

U.S. Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)



St. Louis VHA Academic Affiliate Contracting Forum

Summary Report

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September 13, 2012



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Table of Contents

Overview.....	1
VHA Action Items	1
Welcome and Opening Remarks.....	2
The Value and History of the VHA-Academic Affiliate Partnership	3
The Contracting Process	4
The Pricing Challenge & Potential Tools	6
VHA Café: Improving the Negotiation Process	9
VHA Café: Performance Metrics and Quality Assurance.....	13
VHA Café: Recruitment vs. Contracting for Physician Services.....	15
VHA Café: Credentialing and Privileging	18
VHA Café: Information Security.....	19
Final Questions and Answers	20
Closing Remarks	23
Appendix A: Forum Agenda.....	24
Appendix B: Affiliate Attendees	25
Appendix C: VA Attendees	28
Appendix 4: Acronyms.....	30

Overview

This report is a summary of the VHA Academic Affiliate Forum held on Thursday, August 9 at the Sheraton St. Louis Hotel in St. Louis, Missouri. Forty-five Academic Affiliate representatives and thirty-five VHA representatives participated in both plenary and breakout sessions during the day. It was the final event in a series of three forums being hosted by VHA to share information with its Affiliate partners.

Full plenary topics included:

- Value and History of the VHA-Affiliate Partnership
- Contracting Process
- Pricing Challenge & Potential Tools
- Credentialing and Privileging
- Information Security
- Ask the VHA and Improvement Forum Question and Answer Session
- The Path Forward

Breakout "VHA Café" sessions topics included:

- Improving the Negotiating Process
- Performance Metrics & Quality Assurance
- Recruitment vs. Contracting

VHA Action Items

- VHA will assemble a list of contracting, contracting policy, and regulation courses and descriptions and share with Affiliates.
- VHA will have further conversations about the implications of providing benefits to staff under the eighths program.
- Mr. Doyle will work to develop a consensus position/point-of-view from the department regarding profit, as Affiliates have noted varying strategies for dealing with profit in contracts.
- VHA leadership will meet to discuss a path forward for utilizing multi-year contracts for healthcare services.

Presentations and handouts have been posted at the following web site:

http://www.theambitgroup.com/vasrt/VHAfiles_StLouis.php

Welcome and Opening Remarks

Norbert Doyle, Chief Procurement and Logistics Officer, Veterans Health Administration

Mr. Doyle welcomed participants to the third Affiliate forum this summer. VA has been planning these events for some time, and they are based on similar events that have been hosted by VA for its suppliers of products and services. He encouraged participants to meet their counterparts at VA or the Affiliate institution and to share their experiences and suggestions honestly and openly throughout the day. He then introduced Dr. Madhulika Agarwal, Deputy Undersecretary for Policy and Services at VHA.

Speaker: Dr. Madhulika Agarwal, Deputy Under Secretary for Policy and Services, VHA

Dr. Agarwal emphasized the importance of the VHA-Affiliate partnership in delivering better care for our nation's Veterans. She highlighted the long history of the partnership that began with a memo in 1946 to help VA care for the Veterans returning from World War II. Today about 60% of the nation's doctors have received some training at a VA hospital. Last year, 116,000 medical professionals spent some of their training in VA hospital.

She briefly described the demonstration projects or Centers of Excellence for professional primary care training in Boise, Idaho, and Cleveland, Ohio. In these Centers of Excellence, primary care physicians, trainees and nurse-practitioners are training as a team. VA has launched several such projects in specialty care as well as in rural health – all in partnership with Academic Affiliates.

Dr. Agarwal also discussed a new federal advisory group called the National Academic Affiliations Council. This is a distinguished group of educators and leaders that represent a breadth of health professions. The Council has already met twice and is re-asserting the value of the partnership. The Council is considering ways to strengthen the partnership including forming new sharing agreements, new strategic alliances, and new joint ventures.

Dr. Agarwal went on to discuss sole-source contracting. She mentioned that VA is in the process of revising Medical Sharing Office (MSO) procedures to create highly functioning contracting partnerships. VA is trying to ensure that the healthcare resources and contracts result in the safest, most effective, and highest quality healthcare. VA is also providing field guides, increasing its competencies, and standardizing its processes.

She also discussed the re-organization of acquisition services that is underway. VHA recently decided to adopt a new regional operation model that gives administration decision makers more authority and enhances our ability to clarify the role of non-contracting personnel in the acquisition process.

Lastly, Dr. Agarwal discussed VA's desire to move to a preventative healthcare model. VA has extensive rich electronic medical records with a wealth of data. This data provides an opportunity to learn more about the health of the Veteran. VA is moving towards a new kind of healthcare called Patient Alliance Teams that will be patient-centered, team-based and data-driven.

Following Dr. Agarwal's comments, participants introduced themselves and a few shared their thoughts about the value of the VHA-Affiliate partnership.

- Affiliate: We do not profit monetarily from the services we provide to VA – we generally break even. However, we do derive a lot of benefit from the ability to strengthen our residency program.
- VHA: One of the benefits of our partnership is that we are able to provide services that we wouldn't normally be able to without it. Having resident and fellowship training programs at our

facility provides a great depth and breadth of expertise that Veterans can receive. I hope we can find a way to iron out the quirks in the system so we can continue to provide better care for Veterans – the partnership enhances services and enhances academics.

- VHA: We service 40,000 Veterans. Without our academic relationship, we would not be able to run specialty and sub-specialty services. The professionalism of the medical school staff is without doubt. They see our patients and their patients as the same, so when they do their scheduling and they set up their early requirements, we are part of that. They don't let us go without service.

The Value and History of the VHA-Academic Affiliate Partnership

Presenter: Dr. Judy Brannen, Clinical Director, Undergraduate and Graduate Medical Education, VHA Office of Academic Affiliations

Dr. Brannen briefly discussed the history and value of the VA-Affiliate Partnerships, the current status of medical education in VHA, residency supervision, and why it's important to make the contracting process work. Key points discussed are included below.

- Ninety nine per cent of VHA's physician residency programs are sponsored by an Affiliate. We want Veterans in our medical centers to have the same care as the Veterans getting care at the Affiliate level. This will happen through partnerships, not creating our own programs.
- VA and its Affiliates have experienced 65 years of educational leadership. Currently, VA has an innovative specialty care program that is delivering specialty care in an inter-professional manner. These programs include women's healthcare in Atlanta, cancer care in Cleveland, and muscular skeletal care in Salt Lake City. These programs bring together different physician disciplines and associated health trainees to deliver healthcare in clinics.
- VA typically funds the direct costs (salary and benefits) for trainees through disbursement agreements with Affiliate. Money is fenced and allocated by OAA (Office of Academic Affiliations). Available funding is based on the number of positions that are allotted to a VA facility. In Richmond, for example, we funded 160 positions. Veterans Equitable Resource Allocation (VERA) money is not fenced and is meant to be used to support all trainees. The money can be used for whatever the facility needs and this doesn't mean it's dedicated to education.
- It's important that VA and its Affiliates work together to make sure that appropriate supervision requirements are met. There is money available to make sure this happens.

Attendees shared the following questions and comments as a result of the presentation.

- *What is "fenced money"?*
 - **Dr. Brannen:** Fenced money is money that can only be used for trainee's salaries. Direct money goes through OAA to the facility and can only go to trainees. Any unused money goes back to OAA.
- *Is there a conflict between Title 38 vs. Directive 1663?*
 - **Dr. Brannen:** Directive 1663 provides guidance on contracting while Title 38 focuses on hiring; regulations do overlap but are generally not in conflict.
- *Do we have to try re-recruiting personnel for every six month extension?*
 - **Dr. Brannen:** The VA team needs to work with their Human Resource (HR) partners and do the due diligence in hiring. You should at least expect to do it annually. The VA has to show that we are hiring first, and we need to advertise for the position.

- *In exploring opportunities with Affiliates, we are considering bringing on new trainees from an Affiliate program on 0.1 and 0.2 schedules. Are there any minimum requirements for sole-source contracting? Would you be able to use a sole-source contract even though it's not full time?*
 - **Dr. Brannen:** If your Affiliate says they want to send more trainees over, look at your facility allotment and then your VISN allotment to see if you can redistribute your trainees. In some cases, OAA has had some physician positions returned, and these can sometimes be temporarily re-allocated. If you're interested in adjusting, even mid-year, your allotment of trainees at VA, it's probably going to be temporary. We could probably help you find additional trainees next week if needed. If the residency program is the reason you are involved in sole-source contracting for attending physician hiring, you must show that you can't hire a physician as a VA employee.

The Contracting Process

Presenter: Charlie Benmark, Director, MSO, VHA Procurement & Logistics Office (PLO)

Ms. Benmark provided an overview of the contracting process, including recent changes, challenges, and planned improvements to the process. She also reviewed the organizational structure at VHA that supports this process.

Key points discussed not included in the presentation are included below.

- PLO is organized into three Regions – Service Area Organizations (SAO) East, Central and West. Each SAO has a Network Contracting Office (NCO) led by a Network Contracting Manager (NCM), which is focused on contract activities in that Region. This new organizational structure is more performance-driven, is more efficient in using resources, reduces redundancies in business processes, and enables employee development and increasing competency.
- MSO provides administrative oversight, initiates policy guidance, and standardizes how VA does business out in the field. MSO performs all pre-solicitation reviews and pre-award approvals under Directive 1663. MSO is the principal negotiator for sole source contracts greater than \$500K (aggregate amount), serves as advisor to Contracting Officers, chairs the contract review board for procurements over \$5M, approves or disapproves Interim Contract Authority (ICA), and handles Congressional reporting.
- A training course for acquisitions has been developed to address the many changes made in the last two years and help foster an understanding of VHA policies. This will translate into a smoother process with an outcome of better healthcare for the Veterans.
- The Network Contract Managers (NCMs) are an important resource for you in helping to get issues resolved if you are unable to address things with your Contracting Officer.
- Contracting Officers (COs) have the authority by law to change contracts. Their responsibility is to make sure VA lives by the letter of the law and to ensure impartial, fair and equitable treatment. All COs are held accountable for their actions.
- Office of the Inspector General (OIG) Findings: OIG 2005 and 2009 Reports identified opportunities for contracting improvement. VA is very focused on addressing the concerns identified to ensure that the findings are not repeated.
 - Conflict of interest issues were identified in the OIG report. There will be Conflict of Interest training within VA. If you're not sure of who can meet when, talk to your Contracting Officer or NCM to get that clarified.

- There are some repeat findings in the two reports. It is important that these be addressed as soon as possible.

Participants shared the following questions and comments as a result of the presentation.

- *Affiliate: One of the things you mentioned was all the educational courses you're offering. Can Affiliates attend these courses to better understand the contracting process?*
 - **Ms Benmark:** We are not currently offering courses outside of the government. That doesn't mean we won't explore that idea, or share what kinds of courses the government offers. I would like to see more cross-functional educational opportunities so we can see how each side works. We can also create an informational guide so you can know our process and what to expect during that process.
 - **Mr. Doyle:** Are you asking for a basic contracting 101 course or a more specific class?
 - *Affiliate:* We are looking for transparency. We need to understand the regulations and policies.
 - **Ms. Benmark:** We could put together a list of courses and descriptions and we can share that with Affiliates.
 - **Ms. Sandra Hallmark:** There's a list that is given out to each VISN office and they should share that with you.
 - **Action:** Assemble a list of contracting, contracting policy, and regulation courses and descriptions and share with Affiliates.
- *Affiliate: We have several positions in our medical facility that go to a local Community Based Outpatient Clinics (CBOC) to provide outpatient services in specialty areas, some of them have been doing that for 20 years. Recently, they were told their contracts will be ending. I'm confused with the information presented; are sole-source contracts the preferred method of contracting personnel and trainees, and do you still need to advertise to fill a part-time position?*
 - **Ms. Benmark:** Hiring is the preferred option for specialty care. If you can't hire and you are going to contract, then sole-sourcing would be a preferred method if a residency program is involved. The policies stipulate the hierarchy.
- *Affiliate: Dr. Agarwal mentioned there is a process standardizing and streamlining effort through the MSO to reduce redundancies. Is there going to be standardization of the pre-award documents that are required for acquisition planning and a streamlining of the process?*
 - **Ms. Benmark:** We have created a consolidated certification and approval document, which we are teaching in our classes. This allows the acquisition team to start planning for all the required justifications. This will give you a roadmap. We want to give you the tools our medical centers use and put them into comprehensive packages. That way, when you go through the approval process, you should have all of the documentation required to meet the policy and regulations. The document eliminates all the redundant work and makes sure nothing gets left out.
- *Affiliate: How can the Affiliates assist in identifying or resolving contracting issues? Instead of me having to contact the Contracting Officer (CO), is there a system that Affiliates can access? Is there a way for us to figure out if there are missing documents so we can get them to them as soon as possible, or a way to facilitate the process?*
 - **Ms. Benmark:** We suggest that the CO generate a report from VA's Electronic Contract Management System (eCMS). This would allow you to identify expiring contracts. You should be

meeting with your Contracting Officer's Representatives (COR) as often as possible. Consider standing up a monthly meeting to go over contracts and where you're at. As part of the new negotiation process, we are looking at the pre-solicitation process to align expectations. We need to look at the millstones together, point by point, so that everyone is aware of them and that they are reasonable. Get to know your Network Contract Manager (NCM) so that you can engage them early. You can talk about capabilities and plan early, but you can't discuss the requirements or conduct any negotiations. What we need to do is talk to each other more and more regularly.

The Pricing Challenge & Potential Tools

Presenter: Katherine L. Peck, MBA, Executive Associate Dean of Administration, Operations and Finance, Indiana University, School of Medicine

Ms. Peck spoke about strategies that the University of Indiana uses with VHA contracting and addressed some of the challenges they have experienced. As the Executive Associate Dean of Administration, Operations and Finance Ms. Peck is the equivalent of a Chief Financial Officer and Chief Operating Officer for the Medical School. She is responsible for financial reporting, financial health of the medical school, IT, facility planning and maintenance, and generally the entire administrative infrastructure that enables the faculty to do the teaching they do and the research that supports the clinical care.

One of her key points was the importance of the partnership between the Affiliates and VA. VHA and medical schools have a long history as partners, which include clinical care to Veterans, training future physicians, healthcare research and joint faculty recruitments. Without the partnership, neither VA nor the Affiliate could achieve its goals for providing care and for making positive changes. The Affiliates and VA should move as one unit and focus on the overall care of the Veterans.

Unfortunately, the partnership disintegrates when it comes to the contracting process. Ms. Peck had the following observations about the VHA-Affiliate contracting process:

- Affiliates should view the sole-source contracting process as a continuation of the VHA-Affiliate partnership.
- Affiliates and VHA need to commit to jointly solving problems and making improvements of the sole-source contracting process.
- Partnerships between the VHA and the Academic Affiliates are each different.
- Patient care, teaching, and research are included in the mission of the Academic Medical Centers (AMC).
 - Sole-source contracting becomes a problem because not all three aspects of the mission are implemented at each medical school.
 - Contracts and agreements between the components may make it difficult to determine the true cost of services.

Ms. Peck also noted the importance of understanding the different world views of Affiliates and VHA and provided some insights into the Affiliate perspective. She highlighted the following specific challenges:

- Information security requirements.
- When paid hourly, there is no reimbursement for overhead.
- Affiliates do not know who makes the decisions about various terms of the contract.

- There is apparent inconsistency across VA.
- Miscommunication or lack thereof from Affiliate to Affiliate and VHA to Affiliate can create distrust.

She also noted challenges from the VA's perspective, including:

- CO's are required to follow the federal regulations and mishandling a requirement could result in civil and criminal penalties.
- Sole-source contracts need no competition.
- VA has to pay market value.

Following her presentation, participants shared the following questions and comments.

- *Affiliate: Do you think it is better having a single point of contact in your medical school for VA contracting? What does that mean? How much FTE was devoted?*
 - **Ms. Peck:** Yes I do. It means we can get the departments' feedback and facilitate the contracting process. It is helpful because VA contracting is unique so one person develops this expertise.
- *VHA: Would it be better to have a higher-level faculty executive as a POC in addition to yourself as a CO POC? That would be the person who the department chair would go to and escalate when there are medical practice issues verses contracting issues.*
 - **Ms. Peck:** I don't have experience with that structure, but a lot of the terms of the contract are related to medical practice. You need a reasonable person to respond to those issues.
- *Affiliate: With FTE-based contracting, it gets overwhelming when dealing with security issues, especially when physicians have not done their finger printing correctly or in a timely manner.*
 - **VHA (NCM):** From all of your challenges, it seems like working for the University is like working for the government. If we can communicate more efficiently, we can get through a lot of these issues. We can come to some negotiation agreement and find out a solution.

Presenter: Brian Vasbinder, Procurement Analyst, VHA Service Area Organization (SAO) East

Mr. Vasbinder presented essential information on regulation and policies, pricing methodologies (which included guidelines for the pricing process), the Federal Acquisition Regulation (FAR) and Directive 1663, FTE considerations, and proposal preparation. He highlighted some of the challenges related to pricing, including several constraints, the list of initial other than cost and pricing data that is required, and the difficulty of internal and external coordination. Below are some key points from his presentation.

- Medical sharing services are considered commercial items as described by FAR 2.101. Mr. Vasbinder suggested using firm-fixed price or fixed price with economic price adjustments for these types of contracts. Because these are commercial items, they are exempt from providing certified cost and pricing data, but the CO will request other than cost and pricing data.
- FAR part 15 provides policies and procedures governing noncompetitive, negotiated acquisitions. Mr. Vasbinder assists the MSO negotiation team in the performance of proposal analysis. In that analysis, the MSO negotiation team is reviewing various information (e.g. historical costs, market research, other than cost and pricing data) to develop pre-negotiation objectives in hopes of determining a fair and reasonable price for the services, which is noted in FAR part 15.405.

- According to VA Directive 1663, if a contract is over \$500,000 the OIG will conduct a pre-negotiation review. The MSO negotiation team will review the VA OIG's findings and incorporate them into the negotiation objectives.
- For pricing methodologies, VHA considers an FTE/ Fixed Hourly Rates, Per Procedure, or a hybrid that utilizes both the FTE and Per Procedure. If the procedure is performed in a VHA facility, the preferred method is using an FTE or an hourly basis. The preferred method is to develop an hourly rate for each physician or categories such as professor and associate professor. Hybrid methodologies are mixed pricing models that may be used when a surgeon performs services off-site and has to do follow up work at the VHA facility. This method requires internal reviews.
- When an Affiliate proposes an FTE/hourly based contract, VHA likes to see where the salary numbers are coming from. VHA will ask for the salary agreement and W2 information. When it comes to proposal preparation, documentation is essential.
- Cost Reimbursement is associated with direct service performance. Reimbursable costs can include salary, fringe benefit, malpractice, professional dues, continuing professional education, administrative cost (billing, invoices and scheduling) and travel (depending on the distance that the physician has to travel to the medical facility).
- On the per procedure basis, they want to see market research based on the specific Relative Value Units (RVU) (e.g. Work, Practice Expense, Malpractice), any modifiers that were used (TC and 26 modifiers), and see where that information is coming from (internal or Center for Medicare and Medicaid Services (CMS)).
- Regarding direct versus indirect cost, direct cost is any cost that is identified with a particular final cost and indirect cost is cost remaining. Fringe benefits can be direct or indirect cost – it all depends on your accounting and estimating. Indirect costs include administrative expenses (scheduling, billing and invoicing) and are usually based on a percentage of time (e.g. 5% or 7% of the work). On VHA's side, they will evaluate if it is reasonable for the amount of work. Unallowable costs include general department or university overhead, for example, the "Dean's Tax."
- On-call costs should not be broken out of the contract. On-call requirements above what is stipulated in the compensation agreements are included in the contract. Incentive Pay is usually paid when it is paid by the Affiliate and an invoice is submitted.

Participants shared the following questions and comments as a result of the presentation.

- *Affiliate: With indirect costs, I understand the logic behind not including the Dean's Tax and department cost because those are indirect cost that provides support to other missions. If you contract with one FTE or faculty person, there are costs associated with processing the payroll of that person, benefits, and recruiting. If they were VHA employees, VHA would incur all of these costs. If they are not a VA employee, do you think there is a way for the school to get reimbursed for that type of overhead cost?*
 - **Mr. Vasbinder:** The CO actually has the final say. If you can reasonably show that the cost are directly related to the contract, yes the costs could be determined allowable by the CO. Again, the OIG may see it one way, and the CO may see it a different way. Unfortunately, when it comes to the FAR and cost principals there is a big gray area, but it is possible that these costs could be allowable.
- *Affiliate: How do we define one FTE if hours change depending on the situation?*

- **Mr. Vasbinder:** That has always been an area of contention when it comes to available hours. We want to equitably allocate the costs.
- **Ms. Benmark:** In the OIG report, one of the biggest things they found is that VHA has to define the FTE. That is very difficult to do because the definition will depend on the specialty or sub-specialty. One of the things we have looked at is that you cannot put a definition on the FTE depending on what type of position it is. You need to make sure in the contract you define the requirements so that you know what you are buying. The VHA and your negotiation teams will look at all of that. Hopefully new policies and guidance will come out to make it clearer.

VHA Café: Improving the Negotiation Process

VHA Representative: Charlie Benmark, Director, MSO, VHA OPL

Ms. Benmark opened the session with background on the negotiation process and reviewed the associated handouts, which demonstrate the makeup of the negotiation team as well as the negotiation process flow.

VHA negotiation teams were formed in December 2010 with the intent of establishing inter-disciplinary teams that could ensure that VHA was getting the best value in the contracting process. The team members will vary depending on the size of the contract.

Ms. Benmark briefly reviewed each team member and their role on the team:

- The CO has the ultimate authority with a warrant to obligate the government. COs making the decision alone is not the best practice. Rather, decisions should be made with input from technical representatives.
- The Clinical Representatives are very important because they are the users of the services. They must be present to advise the CO. They are the experts in patient care. An Administrative Officer (AO) could be a clinical representative, but they are not a physician and not an ideal part of the negotiation team.
- The Principal Negotiator must be present to represent MSO. If the contract is under \$500,000 (an aggregate amount, not just the base year), the MSO is not involved.
- Regional Counsel may be involved, and Affiliates usually have legal counsel of their own present.
- The COR is present to gain early insight into the contract during the negotiation process.
- The SAO Procurement Analyst will be present to analyze pricing. Brian Vasbinder has this role for SAO East. The position is vacant in SAO Central and SAO West.
- The OIG is not required to be a part of the negotiation team, but they are sometimes needed for subject matter expertise and advice. They are a resource for the team. They take part in the pre-negotiation review. Their review findings are reviewed for validity. If the team decides to disagree with the OIG recommendation, the reasoning must be well documented as the OIG conducts a post award audit after the CO executes the contract. We must ensure our decision ties in with price realism and reasonableness. Should we disagree with the OIG, and there is an issue with the contract, there are consequences depending on the severity.

Participants shared the following questions and comments across two rounds of breakouts.

- *Affiliate: Why is the negotiation process so lengthy, and why isn't it standardized? I feel as if there are a lot of people involved in the process from VHA.*

- *Affiliate: I know of a highly affiliated VA facility where 90% of the staff have faculty appointments. How can we deal with getting clinical representation on the negotiation team when the lawyers say this is a conflict?*
 - **Ms. Benchmark:** In that case, VA could reach out to another medical center to see if they have the specialty there to be represented on the negotiation team. If they don't have the specialty within their VISN, we will go to VA Central Office (VACO) patient care services and ask for a clinical representative.
- *Affiliate: Are there circumstances where there's an urgent need that needs to be exempt from the negotiation process?*
 - **Ms. Benchmark:** Yes, "Life or Limb" circumstances are exceptions. Poor planning does not constitute justification. The parameters are that it is a true emergency justified by the medical center, a brand-new requirement that needs to have the services in place in a short timeframe, or if you are in the long-term contract process. We won't have time to finish the negotiations, so we will approve an interim to continue services until the negotiation is done.
- *Affiliate: We have eaten charges in emergency situations. Should there should have been a Letter of Acceptance (LOA) or Memorandum of Understanding (MOU) when the Affiliate has to perform the services in an emergency?*
 - **Ms. Benchmark:** There is an authority to do emergency contracts. In FAR part 6-if only one source can provide or U.S.C. 8153, Interim authority. Under these circumstances the need for legal or MSO level of review is not required.
- *Affiliate: Is there a fee-for-service system as a back-up?*
 - **Ms. Benchmark:** Yes, under the medical center and the system will depend on the circumstance. Fee Basis, for example, would do that through the medical center. This is different than contracting.
- *Affiliate: If we have someone who goes "damp" (gets sick, no replacement, etc), and we need to replace them, are there other processes to fill an urgent need that is outside of the negotiation process?*
 - **Ms. Benchmark:** If they are VA's employee through the HR process, this would go through HR. If you needed to contract out for services, this is handled through the contract process. U.S.C. 8153 would allow us to award a contract without the reviews. An interim contract is something used to quickly put a vehicle into place so VA does not lose services.
 - **COR participant:** If there needs to be performance by a medical professional, VA will not look at the interim, we will tell the medical center to establish a locum tenens, which is a faster process. If the person needs to be credentialed, the process will not be quick.
- *Affiliate: Is it short-sighted to go into a contract without the "what-if" situation? Maybe a contingency plan could be written into the contract. As a supplier, there is a lot of pressure on us to perform. Payment is fuzzy. We need the mechanism to deliver the service. We cannot perform for free. A "without pay appointment" costs us money.*
 - **Ms. Benchmark:** This issue is one for HR and not acquisitions, but if VA is asking you to work without compensation, that is also a business issue. Maybe you need to talk to your dean/medical center director and tell them about the "without pay appointment" situation. That is a whole different program, and highlights what is so complicated about our relationship. I want the COs to know that

there is a difference in HR, business and contracting issues and they need to be able to understand these differences.

- *Affiliate: It seems like Chiefs of Staff are going to eighths that are not FTE and not contracts. Are contracts going away? Is this a partnership without a contract? Would medical centers rather employ than contract?*
 - **Ms. Benmark:** VA does not have the authority to award personal service contracts. The OIG reported in June that we seek legislation to do personal service contracts which would change the dynamics of contractors involved in the VA. We cannot supervise Affiliates because that is a non-personal service.

VHA Café: Performance Metrics and Quality Assurance

VHA Representative: Dr. Andrea Buck, Chief Medical Officer/Clinical Operations

Dr. Buck briefly reviewed the context for VHA's current attitudes and policies regarding Performance Metrics and Quality Assurance. As she noted, the current situation is informed by past practices.

Dr. Buck reviewed a brachytherapy case that occurred at the Philadelphia VA Medical Center. A physician employed under a contract with the Affiliate performed the procedure. In that case, a patient received brachytherapy for prostate cancer using the incorrect strength of radiation emitting seeds. After the event, the VA's Office of Inspector General found that from 2002 to 2006, no peer review or quality assessment took place at the medical center. Although the patient wasn't harmed, there was harm to the Affiliate's partnership with VA, harm to Veterans who were dissuaded from this important care, and harm to the university's reputation. This case demonstrated the need for clarity in the quality assurance obligations of contracts and who will be executing those obligations.

Participants had the following questions and comments across two breakout sessions.

- *Affiliate: How do you decide whose obligation it is and departmentalize all those responsibilities? Should the Affiliate be in the middle if the script is miswritten?*
 - **Dr. Buck:** First try to clarify the overall process. If VA and the Affiliate had been appropriately providing their quality management (QM) processes, the incident in the Pennsylvania case would have been caught through the normal peer review process. The contract should specify how it would blend into the existing QM service provider.
- *Affiliate: Would it be VA's obligation if things happen within the VA environment? For example, if a surgeon cuts off the wrong leg, it is clearly the surgeon's fault.*
 - **Dr. Buck:** No, it is the VA's fault if the script is given; it is not the Affiliate's fault. VA is responsible for the quality of care that physicians give in VA's institution. The question becomes does the Affiliate want VA to peer review their physicians, or does the Affiliate in the contract want to do that themselves?
 - **Ms. Kate Enchelmayer:** The question in that case is whose malpractice is going to pay for it, but VA is responsible for the Affiliate provider who is on contract; both get to carry that burden, because it is the physician's malpractice, but we have the obligation to the patient because we have the person on board. In the Philadelphia case, it was a shared burden, with the Affiliate and VA's attorneys in the same room.

- *COR participant: What would be your suggestion for a COR's role in monitoring quality?*
 - **Ms. Hallmark:** As a CO, he or she should work with her/his COR and go over the standards with the Affiliate.
 - COR participant: The CO is always telling us (CORs) not to go over standards of care.
 - **Ms. Hallmark:** The CO is responsible for the contract overall, but you (the COR) are the expert and should show the Affiliate the VHA standards of care and let them know what the different tools are.
- *Affiliate: Does each contract have a Quality Insurance Surveillance Plan (QISP) associated with it?*
 - **Ms. Hallmark:** Yes it should always be in there.
 - **Dr. Buck:** The contract is there to protect the two institutions.
- *For standards of care, is it VA's or the facility's responsibility to provide that?*
 - **Dr. Buck:** VHA does establish national standards of care. We want standards of care to be addressed during the contract process.

VHA Café: Recruitment vs. Contracting for Physician Services

VHA Representative: Dr. Judy Brannen, Office of Academic Affiliations (OAA)

Dr. Brannen opened the session by providing some brief background on the topic of recruitment versus contracting. She reminded participants that the first objective of VA is to hire to fill open positions. This is easier for some professions than for others. Because VA's goal is to provide Veterans with the same level of care regardless of location, contracting is sometimes used to fill positions.

She invited participants to share their questions, comments and best practices related to contracting and recruiting as well as other topics – summaries of the discussion from both breakout sessions follows.

- *Affiliate: In the employment of non-citizens (e.g., international graduates), one of the issues we've run into is that there are international residents that want to work for VA but either can't get visas or have a two-year limit. Given we need to advertise the position annually, what are VA's expectations for posting the positions?*
 - **Dr. Brannen:** In Richmond, our Human Resources guidance indicated we advertised annually in local newspapers and USAJobs. VA does not have any particular expectations related to visa issues. However, there are additional hoops to go through and delays for hiring non-US citizens into VA staff positions, as they may be hired only after demonstrating that hiring a US citizen is not possible.
- *Affiliate: There seems to be a preference for the eighths system versus contracts? Is that true?*
 - **Dr. Brannen:** This would vary by VISN, network and area. I think sole-source contracting, especially for sub-specialists, is fine. This may become a problem when you get into big surgical sub-specialties and it is important to make sure you meet residency requirements.

There are some facilities that want to contract out the entire surgical team. This would make it difficult to meet performance and supervisory requirements of VA. There needs to be accountability and commitment, that's why the VA encourages hiring.
- *Affiliate: The Cincinnati VA has done a good job placing people in the eighths system. We're running into issues of benefits and physicians wanting to have full-time benefits even though they are working*

part time. One thing that was proposed was that we should consolidate the eighths and put specific people at VA. The Department Chief was concerned that these individuals working on site at VA will become estranged, and we would not get the type of interchange we've always had among the staff members. What are your thoughts about consolidation and this concern about communication?

- **Dr. Brannen:** The Department Chair can set the expectation that conferences will be split between the Affiliate location and the VA facility. At VCU, they agreed every 4th week they would meet at the VA at 5pm so that people could socialize afterwards. Another approach is to put people from one institution on the other institution's committees.

In terms of benefits, one option is to have both buy and sell contracts for physician services. This would mean that staff are credentialed at both VA and the Affiliate. This allows people to keep their full-time benefits. Another option is to do no-cost contracts (without compensation – WOC). This is where the two institutions agree that individuals will spend certain amounts of time at each facility. In this scenario, individuals can also keep their benefits.

- *Affiliate: How would you go about implementing buying and selling contracts?*
 - **Dr. Brannen:** This is fairly new, but you can be creative. For example, if you only have capacity for a .5 position, and the university does not have capacity for them; consider using telemedicine or involving them in research to fill some more of their time. Try to think of ways to hire someone full-time and sell their services.
- *Affiliate: We don't have the capacity to pay the physicians because we can't match their salaries. What incentives could we use to keep them?*
 - **Dr. Brannen:** Packages can be submitted to Central Office for approval for higher salaries, exceeding the cap; do what you can to push the limit. Push to the absolute maximum in terms of incentives and things other than salary. I would look at your fee-based costs. If they are too high, I would argue that it would be cheaper to have a full-time hire.
- *Affiliate: What should my expectation be of a VA Chief that hires a staff person that is inappropriate for supervising our residents? Since that person can't supervise our residency program, the person isn't doing anything.*
 - **Dr. Brannen:** If you have a residency training program, the program director has to sign off on the VA hire as qualified to supervise the residents. The VA needs to make sure the hire is acceptable to supervise your residents. This might be a good topic for a Deans' Committee (Affiliations Partnership Council) Meeting. Joint recruitment would be another way to approach this issue. If the affiliate participates in the recruitment efforts, then one is assured of hiring VA staff who are qualified for faculty appointments.
- *Affiliate: What are the problems with hiring on an eighths contract?*
 - **Dr. Brannen:** If you have someone that is less than full-time (say 2/8ths), it may cost more for insurance than if they were full time. Being in two different retirement systems and two different leave systems can also be complicated. Then there are the difficulties of time and attendance and pensions. If someone is looking to apply for VA grants they will need to be a minimum 5/8ths hire.
- *Affiliate: For retirement benefits, the university will cover you with the full retirement plan, but only up to the money you make at the university. Is it similar to that at the VA?*
 - **Dr. Brannen:** There's a thrift savings plan and a matching program that's a percent of your salary.

- *Affiliate: We are predominantly eighths, but we are having problems getting more eighths because here is big difference in benefits for full-time staff versus part-time staff. We asked VA if we could offer our VA employees full-time employment benefits even though they were less than full time (i.e., working on eighths). This question actually went all the way to D.C., and the OIG felt it would have several other implications. We're trying to be a good partner and understand the need for eighths, but it is also important to get good academic doctors that have great benefits. Are any other Affiliates facing this problem and is there a best practice for how to provide part time staff with adequate benefits so that they will agree to work under an eighths contract?*
 - **Dr. Brannen:** This is an excellent question and worthy of follow up. We would need to determine more specifically which benefits you have in mind. For many, such as retirement, the contributions and hence the benefits are proportional. However, for some, like health insurance, only has to have a 51% appointment to qualify for health insurance in the VA.
 - **ACTION:** Have further conversations about the implications of providing benefits to staff under the eighths program to address OIG concerns.
- *Affiliate: Are people allowed to turn over their salary to the university?*
 - **Dr. Brannen:** It has to be done by contract with VA and the university.
- *Affiliate: What if an individual is being paid full time by the Affiliate organization and works part time at VA? Can the individual turn over any salary they earn at the VA to the Affiliate institution as a way to demonstrate they are not inappropriately benefiting from their relationship with VA? If the Affiliate institution deducts the time that individual spends at the VA from their regular schedule at the Affiliate institution, that will impact the employee's benefits, which is not desirable. Is there anything prohibiting this type of "give back" arrangement?*
 - Dr. Brannen asked the Affiliate to send her more information on the question. Following the event, some additional research indicated that this process may not be appropriate from a tax perspective - the IRS would likely see this "giving back" to the Affiliate as a donation, if the Affiliate is a non-profit. Some Affiliates deduct the VA pay from a person's compensation at the time of the annual faculty contract - so the VA pay is taken into account and pay is equalized across various faculty levels. Alternatively, the person could work part time at both locations or work full time at one institution and have the costs of any participation in the clinical or other duties at the other institution be paid using a contract mechanism.
- *Affiliate: With split hires, you've mentioned several times that benefits are an issue. Is there a place, website or policy where we can see what the VA benefits are for positions?*
 - **Dr. Brannen:** I'm sure there is a website or a policy that would list out the benefits. I don't have it. Please email me, and I will find you this information.
- *Affiliate: I have heard that if you're at a university before you start working for VA, you can keep the full medical benefits, but then your retirement it is split. I'd like to know how much more they would have to pay for health insurance if you are a 3/8ths?*
 - **Dr. Brannen:** I know if you're 5/8ths, then it's a percentage of the 5/8ths salary. It's also based on the number of years you've worked there. What I haven't seen is how much the rate goes up from a 3/8ths.
 - *Affiliate: We just found out that after 1/3 FTE they have to pay almost double for insurance and then it goes down when you reach 75%. In order to not disadvantage our part-time VA*

appointments, we give them a blind contribution from our side that way they don't get partial benefits from each side. We have been working with legal counsel in DC on this very issue. From the OIG's perspective, this is not legal. Something needs to happen so you can treat your faculty as full-time. Sometimes you have to be flexible when people don't want to move to VA because they know their benefits are going to substantially change.

- *Affiliate: You can do short term sole-sourcing.*
- *Affiliate: We had our Chief of Staff say that sole source contracting is not an option. There is no incentive based on your fee schedule for faculty to go over to VA. We're trying to do the right thing for the VA system, but it has been a struggle. This is impacting Veteran care. Could we, as a group of Affiliates ask the federal government to waive the restrictions and allow them to come over to VA full-time?*
- *Dr. Brannen: We have noted this issue and will follow up on it.*
- *Affiliate: We have with three civilian hospitals in our town. One is an Affiliate with VA and the others are jealous of this relationship. Is there any legal action that they can take against the VA Affiliate?*
 - **Dr. Brannen:** I've never heard of anything like that. If you are doing a sole-source contract the way you are supposed to, this should not be a problem. I would just follow the rules and do the right thing for the Veteran and the residency programs.
- *Affiliate: If I have a physician coming over from the medical school to the VA facility as a 1/10th FTE, what seems to be the breakdown for how many of these individuals are able to draw their full salary plus the 1/10th they are getting from the VA versus how many are getting the 1/10th subtracted from their salary by the medical schools?*
 - **Dr. Brannen:** I would talk to the Dean. I know it varies by department. In general, they try to keep salaries the same, so that people cannot profit from going to the VA.
 - *Affiliate: There's a salary offset, if I'm going to increase or decrease someone's salary, I coordinate with the Affiliate program director. The same is true for performance bonuses, when I pay them for what they have done at VA, their compensation level at the Affiliate is the driving force behind their paycheck. So if they're eligible for \$30,000 in performance pay, then whatever the university gives them will be deducted from their overall bonus.*
 - **Dr. Brannen:** In Richmond, we allowed them to keep their performance pay.
- *VA Staff: We lack a sub-specialty at our facility and have been approached by a VA Affiliate who would like to initiate a training program. If you don't have a supervisor for the program on site, can you sole-source contract for a supervisor in addition to or as part of the training program?*
 - **Dr. Brannen:** You could start the training, advertise for the supervisor position, and contract to fill it if you are unable to hire someone.

VHA Café: Credentialing and Privileging

VHA Representative: Ms. Kate Enchelmayer: Director, Credentialing and Privileging, VHA Office of Quality and Safety

Ms. Enchelmayer reviewed some of the topics on the Frequently Asked Questions handout she provided to participants and encouraged participants to ask questions. She emphasized that after a contract is in place, VA must credential the contracted employees. She stated that it takes at least 45 days after a candidate

has completed their information in the VetPro system. It usually takes 2-3 months the first time someone goes through credentialing. VA credentials everyone who plans to have a license, and people must be credentialed to the level of service they will provide at the VA facility and regardless of the length of time the individual will work at a VA facility.

She then invited participants to ask questions or provide additional comments.

- *Affiliate: Can an assistant load the information for the practitioner to validate?*
 - **Ms. Enchelmayer:** No, because it is a VA IT system that is logon and password protected. At the very end, there is an electronic signature system for individuals to sign and submit their forms, which can only be done by the individual.
- *Affiliate: Can you talk about credentialing trainees?*
 - **Ms. Enchelmayer:** No. Dr. Brannen has to follow up with you. That is managed by Academic Affiliations.
- *Affiliate: If we have a medical student coming onto the site for a day or a few months, do they have to go through the credentialing process just to get access to the computer system?*
 - **Ms. Enchelmayer:** There needs to be a trainee verification letter on file. This is because they need to be covered for Workers Compensation if they happen to slip or fall or if they could violate HIPPA. It could be a HIPPA violation if you have a medical student with you even for one day. Credentialing is the first step to ensuring patient safety.

VHA Café: Information Security

VHA Representative: Mr. Dennis Smith, Region 5 Information Security Director, VHA

Mr. Smith provided insight into the responsibilities and importance of the Information Security Officer (ISO). He particularly re-emphasized the importance of the Affiliate partnership and asked participants to share what security issues they are facing. Mr. Smith also discussed the Continuous Readiness Information Security Program (CRISP). Key points of CRISP are as follows:

- "Material weakness" refers to finding a weakness at one facility, and then looking at another facility and finding the same weakness.
- Last fall, the IG went to the Secretary and reported that VA had addressed every weakness in the Department except for the IT weakness. This is when the CRISP program was started.
- The ISO is trying to do their part to keep the VA out of trouble. These processes are mandated by Congress.

Mr. Smith invited participants to ask questions related to information security and security reviews.

- *Affiliate: I have a question about remote access. We have been given the impression that remote access is not acceptable. Are there certain situations where remote access is allowed?*
 - **Mr. Smith:** The facility has the overall approval, but remote access should usually be allowed. The ISO will process if approved by the facility. You should start with the administrative top level.
 - *Affiliate: We are seeing improvement with the badge system.*
 - **Mr. Smith:** Yes we have been improving the security of our ID badges. The ID badge works with your log in.

- *Affiliate: Does the badge have to stay in the computer?*
 - **Mr. Smith:** Yes. In some cases, you have to put your badge into the keyboard of a computer to make it work. If you leave the computer, you are supposed to take your badge with you.

Final Questions and Answers

VHA Panelists: Charlie Benmark, Norbert Doyle, Susan Taylor, and Rick Lemmon

Mr. Doyle expressed his appreciation for everyone's participation at the Forum. It shows the level of importance people place in the VHA-Affiliate partnership. This forum is a great initial step for improving that relationship, but we need to figure out what's next. He invited participants to share any additional questions and answers they may still have.

- *Affiliate: Ms. Peck mentioned the need for a common model for the Academy Medical Center and Physician Faculty Practice (practice plan). How does VHA determine what entity will contract with physician services? Is there a rule or standard?*
 - **Ms. Benmark:** The definition of an affiliated institution includes the practice plan group. There is no real rule of thumb for determining which entity will contract. Residency training is a key for determining which is more appropriate.
 - **Ms. Hallmark:** The decision may depend on the partnership between VHA and your center's Chief of Staff. They need to agree on what is best for the types of services the Affiliate will provide. Sometimes it starts as one contract and then they decide to split the contract. That can streamline the task orders.
 - *Affiliate: We have contracts with VA through the School of Medicine and some through the practice group. No one knows why or can distinguish between the two; we just think VHA makes the decision. From the VHA's perspective, they are authorized to contract with either group and it's a matter of negotiation. The practice by definition is an affiliated institution and can receive sole-source contracts if there is an educational activity involved.*
- *Affiliate: Regarding residents and fellows, to get reimbursement for them in contracting, we have a unique situation where most of them are employed by the county hospital district and not by us. The county is refusing to payroll a non-reimbursed fellow – no Graduate Medical Education (GME) funding – and we are having a hard time figuring out the VHA contact for placing distribution agreements between VA and us.*
 - **Dr. Brannan:** I will put you (Shawn Cohenour) in touch with Joan Malaconsus to address this issue.
- *Affiliate: Can you please discuss the profit option?*
 - **Ms. Benmark:** It's not that profit is not allowed, it's just discouraged by the OIG. I've seen profit as a part of the contract, and not a part of the contract. The OIG discourages the use of profit, but it can be included. If you are a non-profit organization asking for profit, that is a different issue.
 - **Mr. Doyle:** Maybe VHA could come up with a consistent application to add profit; this option varies across the department.
 - **Mr. Vasbinder:** Negotiations come to a point where the two entities must come to a business decision. The teams may turn to alternative pricing. We need to understand all options. A lot of times, the OIG says "call it what it is: profit."

- *Affiliate: What do you provide as justification for profit? We can't charge overhead when they are real costs. Please explain the difference.*
- **Mr. Vasbinder:** If your overhead is based on an administrative department costs, such as credentialing and scheduling, the costs could be determined to be allowable.
 - *Affiliate: The cost of employing these physicians is all part of university overhead.*
 - **Mr. Vasbinder:** We have heard this from many Affiliates. However, determining the true dollar value associated with these expenses can be difficult. We are reviewing alternative strategies.
 - **Ms. Benchmark:** Is there a percentage of overhead that we can allow? We know it's realistic and reasonable and will allow a certain percentage in your contract.
- **ACTION:** Mr. Doyle will work to develop a consensus position/point-of-view from the department regarding profit, as Affiliates have noted varying strategies for dealing with profit in contracts.
- *COR Participant: Regarding overhead and profit, if the Affiliate demonstrates that they're profitable, they could expand their service. This is justification for profit. Is that a reasonable negotiation?*
 - **Mr. Lemmon:** Reasonable overhead is something VHA should do, but paying Affiliates an opportunity cost is unlikely.
- *Affiliate: When dealing with residents and fellows, the University takes care of them from a hiring and salary perspective, but when it comes to payroll, it's a fixed amount of money. VHA cannot pay for that. Is there another mechanism for VHA to pay an administrative payroll cost?*
 - **Dr. Brannen:** Most of this is based on what results from the concurrence process on the pending Handbook on Educational Costs. Typically, any allowable indirect costs will be paid by contract. Once the handbook is out, payment will be done by contract.
 - **Ms. Benchmark:** We wanted to make the process truer to the services being provided. We know there is an administrative cost that is legitimate. There is a list of separate costs that will be paid by a separate contract. If the need is outside the list, there is an approval process for those to be paid by VHA.
 - *Affiliate: Does that mean the amount of VERA funding will now increase?*
 - **Dr. Brannen:** Not that we are aware of.
- *Affiliate: Will allowable costs change when the handbook comes out? The CO says a variety of costs are not allowable, like a GME program improvement or coordinator salary. Are these allowed in the separate contracting process?*
 - **Dr. Brannen:** Costs for running offices at the affiliate are not included in separate contracts. The handbook is in concurrence and subject to change, but the allowable costs will not cover large chunks of costs of doing business, unfortunately.
- *Affiliate: What is VERA funding?*
 - **Dr. Brannen:** VERA funding goes to medical centers based on the numbers of physician trainees they have. That money is used for the DEO staff and covers the costs of doing business at VA. This also covers VHA site directors. When VERA money goes out to the medical centers, we hope that the money supports education and research at VHA. Many centers do not separate this funding from operational funds.

- *Affiliate: My question is regarding contracting structure with a base year and 1-2 option years. With a desire for multi-year agreements, the option is a unilateral right? Is it really a one-year deal, or is it a package of three-year agreements? We need advanced notice if VA is not going to exercise an option.*
 - **Ms. Benchmark:** It is a unilateral right to exercise an option.
 - **Mr. Doyle:** Most government contracts are base year with four option years. This can be done for funding reasons – sometimes we cannot issue multi-year contracts because many times we need Congress to provide us funding. We must have the dollars up front.
 - **Mr. Lemmon:** Multi-year contracts are something VHA should look at. We need to establish a cancellation ceiling. We haven't explored this in medical sharing. If VHA developed a mechanism to go up to a five year contract (Affiliates want five year contracts), the issue then is predictability.
 - **Ms. Taylor:** Key personnel under the contract are important. You may need to substitute out an employee with someone with equal credentials, and this substitution needs to be cleared with the CO.
 - **Action:** VHA leadership will meet to discuss a path forward for moving healthcare to multiple year contracts.
- *Affiliate: Will a move to multi-year contracts increase the complexity and the cost associated? Will that include additional reviews?*
 - **Ms. Benchmark:** No.
- *Affiliate: There appear to be three layers to the negotiation process – the CO who binds the government into an agreement, the regional negotiator, and the OIG. Are there really three layers of negotiation, or are we just working with COs?*
 - **Ms. Benchmark:** OIG is not a part of the negotiation team unless their support is solicited. The CO is the only authority to obligate the government. The negotiator is there to facilitate the process. In VHA, we have a team approach. We take the input of OIG, clinical staff, and/or the evaluators.
- *Affiliate: There will be one point of contact to deal with the Affiliate and this is a great mantra, and VHA discussed this in a session today. How can I get one designated point of contact? I want to deal with someone in the local Minneapolis office.*
 - **Ms. Benchmark:** This is a management decision at the NCM level and this will depend of the span of control of a particular individual.
 - **Mr. Lemmon:** VISN 23 is one of the few organizations that have not been organized by product team. You will have a healthcare team and a healthcare supervisor. There will be a small number of COs who the Affiliate works with, but they will have one supervisor. That may be your one contact point to get issues resolved.
- *Affiliate: If our organization wanted to change the way it was working with VHA, and seek a single point of contact, would we do all contracting through the University or the practice plan; who would we talk to?*
 - **Mr. Lemmon:** The health team supervisor would be the best point of contact.
 - **Mr. Doyle:** Curtis Jordan from VISN 19 can refer you to the specialty team.

Closing Remarks

Ms. Benmark thanked the Affiliates and VHA personnel for participating. This forum is the first step in the effort to strengthen the partnership between VHA and Affiliates and for improving VA's business processes. VHA intends to review the final report from the forum and determine targeted, specific problems in an effort to resolve these problems. She encouraged participants to continue to offer suggestions for how to improve communication and training on contracting issues.

Appendix A: Forum Agenda

8:15 am	Welcome
8:30 am	Agenda Review and Introductions
8:50 am	The Value and History of the VHA-Affiliate Partnership - <i>Dr. Judy Brannen</i>
9:20 am	The Contracting Process - <i>Charlie Benmark</i>
10:30 am	Break
10:45 am	The Pricing Challenge & Potential Tools - <i>Brian Vasbinder</i>
12:15 pm	Lunch
1:15 pm	<p>Topic Café Sessions</p> <ul style="list-style-type: none"> • Performance Metrics & Quality Assurance • Information Security • Recruitment vs. Contracting • Improving the Negotiating Process • Credentialing and Privileging
3:30 pm	Real-World Scenarios & Final Questions and Answers
4:15 pm	The Path Forward
4:30 pm	Adjourn

Appendix B: Affiliate Attendees

Last Name	First Name	Job Title	Organization or Agency	Email Address	Preferred Phone
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Appendix C: VA Attendees

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Appendix 4: Acronyms

AMC	Academic Medical Centers
CBOC	Community Based Outpatient Clinics
CO	Contracting Officer
COR	Contracting Officer
CMS	Center for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DEO	Designated Educational Officer
eCMS	Electronic Contract Management System
EPA	<i>Economic Price Adjustment</i>
FAR	Federal Acquisition Regulations
FTE	Full-Time Equivalent
GME	Graduate Medical Education
HHS	Department of Health and Human Services
HR	Human Resources
ICA	Interim Contract Authority
ISO	Information Security Officer
IT	Information Technology
LOA	<i>Letter of Acceptance</i>
MOU	<i>Memorandum of Understanding</i>
MSO	Medical Sharing Office
NCM	Network Contracting Manager
NCO	Network Contracting Office
OAA	Office of Academic Affiliations
OGC	Office of General Counsel
OIG	Office of the Inspector General
OPL	Office of Procurement and Logistics
PWS	Performance Work Statements
QAP	Quality Assurance Plan
RVU	Relative Value Units
SAO	Service Area Organizations
SOW	<i>Statement of Work</i>
QISP	<i>Quality Insurance Surveillance Plan</i>

QM	<i>Quality Management</i>
VA	U.S. Department of Veterans Affairs
VACO	VA Central Office
VERA	Veterans Equitable Resource Allocation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WOC	Without Compensation