Senate Committee Looks at VA-IHS Collaborations

Both the VA and the IHS should be doing more to improve health care for American Indian and Alaska Native (AI/AN) veterans, according to several speakers at the Senate VA Committee's November 4 hearing on collaborations between the agencies.

The hearing included testimony from James R. Floyd, director of the VA's VISN 15 (a region that encompasses Kansas, Missouri, and part of southwestern Illinois); Randy E. Grinnell, deputy director of the IHS; S. Kevin Howlett, head of the Confederated Salish and Kootenai Tribal Health Department; and Andy Joseph, the Portland area representative for the advocacy organization National Indian Health Board. While Floyd and Grinnell described their agencies' collaborative efforts, Howlett, Joseph, and several senators were critical of these efforts or made suggestions for improving them.

Committee chairman Sen. Daniel K. Akaka (D-HI) opened the hearing by noting that, while many AI/AN veterans are eligible for both VA and IHS health care, they "report unmet health care needs at four times the rate of other veterans." He added that he looked forward to hearing testimony on the progress of the two agencies toward the five mutual health care goals they agreed to in a 2003 memorandum of understanding (MOU): (1) improving access to quality of care, (2) improving communication, (3) encouraging the development of partnerships and sharing agreements, (4) ensuring the availability of appropriate resources, and (5) improving health-promotion and disease-prevention services.

The agencies' progress on these goals was a point of contention between some speakers. Sen. John Tester (D-MT) complained that there are no reliable data on such progress. Howlett said that the MOU currently "represents more symbolism than action," and he suggested that the IHS and the VA establish an internal and external work group for creating a strategy to implement it. Floyd said that the VA and the IHS assess the progress of their collaborations through a spreadsheet and ongoing conference calls. Both he and Grinnell declined Tesler's request that they grade their agencies' efforts, however.

Some speakers discussed the coordination of care for patients being treated by both the VA and the IHS. Tesler said that some AI/AN veterans have presented to IHS facilities "only to be told to go to a VA hospital hundreds of miles away." Similarly, Joseph said that some native veterans have had to take the same tests at both VA and IHS facilities and to communicate their own diagnosis and treatment information between the two agencies. Floyd said that some VA facilities within his network are working to improve care coordination, however, by sharing providers and medical records.

Outreach to AI/AN veterans who qualify for VA services was a frequent topic at the hearing. Several speakers mentioned the Tribal Veteran Representative program, through which volunteer members of Indian tribes are trained to help other tribe members obtain VA benefits and services. In addition, Floyd said that when he was director of the VA Salt Lake City Health Care System in Salt Lake City, UT, the facility worked with the IHS to identify and reach out to veterans who were enrolled in the IHS but not in the VA. When Sen. Richard Burr (R-NC) asked why the VA doesn't import "all the folks who qualify for VA services that may not be enrolled" into its system, Floyd replied that the proposed Virtual Electronic Record, which would transmit information from the DoD to the VA, could help in that regard.

Howlett recommended giving the VA the ability to purchase health care for veterans through contracts with tribal clinics. Such an arrangement, he said, would help tribes that "rely heavily upon third-party collections to support clinic operations." Tester added that this would be a practical way of treating AI/AN veterans in geographically isolated areas. When Sen. Mark Begich (D-AK) asked why the IHS can bill Medicare and Medicaid but not the VA, Floyd offered to answer the question as a follow-up to the hearing.

Multiple speakers described underfunding of the IHS as a barrier to health care for AI/AN veterans. Joseph said that more funding is the "first and obvious answer" to addressing such veterans' health needs, and he suggested that the VA help to fund the IHS. Grinnell noted that the IHS's proposed fiscal year 2010 budget is 13% higher than its FY 2009 budget, and he said that some of the extra funding will be targeted toward telemedicine partnerships with the VHA.

Floyd and Grinnell also described several other VA/IHS collaborations throughout the hearing. Grinnell said that the IHS is now using the VHA's VistA Imaging System at over 45 of its own sites and that an upcoming pilot program will process IHS outpatient prescriptions through the VHA's Consolidated Mail Outpatient

Program. Floyd said the VA is currently providing seven telehealth programs—most of which focus on mental health or diabetes—to tribal communities and has nine such programs in development. He also noted that the IHS has helped to train VA providers in preventive practices for diabetes and hypertension.

VA's OIG Finds Ongoing Problems at Marion Facility

About 21 months after the VA's Office of the Inspector General (OIG) reported on extensive problems with the Marion VA Medical Center (MVAMC) in Marion, IL, a new OIG report found that many of these problems remain.

The new report, published on November 2, was based on an assessment of the MVAMC conducted from August 17 to August 21, 2009. It said that the OIG reviewed five operational activities at the facility—quality management (QM), physician credentialing and privileging, environment of care, medication management, and coordination of care—and found shortcomings in all but the last one. The report included 10 recommendations for improvement, as well as a memorandum from Warren E. Hill, then the facility's interim director, in which he concurred with the report's findings and offered action plans for implementing its recommendations. Hill said that most of the areas for improvement identified by the OIG already had been identified by the facility's management and that the facility was taking action accordingly.

James R. Floyd, director of VISN 15, said on the day of the report's release that eight of its 10 recommendations already had been implemented and that the other two would be implemented within the next two weeks. Floyd added that Hill, whose performance he praised, had taken a new position and that retired VA employee James Roseborough would serve as the facility's acting director during a year-long search for a permanent replacement. Also on November 2, Sen. Dick Durbin (D-IL), Sen. Roland Burris (D-IL), Rep. Jerry Costello (D-IL), and Rep. John Shimkus (R-IL) called the OIG's findings "appalling" and "inexcusable" in a letter to VA Secretary Eric K. Shinseki. Shinseki met on November 4 with these representatives, as well as with Rep. Debbie Halvorson (D-IL) and Illinois Governor Pat Quinn, and said that a high-level quality management team would visit the facility, perform an assessment, and issue a report in about six weeks.

The OIG report called the MVAMC's QM oversight and reporting structure "fragmented and inconsistent." QM staff failed to screen for deaths within the required 30 days of surgical procedures, it said, and these staff documented different numbers of deaths for the month of April 2009 on different forms. The office added that QM staff failed to determine whether the deaths of three patients with infections were related to the infections and whether the infections represented a pattern or cluster.

The OIG said that two providers at the MVAMC performed procedures—an arthroscopy and a conscious sedation—for which they did not have privileges. It found that 20 (87%) of 23 physicians at the facility had "insufficient proctoring or monitoring information to confirm privilege-specific competency," that seven (12%) of the facility's 58 environmental management service employees did not receive required training on cleaning and disinfection procedures, and that 17 (29%) of these employees did not receive required annual training on bloodborne pathogens. The office said that the MVAMC violated VHA infection control policy by having a patient with an order for contact precautions and a history of methicillin-resistant *Staphylococcus aureus* infection share a bathroom with two other patients who did not require contact precautions. It also found that the facility violated certain National Fire Protection Association standards.

Concerns about the MVAMC first arose in 2007, when the VHA's National Surgical Quality Improvement Program (NSQIP) found that the facility's patient mortality rate was over four times the expected rate during the first two quarters of fiscal year 2007. The NSQIP visited the facility in August 2007 and identified a number of problems, which led to the suspension of inpatient surgery at the facility, the placement of some facility staff on administrative leave, and an OIG review of the facility's surgery service.

The OIG reported on January 28, 2008 that the facility had an ineffective QM program and deficiencies in the credentialing and privileging of physicians. On the same day, the VA announced that a separate, internal review by its medical inspector had identified nine deaths directly attributable to substandard care at the facility in fiscal years 2006 and 2007. The inspector also found 34 cases in which the facility's care complicated patients' health—including 10 cases in which patients died, although the inspector could not determine whether the facility's care caused these deaths. The VA assessments led to the removal of the facility's director, chief of staff, chief of surgery, and anesthesiologist. ●