



DURHAM VETERANS AFFAIRS HEALTH CARE SYSTEM | DURHAM, NC

Date: April 2-4, 2018

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Chairman’s Statement

In 2003, Ron Conley, The American Legion’s National Commander that year, visited and assessed the delivery of health care at over 60 Department of Veterans Affairs’ medical facilities across the country. Commander Conley wanted to assess the delivery of health care delivered to the nation’s veterans to determine if the VA health care system was truly a “*System Worth Saving*” (SWS). The following year, The American Legion passed a resolution making System Worth Saving a permanent program under the National Commander. The American Legion’s National Executive Committee later realigned the program under the Veterans Affairs and Rehabilitation Commission.

After nearly two decades, The American Legion has conducted more than 150 System Worth Saving visits to VA/VHA medical facilities in the United States, its territories, and the Philippines. Over the course of those visits, The American Legion has played an integral role in shaping federal legislation that improves the delivery and quality of healthcare at VA/VHA medical facilities. Furthermore, each System Worth Saving visit culminates with a report that informs members of the American Legion and provides additional insight to the president of the United States, members of Congress, the Secretary of Veterans Affairs, and other senior leaders at the Department of Veterans Affairs/Veterans Health Administration about the challenges and best practices at VA medical centers.

Purpose

The purpose of the visit to the Durham Veterans Affairs Health Care System was to assess whether or not there were improvements in the areas of Quality of Care and Patient Satisfaction since The American Legion’s last visit in 2012.

Scope

The System Worth Saving site team conducted structured and unstructured interviews with the medical center’s staff. The structured interviews focused on the director, Quality Manager, Chief Medical Officer, Associate Director for Nursing and Patient Care assistant directors, and department managers. The team used The American Legion’s internally developed

In-Facility Questionnaire as its primary tool for the structured interviews.

Since access to care is a recurring issue at the majority of VA/VHA medical centers, the SWS team interviewed the Chief of Human Resources Management to determine if the appropriate level of staffing existed at the facility. The structured interview with the Human Resources chief lasted 45 minutes and included the associate director. Discussion centered on staffing levels for physicians, mid-level practitioners – nurse practitioners and physician assistants, and Medical Support Assistants or MSAs.

The scope of the visit did not include questions about the allegations of “inappropriate scheduling practices” that became the focus of an investigation by the VA Office of Inspector General (VAOIG). The VAOIG’s *Administrative Summary* of the investigation did not substantiate “the allegations” lodged by the complainant.¹ The VAOIG did not have any recommendations or definitive conclusions.

Additionally, the VAOIG released a report on March 2, 2017, *Audit of Veteran Wait-time Data, Choice, Access, and Consult Management* in VISN 6. SWS team did not address each recommendation made by the VAOIG. The discrepancies or recommendations outlined in the report addressed the VISN and not DVAHCS. However, the SWS did explore the facility’s accuracy of data related to wait-times involving primary care, mental health and, especially, Specialty Care. The SWS team found that patient-wait times for Specialty Care at the facility in one instance exceeded the national standard by 27 days.²

Overview of Durham Veteran Affairs Health Care System

The Durham Veterans Affairs Health Care System serves the southeast market of the Veterans Integrated System Network or VISN 6 in North Carolina. The 27-county catchment area is home to nearly 200,000 veterans. The hospital has 68,000 veteran-enrollees and claims 54,000 Unique Patients including nearly 6,000 women. The medical center serves veterans from rural and highly rural areas of North Carolina. The medical center reported serving 26,000 veterans living in rural areas and 257 veterans in highly rural communities.



DVAHCS is a level 1A tertiary care referral, research, and teaching medical facility with 251 operating beds with an average daily inpatient census of 123 beds (Average Daily Census = Total inpatient service days for a period / Total number of days in the period). DVAHCS has experienced year-over-year growth of 5.5% in its average daily census since 2016. Currently, the medical center boasts a 90% occupancy rate. Yet, the leaders project decreases in the number of acute care inpatient beds in all categories – Acute Care Inpatient Medicine, Acute Inpatient Mental Health, and Acute Inpatient Surgery – in their five-year strategic plan. Leaders at the medical center project an 8% growth rate in ambulatory care/outpatient services over the next few years. The medical center’s projections followed national growth trends for outpatient care.³

The facility employs 3,000 employees including 1,000 veterans. According to the Chief of Human Resources, DVAHCS has hired 1,325 persons since 2014, including more than 100 physicians and 200 nurses. The medical center employs 266 physicians, 829 nurses and Advanced Practice Registered Nurses, 89 Nurse Practitioners, and 68 Physician Assistants.

Paul S. Crews assumed the leadership role at the medical center on March 19, 2018. Mr. Crews has a wealth of experience in both public and private sectors of health-care delivery. He is also a veteran with more than 20 years in the United States Navy. VISN 6 holds Mr. Crews responsible for administering an operating budget of more than \$716,537,198 (projected budget for Fiscal Year 2018). Doctor Anne “Christie” Emler is Deputy Chief of Medical Staff with almost a year in the position, after the Department of Veteran Affairs promoted the former Chief of Staff to the position of National Director of Emergency Medicine.

Finally, the American Legion conducted the SWS visit to assess progress in the areas of Access to Care, Quality of Care, and Patient Satisfaction. Access to Care has continued being a major challenge at most VA/VHA medical facilities. Nonetheless, DVAHCS has spent \$25 million to expand access to care for veterans through community providers. Likewise, the medical center has maintained excellent professional relations with most community hospitals and medical providers.

For instance, DVAHCS has built a unique partnership with Duke Medical Center of Duke University. Duke Medical Center regularly sees veterans and, when needed, female veterans who have experienced sexual assault. National and international medical and health policy experts have recognized Duke University Medical Center as an innovator, specializing in medical care for patients with cancer, heart disease, and spinal injury. U.S. News and World Report consistently ranks Duke University Medical Center and Medical School as one of the most advanced medical schools and research hospitals in the United States.

Town Hall Meeting

Twenty-two persons attended the town hall meeting held at The American Legion Post 7 in Durham, North Carolina. Paul S. Crew, Director, Kevin Amick, Associate Director, and Dr. Anne Emler represented the medical center. They answered questions from veterans, the community, and members of The American Legion Department of North Carolina. The Department of North Carolina’s Commander and Adjutant were also among the attendees. Local staff from the office of North Carolina Senator Thom Tillis, Austen Shearer and Adam Webb, also attended the town hall meeting. Joel Brown, the local news anchor with ABC News 11, was also present and reported live during the town hall meeting to the local audiences. The town hall meeting lasted nearly two hours.

Veterans who attended the town hall meeting had questions primarily about medical benefits, enrollment issues, and individual medical care scenarios. Many had comments about ways the Veterans Choice program has negatively affected their consumer credit scores. However, the majority of the SWS team’s questions and subsequent discussion concerned patient satisfaction and patient engagement. One veteran complained that VA receptionists who engage veterans often do not have the required “soft skills” and the same was true for appointment scheduling staff.

A young veteran spoke about the lack of help for veterans suffering from post-traumatic stress and suicide ideation in the community. The veteran told of his personal cry for help and the lack of counseling resources available to him and others, which prompted him to volunteer helping veterans at the medical center. Additionally, the veteran felt the Interactive Voice Response or IVR prompts for suicide were not readily available when veterans called the VA hospital. Mr. Crews agreed to investigate the matter and assured the veteran of positive action regarding the sequencing of prompts about suicide. Mr. Crews directed staff to reconfigure the IVR the next day so that callers heard messages about suicide immediately rather than several minutes into the call.

The Department of North Carolina’s Commander raised the issue of privatizing VA/VHA medical facilities. Veterans voiced their discontent with the idea. Generally, veterans responded with comments citing that many community medical professionals and institutions do not know how to care for their unique medical conditions. Veterans questioned the ability of medical providers in the private sector to care for veterans with post-traumatic stress or polytrauma injuries including internal organ damage from bullets or shrapnel. Interestingly, veterans also viewed privatization as a means of stripping away meaningful social contact with other veterans. One veteran stated, “The



VA is the only place where I get the opportunity of feeling the camaraderie with my brothers and sisters who are veterans. I don't ever want that to go away."

A woman felt the VA wrongly annotated medical records or omitted information. She also admonished doctors at the VA and those providers caring for veterans in the community to "read [medical] notes especially when it's for the same thing." She continued with a scathing comment about care in the community calling it "horrible" because of process issues including delayed payment. "VA providers do not answer veterans' calls for referrals to community providers," she wrote.

The American Legion created an email address so veterans unable to attend town hall meetings can submit comments about their local VA/VHA medical facility.

Executive Briefings

Summary

The System Worth Saving team, National Executive Committee Member William "Bill" Kile, and Edwin Thomas, and representatives from The American Legion Department of North Carolina Carol Barker - Commander (Department of NC), Tierian "Randy" Cash - Adjutant (Department of NC), conducted structured (planned questions) and unstructured (unplanned or unscripted questions asked during discussions) interviews with senior leaders and department managers. The SWS team and Department leadership asked questions, "Challenges" and "Best Practices" at the facility with senior and departmental managers and selected staff from Environmental Care, Sterilization Supply, Human Resources, Clinical Services including Nursing Administration, Business Office and Finance, Quality Management, Women's Health Clinic, Public Affairs, and Pastoral Care. Beyond questions and discussions about "Challenges" and "Best Practices," the SWS contingent also asked questions about the facility's operations in each respective area. Many of the staff's answers about "Challenges" and "Best Practices" at the facility level often overlapped. The author reflected those overlapping comments in this report as "common themes" under categories like "Space" or "Access to Care." The report begins below with "Challenges" followed by "Best Practices and Recommendations."

Challenges

1. Budgeting Decision Timeline and Budget Allocation Process

Staff indicated one of their immediate challenges is the extended timeline for decision-making regarding the facility's budget. Additionally, leaders expressed concern about the budget allocation process. First, senior staff agreed they have limited capability of meeting the demands of the operation because of budget issues.

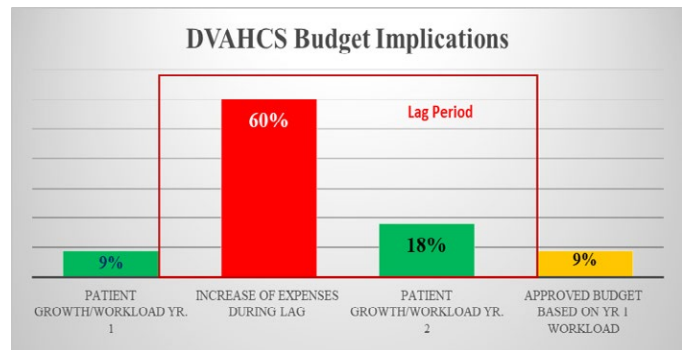


Figure 1

The staff cited a 9% annual patient growth rate at the medical facility. However, the budget approval process has a two-year lag that caused funding shortfalls as costs exceed the budget requested 24 months prior to its approval (Figure 1). The lag in decision-making creates additional operational problems such as increasing access to care. The Veterans Equitable Resource or VERA⁴ exacerbates the budgeting and allocation process at DVAHCS. The Allocation Resource Center (ARC) manages the collection of clinical and cost data each month from various data sources. ARC combines collected to develop patient-specific care and cost data for each hospitalization or visit at the location or treatment level for each hospital.

DVAHCS experiences a unique problem because of its level 1A status. The medical center receives patient referrals from other hospitals and Community – Based Outpatient Clinics, commonly referred to as CBOCs, within Veterans Integrated Service Network 6. While 48% of patients come from outside the medical center's catchment area, the VERA model attributes the bulk of the payments for providing care to those patients/veterans to the referring entity that "owns the patient" even if those referrals come from community providers. The VISN reimburses DVAHCS every two years a fraction of the cost of providing that care to those patients. The situation creates operating deficits for DVAHCS that burdens the ability of senior managers to plan effectively to improve access to care for veterans. One executive noted, "Meeting the comprehensive medical needs of our patients with the resources allocated to us is a challenge. We have limited ability to apply our budget to where we locally feel it will do the most good, again, is extremely challenging"

2. Access to Care – Space and Physician Shortages

While the previous report in 2012 does not denote issues with space and physician shortages at DVAHCS, it is not surprising that staff consider both as barriers for veterans seeking access to medical care – primarily specialty care for established patients and primary care for new patients. Data from the Department of Veteran Affairs National Statistics Center indicate an increase in



two age demographics in VISN 6 – 18 to 44 and 85+ - although overall growth is flat (Figure 2). However, the physical space at the medical center has not kept pace with the veteran population growth or the demand for health services resources in the 65+ demographic;⁵ the 18-month lag between submission of the facility's budget and its approval compels the medical center to absorb a pool of patients with even lesser health resources. Senior leaders at DVAHCS indicate a space deficit of more than 434,000 square feet at the main campus. One manager explained, "Ambulatory Care Services operate clinic space within the main building originally designed as inpatient units. When we retrofitted inpatient rooms to use as outpatient exam space, the design and layout effort created considerable inefficiencies. In the end, we had too few rooms, and the exam rooms we had ended up being too large in many areas." The lack of space contributes to decreased patient access to both outpatient services and primary care appointments. The space constraints exacerbate patient wait-times for outpatient procedures principally for new patients. For instance, new patients must wait 42 days, which is above the standard wait time of 30 days for VA/VHA, for outpatient gastrointestinal procedures requiring anesthesia.

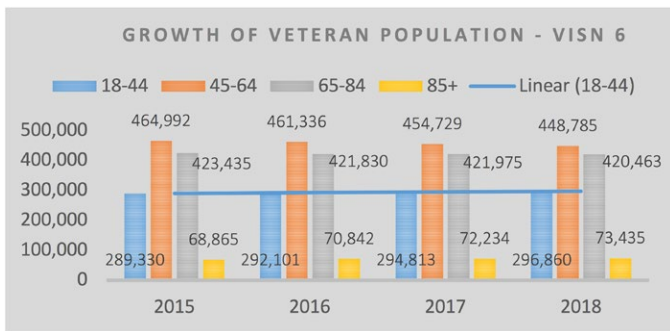


Figure 2

DVAHCS faces the challenge of filling 31 positions with primary care and specialty physicians or 7% of its 455 vacancies. The facility is recovering from a hiring freeze that dragged into late FY2017. Yet, DVAHCS feels its most pressing need for physicians is in remote areas such as Greenville, North Carolina, and Moorehead City, North Carolina home to two of its Community-Based Outpatient Clinics. Unfortunately, space constraints affect hiring decisions, too. One manager indicated, "There is nowhere in the system [hospital] to stage additional care teams of any kind even if we had the salary dollars [sic] to hire them."

3. Care in the Community/Veterans' Choice Program

Two veterans complained about the Veterans Choice program lack of timely payments to community providers that ultimately caused them to experience adverse consumer credit events. The staff at the medical center offered a similar refrain regarding the program:

- HealthNet has not paid some claims from providers dating back to 2016. While those claims age significantly, community medical providers refuse to see veterans, thereby causing access issues and, quite possibly, affecting the health status of veterans awaiting medical care in the community.
- Return Volume for Authorizations (RVA) reached record highs early in FY2018. The record numbers of RVAs stem from the inability of Third-Party Administrators or TPAs like HealthNet to schedule patients for appointments in accordance with contractual terms.
- Veterans and many participating providers in the community lack education and communication that informs veterans about the VA Choice program. The lack of understanding causes administrative burdens and other frustrations for staff at DVAHCS.

4. Front-desk staff /receptionists/staff at informational desks not trained to identify veterans with mental health issues.

Receptionists and other staff, who greet patients and visitors entering the facility, do not possess training that helps them identify veterans with suicidal ideation or other mental health conditions. Contrastingly, the medical center boasts that all employees receive "mandated MST (Military Sexual Trauma) training or can request the MST Coordinator provide training upon their request."

5. DVAHCS sends veterans who become victims of sexual assault to Duke University Medical Center.

While conducting a tour of the Emergency Department, the SWS team asked about veterans who experience sexual assault in the community. One ER nurse explained that veterans experiencing sexual assault in the community often request medical care at DVAHCS. Yet, the medical center does not offer treatment to victims of sexual assault but has a nurse escort the veteran across the street to Duke Medical Center for care. The nurse who accompanies the veteran does not remain with the veteran while Duke's medical professionals render treatment. DVAHCS proffered legal implications and lack of training as reasons for not treating victims of sexual assault.

6. Mental Health Access Center Requests for Clinical Pharmacists

DVAHCS staffs the Mental Health Access Center with innovative physicians like Dr. Jonathan Leinbach, Assistant Chief, at the center. The center uses multiple treatment modalities to help patients manage depression, post-traumatic stress, and suicide ideation. However, the Center has requested clinical pharmacists for several years without any response from the VISN or Veteran Affairs Central Office. Medical and nursing staff stated



the lack of approval or authorization prevents optimal outcomes for patients with mental health issues.

Best Practices

1. Real-Time Location System (RTLS) (Areas: Patient Safety, Quality, Patient Experience)

DVAHCS uses a state-of-the-art tracking system for all of its patient surgical assets. The tracking system use of barcode technology mitigates the risk of having the wrong surgical instruments, not enough surgical instruments, and unclean utensils that potentially cause hospital-acquired infections. Furthermore, the application has the potential to improve patient satisfaction, quality, sterile processing, and patient safety by reducing medical errors. DVAHCS serves as a pilot site for the RTLS technology program. Presently, DVAHCS uses the tracking technology to track surgical instruments and Sterile Supply Processing, but RTLS has many other applications ranging from patient tracking to reducing patient wait times.⁶

2. Stroke – Tracking Model (Areas: Patient Outcomes, Quality, Access)

Physicians involved with ambulatory care spoke of using encrypted messaging for patients who suffered a stroke. Physically locating the patient requires the model to combine the use of Advance Encryption Standard (AES) Cipher Block Chaining (CBC) mode and Quick Response (QR) Code. Advanced Encryption Standard (AES) and CBC algorithm encrypt the URL. Only the patient knows the Uniform Resource Locator (URL) and receives the QR Code. System administrators create a QR code based on patient identification and system encrypted URL to track the patient's location for messaging and functional progress.

3. We Care Rounds (Areas: Employee Morale, Patient Experience)

Senior leaders and managers conduct monthly “We Care Rounds” throughout the hospital. The director and line managers walk around the hospital talking with veterans and their families. Veterans can provide feedback about services. Families can also voice their opinions about service and perceived quality of care rendered by physicians and nurses.

The “Rounds” also include conversing with staff. Leaders talk with employees about challenges. Leaders also give employees “on the spot” recognition or awards. The employee “on the spot recognition” can potentially lead the employee toward participating in a bigger Employee Awards ceremony and a monetary incentive.

4. Environmental Care: Tru-D Smart UVc (Areas: Patient Safety, Patient Experience, and Quality of Care)

When the Chief of Environmental Services spoke about a state-

of-the-art to help combat Hospital-Acquired Infections using Ultraviolet light, the SWS team had never heard any other facility with the same capability. Tru-D SmartUVc produces an UVc short wavelength. UVc short wavelength creates enough radiation or energy necessary to kill microorganisms whereas other ultraviolet wavelengths do not – UVA and UVB.

The environmental care staff uses Tru-D after every normal room cleaning activity or even surgical procedures. The Tru-D device is the only one of its kind in the market that delivers a “guaranteed, scientifically-validated efficacy and efficiency.”⁷ The environmental staff believes Tru-D not only prevents infections but also offers a safe, efficient, and effective robot that disinfects patient areas.

*The American Legion passed Resolution Number 360: Advance Appropriations for all of the Department of Veterans Affairs’ Discretionary Accounts on September 1, 2016. The resolution urged the Congress “to authorize advance appropriations for all Department of Veterans Affairs’ discretionary appropriations accounts particularly for Veterans Benefits Administration operations, construction, research, and information technology.”

5. Coronary Care Unit (CCU) (Areas: Quality, Patient Care, Patient Experience, Patient Outcomes)

The American Association of Critical Care Nurses or AACN awarded DVAHCS its gold-level Beacon Award for Excellence. The CCU houses advanced practice nurses who care for up to eight veterans with serious cardiac problems ranging from bypass surgery to myocardial infarction. The CCU uses several practices such as timeout and secure medication administration. Nurses can lock the medication area from the inside so others cannot enter or disturb them when retrieving drugs for patients. This practice eliminates potential errors that might result in an adverse patient event.

Most CCUs do not allow the family to stay in rooms with patients or permit it for a set number of hours. Yet, the nursing staff allows the family to stay in the unit with the patient for as long as they want because they believe it helps in the curative process. Other novel ideas include having several hours of quiet time where even nurses must keep chatter to a minimum. The effort promotes relation and reduces the stress level in patients.

Recommendations

1. Budgeting Decision Timeline and Budget Allocation Process

The Department of Veterans Affairs designed the Veterans Equitable Resource Allocation model two decades ago to allocate



Congressional budget appropriations. The VA believed an “allocation model” served health-care financing needs of veterans through an “equitable and efficient”⁸ distribution of the fixed amounts received through Congressional appropriations. The Department of Veteran Affairs/Veterans Health Administration has adjusted the model numerous times over the past three years to include prospective patients, expanded cost categories/case-mix, and labor indices for local VHA facilities.

However, the changes still do not hasten the decision-making at the VISN level, which makes it difficult for administrators and staff to estimate and plan for increased demand for health services, costs, and other services related to the delivery and quality of care. Furthermore, in terms of equity and efficiency, VHA still operates on a fixed sum. Essentially, when VHA increases one VISN’s budget, another VISN must absorb a decrease in its allotment. The consequences of such an outdated “allocative model” cause inequities and inefficiencies. Congress exacerbates those inefficiencies by delaying approval of the federal budget for various political reasons. Although the VA is one of few agencies that receive advanced appropriations – advance appropriations is a form of budget authority that becomes available one or more fiscal years after the budget year covered by the appropriations act⁹ – one senior official at VHA described the advanced appropriation* as “a blessing and a curse.”

Recommendations

- Given the dynamic growth of demand for health care services and associated changes needed to meet that demand, The American Legion recommends the VA sanction another study to determine methods that further enhance the VERA and Medical Center Allocation System (MCAS) to avoid unnecessary delays when disbursing funds to medical facilities.
- Most importantly, The American Legion recommends the study explore an alternate legislative process that hastens the federal budget approval. In January of 2001, at the request of Congress, the Veterans Health Administration (VHA) asked RAND National Defense Research Institute (NDRI), a division of the RAND Corporation, to study the Veterans Equitable Resource Allocation (VERA) system. The VA/VHA commissioned a similar study a decade ago, but the study stopped short of recommending process improvements and Congressional delays.^{10,11} However, the rapid changes in veteran population growth particularly among women veterans warrants a new study that not only identifies process improvements but also:
 - » Adequacy and accuracy of Enrollee Health Care Projection Model
 - » New information technology capable of providing accurate, consistent, and complete data demand forecasting

and ultimately budget projections in light of the frequent changes in eligibility, utilization, and costs including community care.¹²

- » Currently, the Department of Defense has a one year gap in their budget cycle and does not receive advance appropriations even though they provide health care to or funding for 9.5 million active, reserve, and retired military personnel.^{13,14}
- The American Legion also recommends VA/VHA disburse all funds for patient research at hospitals closely affiliated with research and a teaching hospital like DVAHCS is with Duke University Medical Center. Presently, Congress may appropriate more funding for patient research but the size of the VERA allocation for that research often remains unchanged from one fiscal year to the next. Typically, VA/VHA research hospitals affiliated with other research and teaching facilities care for sicker patients than other VA/VHA facilities.
- The American Legion recommends VA/VHA clearly identify both clinical and financial scenarios that MCAS does not address including accounting for stark differences inherent in the delivery of health-care services in rural and highly rural areas.

2. Access to Care – Space and Physician Shortages

Shortages of medical professionals exist throughout the United States. Yet, the VA/VHA integrated delivery system appears as the only Integrated Delivery Network (IDN) plagued by lack of space to house primary care physicians and specialists. Congress has addressed the problem by setting aside large blocks of funds for “Major and Minor Construction.” For example, Congress has earmarked \$1.1 billion for Major Construction and over \$700 million for Minor Construction for FY2019. Nonetheless, the capability of VA/VHA facilities to keep pace with the demand for health services varies among the 23 VISNs. Yet, as RAND identified in its 2008 report, “medical facilities with space constraints often understate demand for health services.”¹¹ Likewise, the space constraint not only impedes patient access but also accurate demand and budget forecasting. The VA/VHA space constraint persists across all VISNs and has for at least two decades.

Recommendations

- While writing this report, the legislative and executive branches of the United States government enacted The VA Mission Act. The new law establishes a nine-member committee to review the closing of, modernizing, and realignment of VA’s medical facilities. The Asset and Infrastructure Review or AIR Commission will review recommendations to improve infrastructure from VHA.



» NOTE: The ceiling for Non-recurring Maintenance (NRN) for repairs and modernization will rise from \$10 million to \$20 million in FY2019. However, NRN requests or work cannot significantly expand square footage.

- The American Legion recommends the VA/VHA incorporate more market-based planning to adapt to the rapidly changing local market conditions and demand for health services.
- The American Legion recommends the VA/VHA continue modernizing facilities and systems that will facilitate delivery of highly enhanced quality of healthcare services by the VA.

3. Care in the Community/Veterans' Choice Program

The VA initiated the Veterans' Choice Program that gave veterans access to medical care in the private sector when care was unavailable at a VA/VHA. While VA/VHA has submitted a draft proposal of the new Coordinated Access & Rewarding Experiences or C.A.R.E. program, Congress has yet to take any legislative action regarding the proposal. Meanwhile, VA/VHA medical facilities continue experiencing very strained relationships with non-VA/VHA providers who continue with aged account receivables dating back to 2016.

Recommendations

While writing this report, the legislative and executive branches of the United States government enacted The VA Mission Act. The new law consolidates the VA Choice Program with other VA programs that provide medical care to veterans outside of the VA's medical network. The Veterans Community Care Program is a one-year extension of the Choice Program and provides an additional \$5.2 billion to pay for care in the community.

4. Front-desk staff/receptionists/staff at informational desks not trained to identify veterans with mental health issues.

Veterans who attended the town hall meeting and a member of the American Legion Department of North Carolina noticed that staff in reception areas at the hospital did not appear knowledgeable about recognizing veterans with suicide ideation. However, the director noted staff attends VA/VHA mandatory training on suicide but suggested more training on identifying patients with suicide ideation might prove beneficial.

Recommendation

- The American Legion recommends VA regular employees and volunteers who staff hospital information and clinic reception desks not only attend mandatory VA/VHA training on suicide but also on identifying patients with suicide ideation at the point of care.
 - » While The American Legion does not endorse any public organization or private company, we recognize The Joint

Commission offers resources including a web-based training program and infographic that offers staff in Acute Care and Non-Acute Care settings additional means of detecting suicide ideation. One can find the link to that training and resources on The Joint Commission's website. The title of the module is "Sentinel Event Alert #56: Detecting and treating suicide ideation in all settings."¹⁵

5. DVAHCS sends veterans who become victims of sexual assault to Duke University Medical Center.

Some state laws dictate the practice of transferring victims of sexual assault, including veterans, to hospitals or clinics trained to collect forensic evidence.

Recommendations

- If emergency personnel brings a veteran of sexual assault to DVAHCS or the veteran self-presents, The American Legion recommends the medical center designate either a nurse or licensed clinical social worker to accompany the veteran to the Duke University Medical Center.
- If the veteran requests it, The American Legion recommends the hospital's designee stay with the veteran until released or the veteran indicates a preference for receiving medical treatment at DVAHCS at the conclusion of processes at Duke University Medical Center.

6. Mental Health Access Center Requests for Clinical Pharmacists

The previous secretary of the Department of Veterans Affairs made suicide prevention and access to mental health services among his top priorities. Additionally, the former secretary also championed evidenced – based services such as Cognitive Behavioral Therapy. However, VA/VHA use of clinical pharmacists is not widespread despite evidence suggesting these professionals have added tremendous value to the delivery of health care and improving access at VA/VHA facilities in Madison, Wisconsin, El Paso, Texas, and Kansas City, Missouri.¹⁶

Recommendations

- The American Legion recommends hiring clinical pharmacists for the Mental Health Access Center at DVAHCS.
- The American Legion recommends VA/VHA use the "Hire Fast, Hire Right" model to identify, recruit, and quickly onboard clinical pharmacists specifically for the Mental Health.
 - » NOTE: If evidence-based practices, positive patient outcomes, and access remain priorities of VA/VHA, clinical psychiatrists will prove a valuable addition to the team of mental health professionals and can serve as "the primary source of scientifically valid information on the safe, appropriate, and cost-effective use of medications."¹⁷



Conclusion

Observations

The System Worth Saving team observed during the visit to the Durham Veteran Affairs Health Care System that Quality of Care is improving as evidenced by steps DVAHCS has taken to reduce hospital-acquired infections and adverse medical events (Real-time Location System), and the deployment of a Stroke Tracking Model. While the medical facility's mortality rates are low, one must approach in-hospital mortality rates with caution when using that as a measure of the quality of care because of the variability of Length of Stay (LOS) across VISNs and complexity of illness.

Likewise, Performance Measures have improved since 2012, but the SWS team is confident the medical center's performance will improve even more under the current leadership and increasing tenures of Mr. Paul Crews and Dr. Christine Emler.

Nevertheless, Avoidable Adverse Events, hospital efficiency, and Patient Experience create some concern. The SWS team notes the differences between Patient Satisfaction and Patient Experience. The purpose of this visit was to assess Patient Satisfaction. Yet, high ratings in Patient Satisfaction might indicate patients believe medical care is adequate not necessarily of high quality.

Patient Experience, which DVAHCS measures, is a better tool for measurement because most questionnaires about patient experience avoid value judgments. Patient Experience is often a reflection of Employee Engagement, and it is in that area DVAHCS ranks very high. Nevertheless, DVAHCS has room for improvement in actual Patient Experience ratings, and The American Legion will monitor Patient Experience scores through regular contacts with the medical facility's Director of Customer Service, Mr. Alwood Mangum. Mr. Mangum had a previous engagement the day of the visit.

As mentioned previously, overall patient access is an issue. The lack of space is a confounding variable competing with staffing and efficiency. The American Legion will also continue monitoring veterans' access to mental health services. DVAHCS acknowledged excellent strides in treatment practices but access remains stagnant.

DVAHCS enjoys a wide array of Best Practices in medical research, neurosurgery, and Pastoral Care. The SWS team met with the chaplain. He expressed enormous satisfaction with how Pastoral Care integrated the component in treating patients and achieving positive patient outcomes in both physical and mental health. DVAHCS has a Clinical Pastoral Training Program that annually attracts more than 20 advanced degree divinity students. Unfortunately, funding is always short for the program as well as for staffing the Pastoral Care unit.

Overall, The American Legion feels that DVAHCS is trending toward very positive performance outcomes given the interactions we had with nurses, physicians, and administrative support staff. We also reviewed data given to us by the DVAHCS to make conclusions and summations. However, we will follow up in six months to see if DVAHCS continues its positive trends despite current challenges.

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