



## **MINNEAPOLIS VETERANS AFFAIRS HEALTH CARE SYSTEM (MNVAHCS) | MINNEAPOLIS, MN**

**Date:** August 6-8, 2018

**Chairman of the Veterans Affairs & Rehabilitation Commission:** Ralph Bozella (ex-officio)

**Veterans Affairs & Rehabilitation Commission:** David Rehbein, Past National Commander

**Veterans Affairs & Rehabilitation Commission, National Staff:** Edwin D. Thomas

### **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." 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 American Legion conducted its System Worth Saving visit at the Minneapolis Health Care System (MNVAHCS) to assess the medical center's scheduling operations. The American Legion scheduled the visit after the Veterans Affairs Office of the Inspector General (VAOIG) released a report on July 17, 2017 in response to complaints from veterans. The complainants alleged that MNVAHCS had scheduling and quality challenges that negatively affected veterans.

However, patient-wait times did not surface as a problem during the visit because the MNVAHCS had completed a series of process improvement initiatives that significantly reduced patient-wait times. New patients seeking appointments with a primary care physician have a wait time of only 17 days while established patients wait only four days. New patients who seek mental

health services experience a six-day waiting period while established mental health patients only wait one day. MNVAHCS serves 103,000 Unique Veterans. The medical center also employs more than 1,000 veterans.

### **Scope**

The American Legion conducted a review of MNVAHCS data related to scheduling and clinical operations in addition to on-site assessments and observations. The American Legion limited its assessment to data provided by MNVAHCS and observations at the Minneapolis campus. Moreover, the System Worth Saving team conducted structured and unstructured interviews with the medical center's executive and departmental staff about general business operations, clinical management, and patient access.

MNVAHCS provided data through The American Legion's Mail-Out Questionnaire (MOQ). The SWS team also used the internally developed In-Facility Questionnaire as its primary tool for the on-site, structured interviews. The SWS team did not visit any of the Community-based Outpatient Clinics. Furthermore, the SWS team did not knowingly review or request patient or operational data from or about any CBOC. Yet, data are included in medical center's report on mental health outpatient visits.

### **Overview of the Minneapolis VA Health Care System**

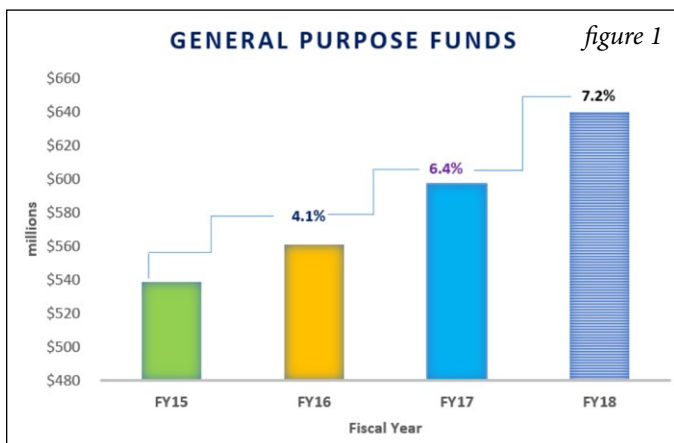
The Minneapolis Veterans Affairs Health Care System serves 103,000 unique veterans. As a 229-bed, accredited teaching and research hospital, Minneapolis VA Health Care System also serves as the system's headquarters. MNVAHCS includes 44 community-based outpatient clinics in Minnesota and Wisconsin providing access to care for nearly 60,000 rural and highly rural veterans.

MNVAHCS has a catchment area with 134,454 enrolled veterans. In 2017, the medical system had 931,000 outpatient visits that included more than 153,000 mental health outpatient visits. The medical center's average length of stay reached 21 days for the facility. To meet the demands of providing health services to veterans, the facility employs 317 physicians, 42 psychiatrists, 1,416 registered and licensed practical nurses, and 83 Advanced



Practice Registered Nurses or APRNs.

Executive and departmental leaders manage a general-purpose budget of \$640,434,0001 (FY 2018) (Figure 1). Typically, VA medical centers struggle with not having enough in their budgets to operate efficiently or provide access to certain specialty care. Budget challenges did not emerge during conversations with either the executive leadership team or department managers. The executive leadership team and departmental leaders must manage the budget to meet the needs of veterans, 3,700 employees, and infrastructure support for 1,300 volunteers.



MNVAHCS also provided a breakout of its operating and specific – purpose funds for FY 2018:

- Medical Services: \$680,245,158
- Medical Support and Compliance \$46,269,811
- Medical Facilities \$41,609,789
- Medical Community Care and Choice \$156,225,584
- Medical Care Collection Funds \$47,444,085

## Town Hall Meeting

The American Legion held the town hall meeting at American Legion Post 435 in Richfield, Minnesota, a suburb a little over eight miles from Minneapolis. The Commander of Post 435, Mark Barthel, and staff acted as hosts. Approximately 35 persons attended the meeting including the MNVAHCS's interim director and Chief Experience Officer (CXO). Local media and congressional staff from the office on behalf of U.S. Representative Tim Walz also attended the town hall meeting.

As expected, veterans expressed a variety of challenges, personal experiences, and recommendations for improvement at the medical center. Veterans asked questions about hospital and outpatient clinic operations. One of the most poignant themes throughout the town hall meeting was the scarcity of communi-

cation between the medical center and veterans.

To illustrate challenges involving communication, one veteran complained about the high cost of quality dental care for veterans. He told the audience about the need for better dental health offered by the Department of Veteran Affairs is just as important as physical health. The veteran expressed the desire for access to lower cost but quality dental care at a VA medical center. Jeremy Wolfsteller spoke about a newly developed dental insurance program for veterans not in VA Groups 1-5.

Delta Dental, Incorporated and MetLife Insurance administer this new benefit for eligible veterans in VA Groups 6-8. However, veterans who attended the town hall meeting, particularly the veteran who first complained about the cost of dental care, did not know about the dental insurance program. The interim director of the Minneapolis VAMC spoke briefly about the program. He mentioned how it exemplifies the need to improve communication between the VA and veterans especially when it comes to new benefits.

Other discussions included issues around privatization of the Veterans Health Administration and The American Legion's opposition to any attempts to move in that direction. The town hall meeting also gave veterans an opportunity to discuss the need to find a simpler way for caregivers to get medications for veterans. According to one veteran, caregivers have a difficult time getting medications because of privacy and other reasons.

## Executive Briefings

### Summary

The System Worth Saving team consisted of National Executive Committee Member and Past National Commander David Rehbein, and Edwin Thomas, Assistant Director, Health Policy from The American Legion's National Headquarters in Washington, D.C. The SWS team conducted structured (planned questions) and unstructured (unplanned or unscripted questions) 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, and Public Affairs.

Beyond questions and discussions about "Best Practices" and "Challenges", 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" often overlapped. The report reflects those overlapping comments as common themes under various categories in the sections titled



“Best Practices” and “Challenges.”

## Best Practices

1. **Behavioral Recovery Outreach Team (BROT):** The Minneapolis VA Health Care System offers BROT, which provides a continuum of care for veterans with distressed behavioral challenges due to neurocognitive disorders. The program strives to develop a comprehensive behavioral management program throughout MNVAHCS. Moreover, the program will eventually become a model for implementing a higher standard of care in the behavioral health sector.

Gary Goldish, M.D. developed the concept, program model, and oversight after noting that veterans with neurocognitive disorders did not have a comprehensive, interdisciplinary evaluation and complementary behavioral stabilization when transitioning to community placements. The program is the only one of its kind in the Minneapolis-St. Paul area.

2. **Strategic Position of the Chief Experience Officer:** Patient experience is a relatively new concept to most VA medical centers. Yet, MNVAHCS is creating an effective model that should prove replicable across the Veteran Integrated Services Networks or VISNs. Their first step was making the patient experience an executive level position. The Chief Experience Officer reports primarily to the director of the hospital. While most VAMCs have made the patient experience position a mid-level management role reporting to an associate director, the director of the MNVAHCS envisioned the value of having the position report directly to him because that would give insight into what the ELT must do to improve patient experience and satisfaction. Based on what the SWS team observed and heard from veterans at the town hall meeting and in the halls of the medical center, the director’s vision is paying great dividends. Caregivers, veterans, patients, and volunteers praised the quality of care, the professionalism of the staff, and cleanliness of the facility. Of course, it helps to have someone like Martina Malek, CXO, who demonstrates empathy, vision, and leadership, three personal qualities needed for success in the role.

3. **Quality:** The Minneapolis VA Health Care System has earned the coveted five-star rating six consecutive years. MNVAHCS is among only 19 other medical centers out of the 146 hospitals in VISNs across the country that have earned the award for six consecutive years. The Department of Veteran Affairs designed the rating system to compare 28 quality measures between hospitals. However, to achieve the rating for six consecutive years provides a testament to the medical center’s leadership and commitment to quality medical care for the nation’s veterans.

4. **Minneapolis Adaptive Design and Engineering (M.A.D.E.):**

The Minneapolis Adaptive Design and Engineering is a unique program. The program combines clinical and engineering disciplines to improve the lives of veterans with physical challenges. M.A.D.E. is a very innovative program and the first of its kind in the Veteran Health Administration’s health care delivery system.

The 12-person M.A.D.E. team consists of engineers, research scientists, physiologists, and medical doctors who work to resolve the challenges veterans face in their daily living environment. For example, the M.A.D.E. team is currently “developing new eye-tracking systems and algorithms that can be used to study how people visually interact with assistive technologies and with their environment. The team is also working to improve augmentative and assistive communication devices for patients with amyotrophic lateral sclerosis” ([www.minneapolis.va.gov/services/made/research.asp](http://www.minneapolis.va.gov/services/made/research.asp)).

## Challenges

1. **Recruitment/Non-compete Contract Clauses:** Staff indicated one of their immediate challenges is non-compete clauses used by local health care employers. The non-compete clauses in contracts prevent local physicians from seeking employment with other employers for up to two years in some instances. Minnesota strictly enforces physician non-compete contracts compelling many physicians to forgo employment opportunities with other local health care organizations. The recruitment challenge primarily affects Community-Based Outpatient Clinics or CBOCs in rural and highly rural areas.

The non-compete clauses create enough psychological dissonance in physicians that they often avoid employment opportunities even when potential gaining employers agree to indemnify against lawsuits from previous employers. Non-compete laws exist in every state as a form of protection for employers. However, many states do not enforce such contracts except in the most egregious cases. Yet, non-compete clauses exacerbate the growing shortage of qualified medical professionals. While Minnesota laws do not prohibit the use of non-compete contracts, the American Medical Association discourages their use by employers because of those shortages.

MNVAHCS also faces the same challenge as other VA medical centers – recruiting staff under three different personnel systems, Title 38, Title 38 Hybrid, and Title 5. Each system has its own requirements that either extends the onboarding timeline or causes prospective candidates to forgo consideration.

2. **Retention – Personnel Turnover due to entry-level GS levels**



**positions:** New employees who qualify for and accept jobs at GS Levels 1-5 often leave those positions after several months. Many candidates for employment apply for jobs just to get into the VA system but then several months later springboard into jobs commensurate with their educational backgrounds, experience and, most importantly, salary requirements. The constant turnover of low-grade level positions such as Medical Support Associates causes access, business continuity, and resource issues.

3. **Centralization of Key Business Operations:** Staff cited centralization of key business functions such as Information Technology, Contracting, and Purchasing and, potentially, Human Resources (new Manpower Office) as barriers to efficient operations especially since IT, patient engagement, patient satisfaction, team-based health care/Patient-Aligned Care Teams (PACTs), and the pending implementation of Cerner EHR at VA medical centers are interrelated. For instance, when MNVAHCS experiences problems with IT and computerized medical devices, it must rely on an often unresponsive or extremely slow IT unit due to the failure to properly prioritize work.

The Department of Veteran Affairs centralized several functional work units in 2008 after the agency made a determination that decentralized operations like IT drained hospital funding allocations. The agency subsequently centralized that function by putting it under the direction of the Chief Information Officer.

4. **Care in the Community:** The Executive Leadership Team expressed several issues with the Care in the Community program. The ELT noted the strained relationships with local health care providers because of the extremely slow payments made by third-party administrators. The ELT also spoke of the Mayo Clinic as a key, regional health care provider that refuses to participate in the program because of very low reimbursement.

## Recommendations

### 1. Recruitment/Non-compete Contract Clauses

The Minneapolis VA Healthcare System has found that many physicians do not want to work for the Veterans Health Administration because of their fear lawsuits by former employers for violation of a non-compete agreement. The employers' practices, real or perceived, often preclude the Minneapolis VA from recruiting unemployed physicians. Minnesota is one state that, according to the staff MNVAHCS, enforces non-compete contracts.

While states differ in their enforcement of laws, staff at the Atlanta, Georgia VAMC, on the other hand, say they actively

recruit physicians because many employers in that state assume the position that the facility does not compete with the VA in terms of market share or revenue. While there is no direct competition between the VA health facilities and private sector companies, competition for health care professionals exists. Nevertheless, many employers in Georgia elect not pursuing legal action if physicians seek employment with VA/VHA because of the federal government's "deep pockets."

**NOTE:** The American Legion is not offering legal advice, neither explicitly nor implicitly, with the following recommendations.

#### Recommendations

- The American Legion supports proposed legislation as written by the U.S. Senate, bill 3302, and U.S. House of Representatives, bill 5521. Section 7413 of S.3302-Effect of non-Department Covenants not to compete on Appointment of Physicians. The proposed legislation states that "in the case of an individual who is an applicant for appointment to a position as a physician in the Veterans Health Administration, any covenant not to compete into which the individual has entered with a non-Department facility or other non-Department entity or individual shall have no force or effect with respect to the appointment of the individual to such a position."
  - Therefore, we support and recommend the U.S. Congress pass "The VA Hiring Enhancement Act." If enacted, the legislation will enable the VA/VHA address the challenges when recruiting highly qualified physicians without trepidation of lawsuits.
2. **Retention – High personnel turnover rates due to entry-level pay on General Schedule (GS) scale for Medical Support Assistants (MSA)**

Chronic employee turnover at lower GS levels in critical positions such as Medical Support Assistants is a system-wide challenge for VA/VHA. The positions require persons with exceptionally developed skills in interpersonal relations, negotiations, verbal and written communications, keyboarding, computer navigation, and scheduling policies. Often MSA candidates become the first persons veterans come in contact with as they either seek access to health services or attempt to understand how to navigate through a labyrinth of scheduling options, policies, appointments, and even information.

The Office of Personnel Management or OPM assists government agencies with implementing personnel policies and setting federal pay grades and scales.<sup>2</sup> The Department of





Veteran Affairs typically needs approval when hiring a new employee at a higher pay grade than OPM assigns to the position. The VA hires MSAs at grade 5 or 6 (10 pay steps that represent about a 3% increase for each grade level) depending on the locale. The majority of MSAs begin their federal employment at GS 5 Step Level 1 that represents \$35,709.2

OPM allows federal agencies to “set the rate of basic pay of a newly-appointed employee at a rate above the minimum rate of the appropriate General Schedule (GS) grade based on the determination made by the agency on”2:

- a) The superior qualifications of the candidate; or
- b) A special need of the agency for the candidate’s services.
  - » While the federal government may have deep pockets to absorb waste, the constant turnover among MSAs does not come without costs even when the person uses the position as a springboard entry-level to a higher paying job within VA/VHA. VA /VHA is one of the largest federal employers in the United States. Yet, many of their human resources practices seem outdated and not competitive according to supervisors and even HR staff at VAMCs across the United States.
- Presently, OPM advertises “Basic Requirements” for MSA positions in accordance with VA Handbook 5005, part II, chapter 3, section A, paragraph 3j3as:
  - » English Language Proficiency: MSAs must be proficient in spoken and written English.
  - » Experience: Six months experience of clerical, office or other work that indicates the ability to acquire the particular knowledge and skills needed to perform the duties of the position; Education: One year above high school.
  - » Experience/Education Combination: Equivalent combination of experience and education are qualifying for entry level for which both education and experience are acceptable.
- Grade Determinations: The following criteria must be met when determining the grade of candidates:

- » Creditable Experience: Knowledge of Current MSA Practices: To be creditable, the experience must have demonstrated the knowledge, skills, and abilities (KSAs) associated with current MSA responsibilities. Experience satisfying this requirement may be paid/non-paid employment as a [sic] MSA.
  - » Quality of Experience: Qualifying experience must be at a level comparable to MSA experience at the next lower grade level. For all assignments above the full performance level, the higher level duties must consist of significant scope, administrative independence, complexity (difficulty) and range of variety as described in this standard at the specified grade level and be performed by the incumbent at least 25% of the time.
  - » Part-Time Experience: Part-time experience as a MSA is creditable according to its relationship to the full-time workweek. For example, a MSA employed 20 hours a week, or on a 1/2-time basis, would receive 1 full-time work week of credit for each 2 weeks of service.
- GS-5 MSA (Full Performance Level) - Experience or Education. One year of experience equivalent to the next lower grade level, GS4, or 4 years of education above high school.

#### *Recommendations*

- The American Legion recommends the Office of Personnel Management restructure the position of Medical Support Assistant from a “clerical” position to one that emphasizes “Patient Engagement Specialist/Customer Service” and the relevant skills and education needed for success in the role.
- The American Legion recommends the Department of Veterans Affairs and the Office of Personnel Management consider, in addition to restructuring, develop a career ladder for MSA by changing the title of the position that would increase recruitment of qualified candidates and retain them for more than one year in the position. The following graphic offers a depiction of what a career ladder should or could resemble if the Department of Veteran Affairs and the Office of Personnel Management adopted the recommendation:



#### **Patient Engagement Analyst**

- Entry-level Grade at the lowest Step
- For candidates with very general clerical experience
- High School/GED

#### **Patient Engagement Specialist**

- Position at Grade 5 /Step 4
- 1 year of customer service experience
- High School Diploma / GED and Associate Degree

#### **Senior Patient Engagement Specialist Analyst**

- Position at Grade 6 /Step 6
- Candidates with 2+ years of customer service and team leader experience
- Bachelor's Degree +

### **Increasingly more complex assignments, job duties, and responsibilities**

- The American Legion recommends that OPM write clear and unambiguous job descriptions regarding the MSA position so that applicants/candidates and, most importantly, hiring managers have a clearer focus of the ideal candidate.

#### **3. Centralization of Human Resources (HR) Operations**

The Minneapolis VA Health Care System and other medical systems within the VA/VHA healthcare delivery system repeatedly mentioned plans by the VA Central Office or VACO to centralize HR operations. While the VA centralized its Information Technology functions and operations with some cost-savings, the agency lost any gains as the added bureaucracy and logistical requirement to repair on site actually added costs. Moreover, hospitals experienced other problems typically associated with the loss of decision-making authority.

##### *Recommendation*

- The American Legion recommends the Department of Veteran Affairs, in harmony with Resolution Number 44 - Decentralization of Department of Veterans Affairs Programs<sup>4</sup> – maintain Human Resources as decentralized functions and operations. Human Resources requires recruiting, selection, and decision-making, at the local level. The American Legion believes that centralized operations create more problems for individual hospitals and, ultimately, veterans than decentralized functions. The American Legion believes decision-making authority for personnel selections should remain with local managers accountable for performance.

#### **4. Care in the Community**

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 submit-

ted a draft proposal of the new Coordinated Access & Rewarding Experiences or C.A.R.E. program. Meanwhile, VA/VHA medical facilities continue experiencing very strained relationships with non-VA/VHA providers with aged account receivables dating back to 2016.

##### *Recommendations*

- The legislative and executive branches of the United States government enacted The Veterans Affairs Mission Act of 2018.<sup>5</sup> 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. Therefore, The American Legion recommends the Minneapolis VA Health Care System await final rulemaking and implementation of the new law. We all remain hopeful the new law will correct the challenges of the old Veterans' Choice Program.

#### **Conclusion**

##### **Observations**

The American Legion believes the Minneapolis VA Health Care System is a well-managed delivery system. Of course, no health care system, public or private, is completely free of challenges. Yet, the health care is so dynamic that today's insignificant patient and operational challenges can become tomorrow's most threatening ones.

While the SWS team has outlined challenges that repeatedly emerged during sessions with the Executive Leadership Team and department managers, the SWS team noted other challenges that did not surface as themes:

- Administrative problems throughout the hospital drive the vast majority of the complaints from patients. This is due to IT centralization at VACO in Washington, D.C.
- Increasing veteran population with physical ailments and de-



mentia due to age.

- Insufficient mental health facilities equipped to manage patients who demonstrate combative behaviors.
- Outdated accounting systems exacerbated by non-standardized procedures that are very slow.
- Space at the facility is very limited. While this challenge appeared three times, the SWS team felt the Mission Act of 2018 appropriately addresses the problem.
- Consolidated call center has created problems with hiring as the OPM downgraded positions from GS – 6 to GS – 5 without any concrete rationale.
- Complex personnel system makes it difficult to recruit top-grade staff for positions at the hospital because of the different requirements under each authority (authority means laws and policies that regulate the processes).

The SWS team ended the site visit with an Exit briefing with the Executive Leadership Team. Every member of the ELT and department managers attended. The briefing culminated with tentative recommendations based on observations, structured interviews, and clarifications about a segment of an interview that needed additional explanations.

## Endnotes

1. The SWS team requests data from every hospital it visits. MNVAHCS supplied The American Legion with data regarding certain aspects of their operations in compliance with laws and VA policies.
2. [www.opm.gov](http://www.opm.gov) is the web site for the Office of Personnel Management. The pay scales used in this report reflected the 2018 Local GS rates for the Minneapolis Veterans Affairs Health Care System.
3. *VA Handbook 5005, part II, chapter 3, section A, paragraph 3j* is the handbook that provides guidance for staffing operations at VA/VHA facilities.
4. Resolution Number 44 - *Decentralization of Department of Veterans Affairs Programs* can be found on The American Legion's web site [www.legion.org](http://www.legion.org)
5. The Veterans Affairs Mission Act of 2018 became law in June 2018. The new laws have sweeping changes designed to improve access to health care within and outside the VA system, streamline VA operations, assess space requirements, and improve the VA's recruitment of health care professionals.