VA Affiliations with Medical Schools Under Health Care Reform
by Elizabeth M. Short, M.D.

The Veterans Health Administration (VHA) will be restructured radically in the coming years as part of the overall realignment of American medical care prompted by health reform. While this restructuring will certainly alter VHA’s affiliations, many of the changes may actually improve, enhance or even expand the historic partnerships between academic medicine and veterans’ health care.

Health Reform and Veterans’ Health Care
Under President Clinton’s Health Security Act, VA would participate as an accountable health plan in each state, offering veteran enrollees and their families a basic benefits package. All 27 million veterans would be eligible to enroll in VA plans. These health plans would act as insurers by enrolling all veterans. Care would be provided by VA facilities and through contractual arrangements with community facilities, academic medical centers and others, as needed. VA provider facilities would function as HMOs, using the principles of managed primary care to provide the benefits package services through cost-effective continuity of care.

Impact on VA Affiliations
While there is no plan to change the affiliations per se, fundamental changes in VHA’s approach to health care delivery would profoundly affect its affiliate medical schools. As the enrolled population in each veterans’ service area is defined under health care reform, reconfiguration of VA’s health care delivery may be necessary. Downsizing or expanding may be required to accommodate its newly enrolled population. Some tertiary care facilities may move, merge, or even close in locations where VA is overbedded or loses patients to other health plans. By the same token, such changes may entail contracting with affiliates to share and coordinate tertiary capability, while expanding primary care capabilities and the distribution of primary care sites. In other cases, tertiary care capability might be expanded into more isolated settings.

The economic, social and legislative pressures driving these changes in the configuration of VA health care delivery, are also being experienced by our affiliated academic medical centers. Some academic centers may undergo even more profound changes than VA. Ideally, with joint strategic planning between each VA provider organization and its affiliate, coordinated changes in health care delivery can enhance both institutions, helping...continued on page 2
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each to minimize the anticipated disruption of income and teaching sites, while jointly providing access to the large populations of enrollees needed to support medical education and research.

VA is committed to continue its missions of research and education and to support these missions, through appropriated or national set-aside funds, so that medical care costs can be accurately determined and tailored to an increasingly cost-competitive environment.

Manpower Implications for Affiliates

Two areas of manpower are critical in the relationship between a medical school and a VA medical center, faculty and residents. Under health reform, VA will strive wherever possible to maintain its current faculty and use them productively.

Assuming that VA can retain an enrolled patient population at least the size and case mix of the present one (three million veterans), there would be a roughly similar need for specialty care as currently exists.

There are, however, the caveats that all hospitals are facing downsizing and pressures to manage care with fewer referrals, procedures and bed days.

Clearly, VA will need more primary care physicians. With today's predominantly older male patient population, internal medicine is VA's primary care discipline. VA will be looking to its affiliate departments of medicine for help in recruiting new primary care faculty, providing faculty role models for students and residents seeking primary care careers, and acquiring academic legitimacy for general internists (e.g., opportunities for promotion, tenure and academic leadership positions).

Given the current configuration of its faculty, with 25 percent generalists and 75 percent specialists, and faced with the need to create HMO care immediately, VA is also exploring opportunities for physician retraining. Clearly, the need for retraining is an area for dialogue with affiliates' departments of medicine.

VA also relies heavily on residents for inpatient care. While this situation has been somewhat ameliorated by the Resident Work Limits Initiative, which has provided $220 million since 1992 to hire ancillary staff and improve supervision of residents, it will still be necessary for VA's long partnership with its affiliates is recognized and cherished, and VA looks forward to planning with its affiliates to support and enhance academic missions, as both VA and university health care systems change to accommodate the new realities.

VA to provide alternate staff to care for inpatients in keeping with the national mandates to move the training of students and residents to outpatient primary care teams.

In addition to a change of venue for training, which also means that faculty must be present in primary care sites, the manpower goals stated in the Clinton health plan would be met through reorganization of the entire U.S. graduate medical education (GME) program. VA, which funds 10 percent of all residents, would clearly be a player in reaching these goals. Whatever transpires, VA and its affiliates are equally concerned about and affected by shifts in the number and mix of residents in training.

Resources Needed Under Health Reform

With regard to resources needed for these academic endeavors, VA intends to continue to support research and education apart from patient care dollars. This will require continued Congressional appropriations for direct research, and indirect costs will still need to be paid by all granting agencies. Ultimately, VA-funded research support will be similar to that at the medical school.

VA will continue its appropriation for direct and indirect costs of medical resident training. Medicare and VA will continue to be the main federal sources of support for resident training. The Clinton health plan would create a fund comprised of a percentage of health alliance premiums to replace GME funds currently derived from patient care dollars.

In the case of VA, faculty salaries and the associated costs of resident education would continue to be met by appropriated dollars, fulfilling VA's federal mission of health professions education.

Conclusion

Under health care reform, VA has a major role to play as the nation's largest health care delivery system. The Veterans Health Administration intends to firmly support its three missions of patient care, education and research, shaping them so they will prosper in a newly configured VHA system. VA's long partnership with its affiliates is recognized and cherished, and VA looks forward to planning with its affiliates to support and enhance academic missions, as both VA and university health care systems change to accommodate the new realities.

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Response
by William T. Butler, M.D.
President and Chief Executive Officer
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Reform of the health care system is a major topic in medical institutions throughout the country. Administrators and physicians, both in the public and private sectors, are concerned about the impact President Clinton's health care reform proposal (HR 3600) would have on the way they practice medicine.

Dr. Short raises many excellent points about HR 3600 and its potential effect on VA medical centers. It is premature, however, to base any final plans on the assumption that the President's plan will receive Congressional approval as introduced. We already have seen changes in the bill, as the debate continues about the best way to achieve health care reform.

I was pleased to note that Dr. Short supports joint strategic planning between medical schools and VA medical centers. It is imperative that we plan the future together and build on the affiliations already in place. History has shown that the relationship benefits VA, the medical schools and, most importantly, the veterans who seek primary and specialized medical care.

HR 3600 places a strong emphasis on uniformly increasing the number of primary care physicians and reducing the number of specialty physicians. It does not, however, take into account the academic health centers' need to maintain a sufficient number of specialty physicians. These centers comprise only 6 percent of the nation's hospitals, yet provide for the majority of patients with trauma or AIDS and for those requiring kidney transplantation and cardiovascular surgery. It also was reassuring to learn that VA intends to continue to stress research. Medical advancements in several specialized areas can be traced back to the cooperative research and clinical care efforts of medical schools and VA hospitals.

Baylor College of Medicine and the Houston VA Medical Center have been affiliated since 1943. Researchers at both institutions have worked together during the past five decades to develop comprehensive treatment methods in a number of areas, including geriatrics, psychiatry, spinal cord injury and AIDS. Veterans and non-veterans alike have benefitted from these advances.

The demand for health care reform most certainly will result in changes for all medical institutions. Clearly, we must work together to make certain those changes are positive and do not destroy existing programs of excellence. Dr. Short suggests that reconfiguration of the VA system may result in the moving, merging or closing of tertiary care capability. Such changes would have profound secondary effects on graduate medical education. The closure of a hospital's cardiovascular surgery program, for example, would have a ripple effect on training programs in internal medicine, anesthesiology, pathology and so forth, and may jeopardize their accreditation.

Our common goal must be to continue to provide the highest standard of patient care, research and medical education. Any reform plan that forces VA medical centers to compromise medical care for the nation's veterans is unacceptable.

President's FY 95 Budget Proposes $41 Million Cut in VA Research

The President's budget for FY 1995 proposes a decrease of $41 million for the VA research budget, which includes medical, prosthetic and health services research. This cut would lower VA's research funding from $252 million in 1994 to $211 million in 1995. The proposed budget would provide $28 million for the Health Services Research and Development Service (HSR&D), a $3 million decrease from the previous year.
The VA health care system is the largest single provider of medical education in the United States. As the nation considers health reform, health care providers, including VA, must be able to demonstrate the costs of medical education and differentiate the patient care provided by residents from their training costs. VA provides an excellent laboratory for investigating medical education issues, particularly because VA is a diverse group of 171 medical centers with a central database that includes patient data input by physicians.

At the St. Louis VAMC, a field station of the Great Lakes Region HSR&D Field Program, interest in these issues has generated several research projects supported by the HSR&D Service. A current study on the Effect of Medical Education on Costs and Productivity in VAMCs, which is the focus of this article, examines the effect of medical education on VAMC profit or loss, on productivity and on costs at the facility level. Another current study is estimating the effects of medical education by service level (broadly categorized as medical, surgical, psychiatric and other).

Future plans include looking at residents as productivity inputs and outputs at the DRG level. The investigators involved in these projects include Kathleen N. Gillespie, Ph.D., Claudia R. Campbell, Ph.D., and James C. Romeis, Ph.D.

Research Methodology

Residents can be viewed as both inputs to and outputs of the production process in a hospital. Because of this, a variety of techniques are being used to estimate the effect of medical education on hospital costs and productivity. The research projects are based on data drawn from VA databases and matched with some outside factors, such as the urban or rural location of the VAMC.

One way to incorporate both the input and output aspects of the production process is to estimate a profit function. Although VAMCs are non-profit, profits and losses were calculated in the late 1980s. By using this cost data and factoring in the number of residents and the ratio of residents to staff physicians, the effect of medical education on overall VAMC cost can be estimated. A second approach is to estimate and compare productivity of teaching and non-teaching hospitals. Resident productivity can be directly observed, while differences in nurse and staff physician productivity indicate the effects of teaching. A third approach is to estimate variable cost functions, which include a measure of teaching intensity.

Results

The profit study estimated two models of a profit function. Both models included a standardized output measure, physician and nurse FTE, number of beds, length of stay, inpatient and outpatient severity, and the peer group of the VAMC. The first model included the number of FTE residents; the second added the ratio of residents to staff physicians.

In the first model, the number of residents is not statistically related to VAMC financial performance. In the second model, both the number of residents and the ratio are related to performance, with FTE residents contributing positively to financial performance, and the ratio of residents to staff physicians contributing negatively. These results indicate that residents provide patient care sufficient to generate profits, but this gain is offset by the indirect teaching costs of resident training. The implied break-even point for a residency program was 86 staff physicians.

Productivity for teaching and for non-teaching VAMCs was estimated by using a standardized output measure derived from VA’s DRG-type reporting system as the dependent variable. This analysis showed that staff physicians are less productive in teaching hospitals, possibly reflecting the time spent in training and supervising residents. Nurses, however, are more productive; residents may relieve nurses of less productive tasks. Finally, the analysis indicated that although residents provide patient care, their contribution to total output is small.

The average cost study began by replicating several average variable cost functions used in the literature and then varied those models. Using the ratio of residents to FTE physicians slightly reduced the estimated costs. These three approaches have been used to examine medical education at the facility level. The current project estimates production and cost functions at the service level.
The Center for Health Services Research in Primary Care, located in Durham, North Carolina, was established in 1982 as one of nine VA-funded Field Programs in Health Services Research. This center has historically focused on health services research in primary care and, in the future, plans to expand into issues related to health care reform, emphasizing the organization of care, practice patterns, patient outcomes, women’s health, and rehabilitation.

The center’s research program is carried out by a multi-disciplinary team including physician investigators and Ph.D. investigators in biostatistics, epidemiology, health economics, health policy and medical sociology.

**Affiliations**

The Center for Health Services Research in Primary Care maintains strong affiliations with the Durham VA Medical Center (VAMC), Duke University and the University of North Carolina at Chapel Hill. Its collaborative ties within the Durham VAMC include the Ambulatory Care Service, Geriatric Research, Education and Clinical Center, and the Quality Management Institute and Education Center. At Duke University, it maintains affiliations with the Center for Health Policy Research and Education, the Center for the Study of Aging and Human Development, and the Comprehensive Cancer Center. Affiliations with the University of North Carolina at Chapel Hill involve the Sheps Center for Health Services Research and the Departments of Epidemiology and Health Policy and Administration.

**Research Priorities**

The center’s research priorities are detailed below:

**Organization of Care** - Two Cooperative Studies in Health Services (CSHS) focus on issues relating to the organization of care. The first is entitled “Can the Provision of Primary Care Reduce Hospital Readmissions?” It will test whether providing rapid access to high-quality, primary care to patients discharged from general medicine wards, will reduce hospital readmission rates and readmission days during the six months following discharge. The second, “Evaluation of Geriatric Evaluation and Management Units and Geriatric Specialty Clinic Follow-up,” will evaluate whether inpatient Geriatric Evaluation and Management Units and/or post-hospital follow-up care in an outpatient geriatric specialty clinic reduce mortality and enhance health-related quality of life compared with usual care.

**Practice Patterns and Patient Outcomes** - The center’s research on practice patterns and patient outcomes for important chronic conditions is exemplified by several research projects. One study examines the relationship of practice patterns (e.g., volume of AIDS cases) to quality of care (e.g., prompt treatment of pneumocystis carinii pneumonia) and outcomes (e.g., health service utilization, mortality). A second project examines utilization patterns of inpatient care by veterans with spinal cord injuries. The center is also involved with an Agency for Health Care Policy and Research (AHCPR) funded Patient Outcomes Research Team (PORT) project on secondary and tertiary prevention of stroke. A project on clinical management and outcomes of veterans with stroke at VA medical center expands the work of the stroke PORT. With the Center for Health Policy Research and Education, and the Rehabilitation Service at the Durham VAMC, the center also plans to examine the effectiveness of stroke rehabilitation.

**Rehabilitation** - The center has a long-standing commitment to research in rehabilitation, particularly as it relates to stroke and spinal cord dysfunction. In addition to the stroke-related research described above, there is a strong commitment at the center to research examining health services utilization among veterans with spinal cord injury. Currently, with funding from HSR&D and the Paralyzed Veterans of America, investigators at the Durham VAMC, the HSR&D’s Management Decision and Research Center, and the San Francisco Information Systems Center are developing a national registry of veterans with spinal cord dysfunction.

**Women’s Health** - Durham was one of eight VAMCs nationwide to obtain funding to establish a clinical program in women’s health, co-directed by physician researchers at the field program. In addition, the center is conducting research on breast cancer in collaboration with the Duke University Comprehensive Cancer Center, and is coordinating the establishment of a Health Services Research Consortium on Women’s Health. Two additional research projects are in progress: (1) Evaluation of Gender Differences in the Diagnosis and Treatment of Coronary Artery Disease, and (2) Strategies to Improve Gynecologic Cancer Screening in Women Veterans.

**Information**

For additional information, please contact: W. Edgar Cockrell, MPH, Administrative Officer, Center for Health Services Research in Primary Care, 152 VAMC, 508 Fulton Street, Durham, NC 27705.
The Prostate Cancer Intervention Versus Observation Trial (PIVOT)

Cancer of the prostate (CAP) is the most frequently diagnosed cancer and second leading cause of cancer-related mortality in men. It is estimated that the United States will spend $4-5 billion annually on early detection and treatment of prostate cancer.

Current Treatment Choices

The rising incidence of prostate cancer, new methodologies for early detection, tumor staging, and treatment modalities associated with morbidity and uncertain benefits, have created questions regarding the preferred therapy for prostate cancer. Radical prostatectomy offers the potential for tumor eradication and may reduce subsequent interventions for disease persistence or recurrence. However, it may be neither necessary nor successful. Expectant management reserves therapy for symptomatic or metastatic progression, and therefore, many patients with clinically localized CAP will never require treatment. Additionally, expectant management avoids the morbidity and mortality of early intervention that can adversely affect quality of life. However, expectant management may miss an opportunity to completely remove prostate cancer and prevent prostate cancer-related mortality.

While the clinical and financial investment required for early detection and treatment of prostate cancer may be appropriate, this investment is being made despite the fact that the most fundamental question about prostate cancer therapy still has not been answered: Does early intervention with radical prostatectomy reduce morbidity and mortality and improve quality of life?

Many patient and health care workers are surprised to learn that currently available data suggests that observation, with palliative therapy for symptomatic or metastatic disease progression (i.e., expectant management), provides all-case and disease-specific survival equivalent to early intervention with either radical prostatectomy or radiation therapy.

However, a randomized controlled trial comparing radical prostatectomy to expectant management for clinically localized CAP is needed to determine the preferred therapy.

Research and Treatment Recommendations

Prostate cancer treatment recommendations from expert panels and clinical decisionmaking groups have been hampered by the absence of data from controlled trials. The results of a new study sponsored by the Cooperative Studies Program of the Department of Veterans Affairs, in collaboration with the Cancer Treatment and Evaluation Program of the National Cancer Institute (NCI), and the Agency for Health Care Policy and Research, will provide the data needed for sound treatment recommendations.

This study, the Prostate Cancer Intervention Versus Observation Trial (PIVOT), is a randomized, controlled trial designed to determine which of the two strategies—radical prostatectomy or expectant management—is superior for managing clinically localized CAP. The trial will enroll 2000 participants from at least 100 VA and NCI medical centers. Patients less than 75 years of age, with clinically localized prostate cancer of all histologic grades, will be randomized to either: • radical prostatectomy with early intervention for subsequent disease persistence/recurrence, or • expectant management with palliative therapy reserved for metastatic or symptomatic disease progression. The primary outcome will be all-cause mortality. Secondary outcomes will include prostate cancer and treatment-specific morbidity and mortality, health status, predictors of disease-specific outcomes and cost-effectiveness of care.

PIVOT will randomize patients over a three-year period and follow them for a minimum of 12 years. The study will provide a 50 percent power to detect a 15 percent reduction in all-cause mortality, and a 35 percent reduction in prostate cancer-specific mortality by either treatment strategy. Broad criteria relating to inclusion in the trial and followup treatment will enable the results of this Cooperative Study to be generalized to many other patients with clinically localized prostate cancer.

Implications

If early intervention with radical prostatectomy is effective, then screening and treatment programs should be aggressively instituted and directed toward the patients most likely to benefit. If expectant management provides equivalent long-term survival, then observation with intervention reserved for palliative purposes would generally be preferable because it avoids the morbidity, mortality, and cost of early intervention.
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The uncertainties regarding detection and treatment of prostate cancer, combined with increasing morbidity, mortality and health care costs, make the PIVOT study of great importance to health care delivery in the United States.

Conclusion

PIVOT is scheduled to begin participant recruitment in September 1994. For further information, please contact: David G. Weiss, Ph.D., Cooperative Studies Program biostatistician; TEL 410/642-2411, ext. 5300; or Timothy J. Wilt, M.D., M.P.H., study co-chairman; TEL 612/725-2158.

BULLETIN BOARD

Carol Ashton, M.D., Receives Computer Award

Carol Ashton, M.D., Associate Director of the Houston Center for Quality of Care and Utilization Studies and Staff Physician with the Houston VAMC, was selected one of Federal Computer Week’s “Federal 100 of 1994.” The group of 100 awardees from government, industry and academia were recognized by a panel of judges as having had the greatest impact on the government information systems community.

MDRC and FHSR Hold State-of-the-Art Conference on Data

In November 1993, the MDRC and FHSR held the second in a series of SOTAs. Entitled Databases: A Resource for Research and Decisionmaking, the purpose of the conference was to identify and prioritize recommendations to VA that will improve the definition, collection, availability and use of data and information to improve the health and quality of life of veterans. Several journals have expressed an interest in publishing the recommendations as a special supplement. For further information, contact: Geraldine McGlynn at MDRC; FAX 617/278-4438.

Special Journal Issue Published on Work Stressors in Health Care and Social Service Settings

Rudolf H. Moos, Ph.D., and Janeen Schaefer edited a Special Issue of the Journal of Community and Applied Social Psychology (Nov. 1993, Vol. 3, Issue No. 4) focusing on work stressors in health care and social service settings. In addition to the overview article, a second article describes some of the work that grew out of an HSR&D funded project on work stressors by the Center for Health Care Evaluation (HSR&D Field Program in Palo Alto, CA).

Victor P. Raymond Dies

Victor P. Raymond, Ph.D., Assistant Secretary of Veterans Affairs for Policy and Planning, died April 1 of AIDS. He was also a member of the Forum editorial board and the MDRC advisory committee. Vic worked for the Veterans Administration and the Health and Human Services Department and served on Capitol Hill before returning to VA in 1990. He was Deputy Assistant Secretary for Policy before becoming Assistant Secretary of the Department of Veteran’s Affairs in 1993. In addition to his duties with VA, Vic served on the President’s health reform task force. He served in the Air Force from 1969 to 1973, attaining the rank of captain. A B-52 pilot, Vic was based in Guam and Thailand and flew bombing missions over Vietnam. A native of Colorado, Vic was a 1969 graduate of the University of Missouri. He received a doctorate in operations research from Johns Hopkins University’s School of Hygiene and Public Health in 1986. Vic was an eloquent spokesman and a strong advocate of health services research. He will be sorely missed.
Future Plans and Implications

The results at the facility level are consistent with results from the non-VA sector. In particular, the Health Care Financing Administration’s (HCFA) model of average costs, and several variations of that model, were all successfully replicated with the VA data. This strengthens the idea that VA is an excellent laboratory for this type of research.

As noted above, the facility level analysis found that the larger the residency program, the lower the cost per resident. However, this study, like all those conducted at the hospital level, ignores the distribution of residents within a facility. Outpatient costs were unaffected by medical education.

Specializing within a VAMC in a particular type of medical education (e.g., surgical programs), could be less costly and/or more productive than distributing residents evenly across services. The study of residency programs at the service level addresses this issue. The project is at the analysis stage now, and results should be available at the end of the year.

Information

For further information about this research, contact: Dr. Kathleen N. Gillespie (Principal Investigator) at the St. Louis VAMC, 922 N. Grand Blvd., St. Louis, MO 63125; TEL 314/289-6527.