins with a strong sense of alignment. Successful organizations' leadership teams know that by focusing on fewer vs. more goals allows for clear communication, clear expectations for middle leaders and a clear path to execution on those goals.

While establishing clear goals and metrics (with emphasis on outcomes vs. process measures) is important, the best leadership teams understand the importance of "connecting to purpose", and thus are able to create buy-in and ownership of front-line leadership and front-line associates. Connecting to purpose allows the front-line associates (whether patient-facing or in support service areas) to keep the patient at the center of their work.

We learn much of what we know about standardizing practices within health care from our physician colleagues. Physician leaders will tell you that the greater good of the organization and patient care should always trump individual autonomy. Strong medical groups are quick to address colleagues practicing outside a body of evidence. The VA would be well served to follow this model and move quickly and strongly to diagnose, create a treatment plan and standardize certain operational and clinical practices across the enterprise.

Key Elements/Areas of Focus:

- Action, Alignment, Accountability
- Culture of High Performance
- Current VA issues: Access, Pre communication, post communication, etc.
- Efficiencies = higher quality = expense reduction

For The Record

THE BOSTON GLOBE DATA-DRIVEN SCHEDULING PREDICTS PATIENT NO-SHOWS

By Michael B. Farrell
Globe Staff July 14, 2014

With all the advancements in health care, the medical profession still cannot get its appointment book in order.

Doctors are constantly overbooked. Patients constantly rescheduling. One day a waiting room is packed, the next it's empty.

So when Gabriel Belfort attended a health care hackathon at the Massachusetts Institute of Technology in 2012, he challenged the coders, engineers, and clinicians there to fix that nagging issue.

"There's a scheduling problem in medicine," said Belfort, who at the time was a postdoctoral student studying brain science at MIT. "If you've had an appointment and you've showed up on time, you've probably had to wait."

That dilemma posed by Belfort generated a very MIT proposal: What if you could use data science to determine which patients are likely to show up and which ones will be no-shows and manage office appointments around those tendencies?

"It was immediately clear to me that this is a problem that computers could solve," Belfort said.

In short order, Belfort and an ad hoc team of nine people—students and health care professionals—at the hackathon built a prototype to prove out the concept. Then, so excited by the prospect that they could solve one of health care's chronic pains, Belfort and three others who were strangers before that weekend launched a startup, aptly named Smart Scheduling Inc.

Here's the gist: Smart Scheduling mines patient scheduling histories to determine who is more likely to cancel or miss an appointment. It then sends alerts to the scheduling programs that doctor offices use to book appointments.

If a patient is in a high-risk category, for instance, it prompts office schedulers to call with a reminder. If the patient cannot be reached, there is a good chance he will not show up at all. So, the doctors could then book another patient for that time slot, keeping the patient flow consistent throughout the day.

Within months of forming, Smart Scheduling attracted the interest of Healthbox, an accelerator program that invests $50,000 in promising startups and gives them free office space and mentoring. It also landed a meeting with executives at Athena Health Inc., which eventually resulted in Smart Scheduling's becoming the first startup in the Watertown Health information company's new accelerator program. Athena Health also made an undisclosed investment to help the company build out its marketing and sales efforts.

So far, Smart Scheduling has attracted some $500,000 in early-stage investment. And already it has two large health systems signed up as customers: Martin's Point Health Care, which runs health centers in Maine, and Steward Health Care System, one of the biggest hospital groups in Massachusetts, where the software is being used by about 40 of its doctors offices.

Dr. Michael Callum, president of Steward Medical Group, said Smart Scheduling helps take some of the ambiguity and guesswork out of making appointments; by eliminating unexpected down time, Steward doctors systemwide are able to see 100 more patients every week.

"When you leave it to the front-desk people in the office, they are not all that good of predicting flow in terms of when patients will show up," Callum said. "It turns out that Smart Scheduling is much better at predicting that."

Here is what Smart Scheduling has learned about us as patients: If we are single, or under 40, we are more likely to cancel an appointment than an older or married patient. New patients miss more appointments than regulars.

In general, expecting patients to show up for the 1 p.m. slot is a bad idea. On the other hand, Wednesdays are great, as patients are not likely to cancel on those days.

So far, Smart Scheduling has developed 722 variables that it uses to make predictions, based on an analysis of millions of data points about patients from Athena Health. And the more data Smart Scheduling can crunch, the better it gets at predicting behavior.

The company says that, so far, its analysis has proven accurate 70 percent of the time when predicting cancellations.

"If everybody got a better schedule, we'd all be happier," said Ateet Adhikari, director of the Healthbox accelerator program. "The patients benefit, the doctors benefit, and the insurer benefits. A more efficient system trickles down."

Smart Scheduling was among the first companies that Healthbox invested in when it launched in Boston in 2012. Since then, it has backed 19 health-related startups.

Smart Scheduling exemplifies a new type of health care startup; instead of going after the big issues in health care—curing cancer, for instance—they are targeting more modest changes to improve the medical experience with technology.

"Companies like Smart Scheduling are dramatically improving health care not by producing a new drug," said Bill Aulet, director of the Martin Trust Center For MIT Entrepreneurship. "It's by streamlining the process and getting increased efficiencies."

Belfort has since gone on to work at a local biotech company, although he remains an adviser to Smart Scheduling. Out of the group that came together to build the original product at the MIT hackathon in 2012, only Chris Moses has stuck around full time, and is now the company's chief executive.

Improving patient flow in the doctor's office is just the first step, Moses said. "The next step," he added, "is to try to figure out who are the sickest patients and who the ones are that need to be seen first."