Mismanagement at the VA: Where’s the Problem?

At the time I retired from my last Veterans Administration (VA) position there was an ongoing investigation into alleged mismanagement of non-VA fee care funds at this hospital. The VA Office of Inspector General (VAOIG) report of this investigation was released on November 8, 2011 (1). The VAOIG report is reflective of a wide-ranging problem of administrators making what are fundamentally clinical decisions and not allowing clinicians to determine the best allocation of resources - issues that are not unique to the VA.

The VAOIG’s report substantiated that the hospital experienced a budget shortfall of $11.4 million in 2010, 20 percent of the 2010 Non-VA Fee Care Program funds. According to the VAOIG report highlights, “The shortfall occurred because the hospital lacked effective pre-authorization procedures for Long Term Acute Hospital fee care. Additionally, staff did not monitor inpatient fee care patients to determine if the patients could receive services in a VA facility”. As someone who spent about 1 week a month in the intensive care unit and cared for several of the patients who ultimately were transferred to receive long term acute hospital fee care, these recommendations seem inconsistent with the facts.

The purpose of the Non-VA Fee Care Program is to assist Veterans who cannot easily receive care at a VA medical facility. This program pays the medical care costs of patients to non-VA providers when the VA is unable to provide specific treatments or provide treatment economically. To initiate non-VA care, clinicians sent a consult form to a physician designated by the chief of staff for review. Almost all of the fee care claims were approved. The single, approving physician received hundreds of requests per week and lacked both the expertise and time to perform a detailed review of the requests.

Among the problems singled out by the VAOIG’s report was the use of long term acute care for the purposes of ventilator weaning. The report suggests that there was no determination of whether the VA could provide these services. To my knowledge there was no VA facility that provided long term ventilator care within 100 miles of the hospital.

It is known that predicting the ability to wean a patient from long-term mechanical ventilation is imprecise (2). According to the VAOIG’s report “…30 days was a reasonable limit to attempt ventilator weaning. if the veteran had not weaned in that time, then the [hospital] needed to re-evaluate the appropriateness of continued weaning and consider alternative medical options.” Thirty days is considerably shorter than the 3 months recommended by a collective task force from the American College of Chest Physicians; the American Association for Respiratory Care; and the American College of Critical Care Medicine (2).

The VAOIG report estimated that overspending on long term acute care resulted in $4.5 million of the nearly 12 million dollar in over spending. Although it is not clear how this figure was calculated, it is almost certainly an over estimate of the potential cost savings since these patients require care whether in an acute care...
facility for weaning or a long-term care facility and is based on a 30 day period rather than a 90 day period of weaning

Later in the VAOIG report two additional problems are identified which more likely explain the overspending: inadequate budgeting and inadequate accounting. Not knowing how much is being spent from an inadequate budget is a problem, but there is also another, more fundamental problem not identified in the VAOIG’s report. Why was there no VA acute care or long term facility available to care for these patients? There is certainly sufficient medical expertise within the VA to perform these services. It seems likely that a comparatively small investment in an appropriate facility could have resulted in considerable savings.

There is no convincing evidence presented in the VAOIG’s report that the non-VA services requested were inappropriate. Yet, the VAOIG’s report suggests replacing the lone, over-worked, part-time clinician with inadequate expertise with a full-time person or committee. These approving official(s) will probably also lack the expertise necessary to make these clinical decisions and do little more than harass clinicians for paperwork and documentation while inadequately reviewing the charts and avoiding responsibility for any decisions.

In response to the discovery of the shortfall, the hospital initiated several interim approaches to save money including a hiring freeze. This seems reasonable, but in the middle of the hiring freeze, administration did hire an assistant director into a newly created position. However, clinical personnel who had left or retired were not replaced. Second, the chief of staff who oversaw this shortfall placed a measure on the clinicians’ performance plan that non-VA fee basis spending be reduced compared to the previous year. Yet, according to the VAOIG’s report, the problem appeared to be inadequate budgeting and accounting rather than overspending. Not surprisingly, morale suffered and was reflected in an employee survey which ranked in the bottom 10% of the VA in 5 of the 6 categories surveyed. In order to improve these scores, the chief of staff charged the chiefs of each service with improving morale when the problem appeared to lie a little closer to home. Lastly, the hospital determined that chronic ventilator patients be held in the ICU in order to save non-VA fee expenses. The cost of this decision is that when the ICU is full, that VA patients needing ICU care are transferred to another hospital, a cost paid by the VA. Whether this administrative decision will save money is unknown.

This VAOIG’s report fails to emphasize the major problems, i.e., failure of the administration to work with the clinicians, inadequate budgeting and inadequate accounting. Rather than suggesting reasonable solutions, the VAOIG’s report rewards these administrative blunders by offering increasing administrative control over clinicians and apparently increasing administrative personnel as solutions. These recommendations do nothing other than waste resources which could be used for care of Veteran patients.
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References
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Editor’s note: Since this budget shortfall came to light, the hospital director retired for medical reasons; the chief of staff was transferred to another VISN as VISN chief medical officer; and the associate director has left the hospital.

The opinions expressed in this editorial are the opinions of the author and not necessarily the opinions of the Southwest Journal of Pulmonary and Critical Care or the Arizona Thoracic Society.