

Other National Recommendations

Introduction

As detailed in the Introduction to Chapter 3, the Commission identified issues integral to its review of the CARES process and the Draft National CARES Plan (DNCP), and determined that recommendations for each issue were essential to provide guidance to the Commission and to VA in developing national policy.

In addition to the issues identified in Chapter 3, the Commission identified other national issues that are distinguished from the crosscutting issues in that they are relevant in selected VISNs, rather than in most or all of the VISNs. These are no less significant than the crosscutting issues discussed in Chapter 3.

These national issues are:

- ▶ Infrastructure and Safety
- ▶ Education and Training
- ▶ Special Disability Programs
- ▶ VA/DoD Sharing
- ▶ Research Space
- ▶ Care Delivery Innovations

This chapter describes these issues and provides underlying rationale for the Commission's recommendations with regard to each of the issues. Chapter 5 details how the recommendations were applied in the specific VISNs.

Infrastructure and Safety

ISSUE

Does the DNCP appropriately prioritize infrastructure and safety funding?

Background

In 1971, the San Fernando VA hospital collapsed during an earthquake, resulting in the loss of patients' and employees' lives. As a result of this tragedy, VA conducted comprehensive seismic reviews of its physical plant infrastructure. In this process, VHA established a seismic inventory database that lists more than 5,000 buildings. Through site visit inspections, the seismic inventory database is continually updated to ensure that deficiencies are properly identified and prioritized for corrective measures.¹

VA assigns two risk categories to the seismic inventory: Exceptionally High Risk (EHR) and High Risk (HR), indicating the level of necessary correction. The categorization is based on the Federal Emergency Management Administration's (FEMA) guidance. To be deemed EHR, a building must: 1) be a main hospital building; 2) be located in an area of high or very high sensitivity; 3) be an essential or critical facility; 4) have been designed before 1977 when VA did not utilize the VA Seismic Design Requirements; and 5) have more than 10,000 square feet.

Analysis

VHA has identified 63 sites requiring seismic correction.² Many of these are large facilities located in high population density areas. Of this total, the DNCP prioritized 14 sites that require immediate seismic strengthening.³ The total funding requirement for these facilities is \$440.7 million.⁴

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Congress appropriates funding to VA for construction-related purposes using two funding accounts. One is for major construction projects where the estimated cost of the project is \$4 million or higher, and the other is for minor construction projects with estimated costs under \$4 million. Over the past few years, Congress has appropriated funding for minor construction projects, but has withheld sufficient funding for major projects pending the outcome of CARES. As one senior VA executive

¹ Seismic Safety of VA Buildings, VHA Directive 2000-012, March 23, 2000.

² Draft National CARES Plan (DNCP), *Chapter 11: Capital Investments (Safety and Environment)*, page 3. [<http://www1.va.gov/cares/>]

³ DNCP, *Chapter 11: Capital Investments (Safety and Environment)*, page 3. [<http://www1.va.gov/cares/>]

⁴ DNCP, *Chapter 11: Capital Investments (Safety and Environment)*, page 3. [<http://www1.va.gov/cares/>]

explained, “Both the Administration and the Congress have frozen VA capital asset spending pending completion of the CARES planning process. Over the past three years, VA has spent more of its capital budget on the cemetery system than on the health care system. [S]ome important needs are going unmet pending the CARES reports.”⁵

Findings

- ▶ VA has a thorough risk assessment process and seismic inventory database to clearly identify buildings at risk, rank them, and develop cost estimates for correction.
- ▶ A number of the facilities identified as having higher seismic risk are large, complex facilities located in high population density areas where a large VA presence will be required for the foreseeable future.
- ▶ Congress has withheld funding for major infrastructure improvements in recent years, pending the outcome of CARES.

Recommendation

The Commission recommends that patient safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

Education and Training

Background

Education and training for health professional students and residents is one of the four statutory missions

of the Veterans Health Administration (VHA). VA currently has affiliations with more than 1,200 educational institutions.⁶ More than 67 percent of all medical students receive a portion of their medical education within a VA medical center.⁷ In FY 2002, VA trained more than 76,000 students, including 16,000 medical students, 32,000 nurses and associated health trainees, and 28,000 medical residents.⁸

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⁵ Mark Catlett, Principal Deputy Assistant Secretary for Management, Department of Veterans Affairs, Presentation to CARES Commission, February 2003.

⁶ Office of Academic Affiliations, Department of Veterans Affairs, *Graduate Medical Education*.

⁷ Stephanie Pincus, MD, Chief Academic Affiliations Officer, Office of Academic Affiliations, Department of Veterans Affairs.

⁸ Office of Academic Affiliations, Department of Veterans Affairs, *Graduate Medical Education*.

ISSUE 1

Should VA more systematically promote medical education and training at its community-based outpatient clinics (CBOCs)?

Analysis

The DNCP proposals have the potential to positively impact VA's education mission. Proposed new facilities and certain consolidations will result in enhanced teaching environments with expanded services and increased physical space for training. Additionally, the expansion of CBOCs will provide a greater number of medical and professional educational opportunities in a community setting.

VA has undergone a significant transformation over the last decade from a primarily inpatient care system to a system with significant reliance on community-based outpatient delivery of care. Generally speaking, however, medical schools and other clinical affiliates have not made the transition from the traditional inpatient teaching modalities to incorporate community-based outpatient primary care and outpatient

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specialty care delivery into their educational programs. Similarly, some medical school and other clinical affiliates have yet to exploit the available training opportunities in community settings, hence missing a vital opportunity. VA and its medical school and other clinical affiliates need a systematic approach to addressing this issue.

Findings

- ▶ Further integration of medical education and training in the community-based outpatient setting will enhance continuity of care for veterans in addition to providing a practical and up-to-date educational experience for students and residents.
- ▶ Absent a clear plan, it is unlikely that a collaborative effort between VA and its affiliates will emerge regarding enhancing medical education programs to include community-based care.

Recommendation

The Commission recommends that VA and its academic affiliates develop a plan to add a community-based outpatient component to existing and new education and training programs.

ISSUE 2

Should VA initiate a formal policy for nursing education and other affiliates?

Analysis

In 1946, VA established a policy for VA affiliations with medical schools through Policy Memorandum Number 2.⁹ VA

provides training opportunities for medical students and medical residents under direct supervision of VA clinicians who hold joint appointments in the affiliated medical school and with the VA facility. While many schools of nursing use VA facilities for clinical practice sites, no formal national VA policy, comparable to Policy Memorandum Number 2, exists for nursing education.

In light of VA's significant involvement in nursing education and the dramatic impact the nursing shortage has on VA's ability to provide access to quality care for veterans, the Commission believes there is strategic value to formalizing the relationships between VA and schools of nursing. Through the systematic use of joint appointments at VA Medical Centers (VAMCs) and schools of nursing, VA could enhance the attractiveness of academic nursing and increase the number of nursing graduates available to meet the need for quality nursing care for veterans. In addition, by formalizing the nursing affiliations on a national basis, VA can play an important role in achieving better cooperation between medical and nursing schools, which will promote interdisciplinary collaboration in both the clinical and academic settings.¹⁰ Consideration also might be given to expanding formal relationships with other health professions. For example, there is a shortage of pharmacists nationally, and VA might play a role in diminishing this shortage as well as meeting its own needs.

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Findings

- ▶ The medical school affiliation model outlined in Policy Memorandum Number 2 has been effective in both enabling VA to recruit and retain medical professionals, and in training the nation's medical workforce.
- ▶ Schools of nursing use VA facilities for clinical practice sites; however, no national policy guidance comparable to Policy Memorandum Number 2 exists for nursing education.

⁹ *Policy in Association of Veterans' Hospitals with Medical Schools*, First published January 30, 1946, VA Manual 8 (M8), Part 1, Chapter 2, Appendix 2-D. (November 8, 1989) [Commonly referred to as *Policy Memorandum Number 2*]

¹⁰ See Institute of Medicine report, "Keeping Patients Safe" (November 2003).

- ▶ Availability of qualified nurses is critical to providing quality care for veterans.
- ▶ Other health professions also should be considered for formal relationships as appropriate.

Recommendation

The Commission recommends that VA establish national policy guidance for schools of nursing comparable to the medical school model in Policy Memorandum Number 2, and actively promote nursing school affiliations, as well as affiliations with other health profession educational institutions as appropriate.

Special Disability Programs

ISSUE

Do the DNCP proposals for the treatment of spinal cord injury and disorder (SCI/D), blind rehabilitation, and other specialty programs enhance services to veterans?

Background

The DNCP proposed to expand both the SCI/D and blind rehabilitation programs in order to sustain current services and to respond to anticipated changes in services as these special populations age. SCI/D and blind rehabilitation recommendations in the DNCP were based on workload requirements, veteran population, enrollee projections, and market penetration projections.

Analysis

VA is a leader in the treatment of individuals with SCI/D and visual impairments. VA uses a hub and spoke model to care for SCI/D patients. Patients travel to the “hub” tertiary hospital for inpatient care or complex services. For more routine services, patients receive care at regional “spoke” VAMCs. There are opportunities for VA to expand and enhance the spoke end of this care model, including providing services closer to veterans’ homes. The Commission also notes that in addition to the SCI and Blind Rehabilitation Centers (BRC) specialty disability programs, VA has had a long history of leadership in other arenas, such as caring for veterans with prosthetic needs. It is important for VA to continue its world-class role in these arenas.

There is no strategic approach to balancing the mix of acute and LTC beds. Current occupancy rates among VA facilities with SCI/D units range from approximately 52 percent to 98 percent.

For SCI Centers, there is no strategic approach to balancing the mix of acute and long-term care beds. Current occupancy rates among VA facilities with SCI/D units range from approximately 52 to 98 percent.¹¹ In spite of current occupancy rates, the Commission’s hearing record indicates that veterans report that they are currently waiting for SCI/D beds.¹² This may be a result of an inefficient mix of SCI/D beds, staffing shortages or of certain SCI/D units being located in less than optimal geographic locations. The proposed addition of four new SCI Centers and additional beds in four other locations will benefit many veterans.

Today, VA’s BRCs are structured to serve blinded veterans in an inpatient environment. The proposed addition of two BRCs in VISNs 16 and 22 will assist blinded veterans throughout the country. Inpatient settings are not the only solution, however, particularly because “many of these blinded veterans do not require a residential program.”¹³ A more appropriate response to serving many blinded veterans is to provide rehabilitation and retraining in community or home settings.

The proposed addition of four SCI Centers and additional SCI beds in four other locations will improve access to health care and rehabilitative services to veterans with spinal cord injuries and disorders.

Findings

- ▶ Veterans with special disabilities are likely to turn to VA for health care services since alternative community resources are often limited and difficult to obtain.
- ▶ Veterans with SCI/D and veterans with visual impairments, as well as their families, would benefit from new modalities, including outpatient services and telemedicine.
- ▶ The proposed addition of four SCI Centers and additional SCI beds in four other locations will improve access to health care and rehabilitative services to veterans with spinal cord injuries and disorders.
- ▶ The proposed addition of two BRCs will improve access to health care and rehabilitative services to veterans with visual impairments.
- ▶ VA has been at the forefront of other special disability programs such as providing prosthetic services.

¹¹ VSSC KLF Menu Database, *Workload: Inpatient Occupancy Rates*.

¹² Steve Anderson, National Field Director, Paralyzed Veterans of America, Transcribed Testimony from the Orlando, FL, Hearing, September 10, 2003, page 182.

¹³ Rebecca Vinduska, Director of Governmental Regulations, Blinded Veterans Association, Written Testimony, CARES Commission Meeting, October 7, 2003, page 3.

Recommendations

- ▶ VA should ensure coordination among VISNs with regard to the placement of special disability centers to optimize access to care for veterans.
- ▶ VA should develop new opportunities to provide blind rehabilitation in outpatient settings close to veterans' homes.
- ▶ VA should conduct an assessment of acute and long-term bed needs for SCI Centers to provide the proper balance of beds to better serve veterans and reduce wait times.
- ▶ VA should strive to maintain its excellence in other special disability programs, such as the development and advancement of prosthetic services.

VA/DoD Sharing

ISSUE

Does the DNCP appropriately capitalize on the intrinsic value of VA/DoD collaboration?

Background

Over the last decade, a number of commissions, advisory organizations, and the General Accounting Office have studied various approaches to providing quality health care to veterans.¹⁴ One of the recurring recommendations to fulfill this obligation has been to improve collaboration and sharing between VA and DoD. The goal is to improve timely access to quality health care and reduce the overall cost of furnishing services to beneficiaries of both systems.

In the DNCP, there are 75 proposals for VA/DoD collaboration and sharing. Of these, 21 are high priority; 12 are for near-term development; 28 are for local development; nine are for future development; and five are described as “good ideas.”¹⁵ Additionally, the DNCP highlights VA’s mission to provide support to DoD in times of conflict or national disaster.

Analysis

During site visits and hearings, the Commission reviewed a wide range of VA/DoD sharing initiatives across the country and found varying degrees of support and momentum for their completion. The Commission found a number of successful VA/DoD collaborations, such as between the Alaska HCS and Elmendorf Air Force Base; American Lake VAMC and Madigan Army Medical Center; Augusta

¹⁴ President’s Task Force to Improve Health Care Delivery For Our Nation’s Veterans: *Executive Summary*, Final Report 2003.

¹⁵ DNCP, *Chapter 14: Partnering with the Department of Defense*, page 3. [<http://www1.va.gov/cares/>]

VAMC and Eisenhower Army Medical Center; and Cheyenne VAMC and F.E. Warren Air Force Base. At such locations, the Commission noted a clear, mutual commitment to the value of the collaboration, dedication from the senior local leadership to making the collaboration work, and a sustained effort to monitor and manage the day-to-day activities.

The Commission found a number of successful VA/DoD collaborations. At such locations, the Commission noted a clear, mutual commitment to the value of the collaboration, dedication from the top local leadership to the making the collaboration work, and a sustained effort to monitor and manage the day-to-day activities.

At those locations where collaboration was not successful or where it had been proposed for some time but had not gained the necessary momentum, the Commission found the opposite: no mutual commitment to the proposed collaboration, no dedication, and no effort. At such sites, the Commission also detected a lack of direction from national leadership, in some instances, particularly from the Department of Defense, to the local leadership in support of the collaboration.

From its review, the Commission concluded that to ensure a successful collaborative relationship between DoD and VA, there must be clear commitment from their senior leadership, both to the initial establishment of collaboration and to its ongoing maintenance, especially when there is a change in leadership. The Commission noted a number of collaborations that did not continue after one or both of the senior local leaders was reassigned or retired. Both the Congressional Commission on Servicemembers and Veterans Transition Assistance, in its 1999 report¹⁶, and the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans, in its 2003 report¹⁷, focused on the value of increased VA/DoD cooperation and on the need to establish support mechanisms for such cooperation. As the President's Task Force stated in its report, it is vital that VA/DoD leaders establish organizational cultures and mechanisms that support collaboration, improve sharing, and coordinate the management and oversight of health care resources and services, with clear accountability for results.

Findings

- ▶ There is demonstrated value in VA/DoD sharing.
- ▶ In spite of longstanding emphasis on VA/DoD collaboration, few sharing initiatives have been successfully implemented.
- ▶ VA and DoD have challenges in implementing and operating sharing initiatives. To institutionalize collaborative and sharing relationships that transcend leadership changes and local barriers to

¹⁶ Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance, January 1999, page 99.

¹⁷ President's Task Force to Improve Health Care Delivery For Our Nation's Veterans: *Leadership Collaboration and Oversight*, Final Report 2003, page 6.

implementation, there must be clear commitment from senior leadership. These leaders must establish organizational cultures and mechanisms, incorporating incentives that support collaboration, with clear accountability for results.

Recommendations

- ▶ VA/DoD collaboration should be one of the first considerations in addressing health care needs in a local area.
- ▶ VA and DoD leadership should provide authority, accountability, and incentives to local managers to encourage and facilitate sharing activities that improve health care delivery and control costs.
- ▶ VA and DoD should institute policies that prevent changes in local leadership from canceling existing or proposed sharing initiatives.

Research Space

ISSUE

Do DNCP proposals for VA research space meet the CARES objectives?

Background

VA's research mission is to advance knowledge and promote innovations that improve the health and care of veterans. This mission is carried out through the support of scientifically meritorious and VA-relevant research and development.¹⁸ The VHA Office of Research and Development currently funds more than 5,200 investigators at 113 facilities conducting more than 17,000 active research projects to enhance the health of veterans.¹⁹

The VA Research Program provides funding to clinical investigators committed to the care of veterans. Research opportunities are a crucial mechanism for recruiting and retaining highly qualified clinicians who, in addition to conducting research, provide direct care and supervisory services at VA locations.

Analysis

The DNCP classifies research as non-clinical health care services.²⁰ Because research does not generate patient workload directly, workload criteria are not appropriate measures of need. To determine the amount

¹⁸ Veterans Administration Health Services Research and Development, VHA Directive 1204, April 16, 2002, page 2.

¹⁹ Office of Research and Development, Department of Veterans Affairs, FY 2003.

²⁰ DNCP, Chapter 15: *Research and Academic Affiliations*, page 2. [<http://www1.va.gov/cares/>]

of space needed at each facility to support its research program, NCPO utilized a measure that assigns the amount of research space based on the amount of funding for research. The DNCP took the requests for research space in the VISN plans and determined the capital improvement costs.

The DNCP includes more than 20 research leases, new construction and enhanced use leasing (EUL) proposals to address one or more of the following situations: 1) space available at VA facilities does not meet criteria and warrants replacement rather than renovation; 2) future projections indicate a need for additional research space that exceeds the amount locally available; and 3) community and/or affiliate partnering is proposed to provide and/or share research space.²¹ Approximately \$468 million for construction or renovation projects involving research space has been recommended.

Testimony in those VISNs where major research efforts are underway indicated major challenges in obtaining adequate research space.²² Testimony also addressed the deficit in projected research space needs identified in the DNCP.²³ The Commission also notes that the metric used in the DNCP to determine research space (\$150/square foot) is out of date with industry standards, and does not take into account that some research occurs in clinical settings and does not require laboratory space.²⁴

Findings

- ▶ The DNCP contains more than 20 research leases, new construction, and EUL options that address the highest priorities for research space in each VISN.
- ▶ Research space requests were justified on the basis of current research funding and projected research funding.
- ▶ The VA research program is an important tool for recruiting and retaining clinical staff.
- ▶ The metric used in the DNCP to determine research space is out of date and in conflict with industry standards, and does not take into account that research does not always require laboratory space.

Recommendations

- ▶ The Commission concurs with the proposals in the DNCP for enhancing research space, as indicated in Chapter 5.
- ▶ The Commission recommends that VA examine the measures used to determine research space needs.

²¹ DNCP, Chapter 15: *Research and Academic Affiliations*, page 2. [<http://www1.va.gov/cares/>]

²² Leslie Burger, MD, VISN 20 Director, Transcribed Testimony from the Portland, Oregon Hearing on September 26, 2003, page 44.

²³ Robert Weibe, VISN 21 Director, Written Testimony submitted at the Livermore Hearing on October 1, 2003, page 19.

²⁴ DNCP, Chapter 15: *Research and Academic Affiliations*, page 2. [<http://www1.va.gov/cares/>]

Care Delivery Innovations

ISSUE

Can VA enhance access to care through further innovations in care delivery?

Background

VA has undertaken a number of changes in care delivery designed to enhance access to services. Primary among them are CBOCs. The use of advanced practice nurses and telemedicine are other illustrations of new approaches to delivering care.

Analysis

During site visits, in meetings with veterans and during hearings, numerous favorable comments were made regarding the improved access veterans experience when advanced practice nurses are employed. Veterans reported a high satisfaction with the care provided, and access was clearly enhanced when wait times were reduced, services were brought closer to where veterans live, and continuity of care was enhanced.

The Commission also observed telemedicine to be an effective tool to enhance access to care and leverage clinician productivity. For veterans living primarily in rural and frontier areas and in locations where specialty medical clinicians such as psychiatrists, cardiologists, and radiologists are not readily available, telemedicine has proven to be a very-effective tool for care delivery.

Findings

- ▶ Advanced practice nurses are being successfully utilized to improve access to quality care for veterans.
- ▶ Telemedicine is extending medical services and leveraging clinician productivity to enhance access and quality of care.

Recommendation

The Commission recommends that VA use advanced practice nurses and telemedicine to enhance access and quality of care, and urges wider application of these resources throughout the system.