Bio Summary

Vona da Silva

Vona da Silva is currently retired but active in Oregon health policy development issues. She has been a nurse manager for a West Coast insurance company, a national insurance company, CMS policy development and contract management, with 50 years of health care delivery involvement in all types of settings. She has managed multimillion dollar contracts for CMS over contracted agencies at the Regional level in San Francisco as well as involvement in CMS policy development. She has worked CMS for policy implementation for a fee for service CMS contractor under the Seattle Regional office. Most recently she was extensively involved in review of care and durable medical equipment needs with a focus on the Medicare population, including both aged and disabled persons. She has a Masters in Public Health from UC Berkeley where she also completed her doctoral studies. She is concerned about the need to improve the community goals of sustainability and thoughtful resource management to combat wastefulness and poor accountability within the health care system and by end users.

Vona L. da Silva
2221 SW First Ave, Apt 1923
Portland, Oregon 97201
503-380-0255

Employment History

December, 2004 to April 2012 – Medical Management Coordinator Lead - In this position I have been responsible for review of incoming requests for preauthorization of services and inpatient stays. Initially I worked with all types of Regence coverage. For the past several years I have worked with the Medicare Advantage program only. I have been instrumental in revising the web postings for preauthorization requirements, and worked with Claims to assign coding to the categories that were posted. I was responsible for the leadership role in designated day to day functions as Lead. My particular area of expertise is Medicare coverage, understanding CMS policies and related websites for required information. I also assist filled in for the supervisor when she was away.

August, 2001 – October, 2003 As Senior Clinical Specialist for the Member Appeals and Correspondence Unit, I was responsible for responding to special urgent appeal requests, determining whether the request met those criteria (with physician consultation) and responding to the member within the special brief legislated time frames. I was responsible for researching all benefit packages, all legislative guidelines, standards of practice, reviewing medical necessity and consulting appropriately with physician and Health Plan specialists to complete the appeal determinations in a timely manner.

April, 1997 – August, 2001 As Lead Authorization RN for the Provider Service Center, I was responsible for authorizing and documenting emergency department (ED) care and hospital admissions for Mid Atlantic Region members. I directed workflow for staff handling ED visits by members, hospital admissions, hospital transfers and direct admissions from medical centers. I was responsible for understanding all benefit information available to me online and in reference books and using this information to authorize use of resources to provide medical care for members in consultation with physicians representing the Mid Atlantic Region Medical Group. I was also responsible for emergency case management for member alternative care needs and coordination with daytime staff for follow up care needs. In addition, I reviewed and authorized claim payment for services provided outside of authorized Kaiser Permanente facilities or outside the service area. I typically worked at night with supervision responsibility and understanding all services for members available within the Mid-Atlantic Region.

April, 1994 – April 1997 As the Clinical Coordinator for the After Hours Care, I supervised the provision of telephone access for all members in the Mid Atlantic Region at night and rotation to coverage of evening/weekend After Hours Care Supervisory staff as needed. My staff were responsible for answering member calls from anywhere received at night, telephone assessment and disposition (including advice, emergency room care, physician consultation and emergency case management (as above) when the centers were closed. I also completed editing, extensive computer formatting and development of addendums and many new protocols for the revised Advice Protocols prior to the consolidation to the new Call Center.

July, 1990 – April 1997 As the Clinical Coordinator for the Internal Medicine Department, I managed the delivery of services for 27,000 adult members. I supervised 23 ancillary and nursing staff as well as 4-6 midlevel providers for a staff of 16 physicians. I was accountable for every aspect of the daily management of the department. I worked very closely with the Lead Physician and Internal Medicine Chief NOR for the Mid Atlantic Kaiser Region. I worked with staff and physicians to develop and implement quality assurance activities, physician appointment profiles and schedules, telephone advice nurses handling approximately 80,000 annual calls, and clinical nurses providing a full range of services up through minor trauma, chest

pain and multiple intravenous services. I assisted in implementing the PACE system, conducting training programs and regional planning committees.

1988-1990 As the Service Manager for one division of the Internal Medicine Department at the Oakland, CA Kaiser Facility (total center membership of 450,000), I was responsible for implementing a new functional management program for the largest national HMO. I managed all daily operations for the delivery of services for a panel of 20,000 members and supervised the nursing and ancillary staff of 20 for 12 physicians. I also managed the occupational health program, pre-employment screening and annual health assessments for the entire facility and regional staff totaling 6,500 employees.

1985-1988 As Director of Health Care Services for a large retirement community, I was responsible for all health care provided for the 350 residents both on and off site. I managed a staff of 50 and three separate departments including a clinic, home care and 40 bed inpatient unit for subacute and long term care. I was responsible for all daily health care operations as well as planning and leadership for the overall operations and liaison to state regulatory bodies.

1983-1985 As Director of Home Care and Hospice for the Oakland office of the Visiting Nurses Association, I managed the transition of the office through a merger as well as all daily operations for the office in coordination with the regional mangers for the VNA.The Oakland office managed all home care/hospice services for 300 clients.

1981-1982 I supervised 30 staff providing care for 100 home care clients. I was also responsible for liaison with hospital staff to coordinate inpatient care and home care discharge planning.

1973-1979 I administered contracts for conducting medical peer review of federally financed health care practice. I assisted in drafting and evaluating the national program guidelines as well as the development of 25 Professional Standards Review Organizations (PSRO), including their internal management practices, annual planning, staffing patterns and training. I reviewed and approved performance of annual contracts of up to $1.5 million per contract. I was also responsible for conducting a regional health manpower survey to produce recommendations for projected health manpower needs and federal funding needs for related training programs.

Education and Other

U.C. Berkeley, School of Public Health – MPH, Community Health Nursing: Doctoral Study, Health Administration and Planning (all course work and oral exam completed up to thesis).

UCSF, School of Nursing – PHN Certification completed, Certification # 17989.

University of San Francisco at Lone Mountain College – B.S, Behavioral Science.

Hollywood Presbyterian Hosp, CA – Diploma program, CA RN license # U153459

University of LaVerne, CA – 1 year general liberal arts
Register Nurse – Current. Oregon State
Commissioned Officer, US Public Health Service Corps, Grade 04, Inactive Reserves
Certified Case Manager (CCM), #026892, certification
Publication: “A Force Field Evaluation Tool for Telephone Service in Ambulatory Care”, August, 1991, The Journal of Ambulatory Care Management

Exploring the Concept of Repurposing Durable Medical Equipment – February 18, 2013

Durable Medical Equipment, or DME, is required to have at least a 5 year life with normal daily use. I have 50 years experience in the health care field. This includes CMS, insurance company management and health care delivery in the field. I have encountered many problems with DME use, abuse, waste and fraud. Here are some examples:

- End users whose body dimensions are changing rapidly in height, weight, or girth. This makes it impossible for the original equipment to be safely used. In these cases new equipment must often be provided after only one to two years. The original equipment is appropriate for repurposing.
- End users whose bodies are changing rapidly due to healing processes and/or shrinkage require frequent refitting of equipment. This occurs after an amputation of a body part, for example. Such equipment is very expensive and could often be repurposed.
- End users whose needs are changing rapidly due to rapid progression of a disease process. After a year or two they may no longer be able to use the equipment provided. However, the equipment has often been minimally used and is appropriate for use by another person.
- End users who have died after receiving expensive equipment that is only lightly used. Such equipment could also be appropriately used by another person.
- End users who think their limitations would be improved with a specific piece of equipment. They become dissatisfied or unable to use the equipment once they obtain it. The health care worker encounters the unused equipment on a porch or in a closet. Such equipment could be appropriate for use by another end user who needs that type of DME.
- End users who want equipment for which they do not qualify under their CMS or other DME coverage. Such equipment is considered by CMS to be a “convenience item”. There are end users who want a wheelchair for travel use, for example, but who do not qualify for CMS billing for wheelchair use in the home. They might be able to purchase repurposed equipment for their convenience.
- DME companies who do not adequately assess the needs of the end user who then receives equipment that cannot be used. This equipment may also be appropriate for repurposing.
- DME companies who market equipment to end users that does not meet CMS requirements for the specific user and it is not used. Such equipment could be repurposed.

CMS was forced, when establishing a nationwide program, to develop a system of single use for DME to protect the vulnerable end users. Recall the regular news articles of CMS audit findings about DME provided fraudulently.

If a state waiver program for equipment repurposing were thoughtfully established DME waste could be diminished. A program to repurpose equipment that has not met the expected 5 years of average use and is in good condition for further use could save substantial dollars to a healthcare system.

A repurposing program would require a plan to warehouse, clean, repair and catalog equipment for another user. It would require mechanical experts and prosthetic experts to ensure the repurposed equipment is properly fitted to the new user. Nevertheless, because much of the equipment is extremely expensive, this would be more cost effective than adding the equipment to a land fill or allowing it to rust or degrade in an unused condition on a porch or in a closet. For example, a set of temporary prosthetic equipment might cost over $25,000 and be in use for only one to two years while a limb is healing and shrinking before having to be replaced by a whole new set of equipment for permanent use.

One possibility would be to set up a three year trial program to repurpose the most expensive and/or gently used equipment. This could help save significant dollars and be a model program. An example might be the many entrepreneurs that have established repurposing centers for the building supply industry despite building industry safety concerns and other impediments to such a concept.