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S. HRG. 114–748

THE FUTURE OF THE VA: EXAMINING THE COMMISSION ON CARE REPORT AND VA'S RESPONSE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

SEPTEMBER 14, 2016

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE

28–034 PDF WASHINGTON : 2018

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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C O N T E N T S

SEPTEMBER, 14, 2016

SENATORS

	Page
Isakson, Hon. Johnny, Chairman, U.S. Senator from Georgia	1
Blumenthal, Hon. Richard, Ranking Member, U.S. Senator from Connecticut	26
Brown, Hon. Sherrod, U.S. Senator from Ohio	27
Boozman, Hon. John, U.S. Senator from Arkansas	28
Moran, Hon. Jerry, U.S. Senator from Kansas	30
Tester, Hon. Jon, U.S. Senator from Montana	32
Manchin, Hon. Joe, III, U.S. Senator from West Virginia	54
Sullivan, Hon. Dan, U.S. Senator from Alaska	58
Tillis, Hon. Thom, U.S. Senator from North Carolina	61

WITNESSES

McDonald, Hon. Robert A., Secretary, Department of Veterans Affairs; accompanied by Hon. David J. Shulkin, M.D., Under Secretary for Health	2
Prepared statement	4
Enclosure	11
Response to posthearing questions submitted by:	
Hon. Johnny Isakson	37
Hon. John Boozman	38
Hon. Sherrod Brown	38
Hon. Mazie K. Hirono	40
Schlichting, Nancy M., Chairperson, Commission on Care	41
Prepared statement	43
Response to posthearing questions submitted by Hon. Mazie K. Hirono	65
Harvey, Hon. Thomas E., Esq., Member, Commission on Care	48
Prepared statement	50
Steele, Jeff, Assistant Director, Legislative Division, The American Legion	66
Prepared statement	67
Ilem, Joy J., National Legislative Director, Disabled American Veterans	71
Prepared statement	72
Augustine, Lauren, Senior Legislative Associate, Iraq and Afghanistan Veterans of America	79
Prepared statement	81
Campos, CDR René A., USN (Ret.), Deputy Director of Government Relations, Military Officers Association of America	87
Prepared statement	89
Fuentes, Carlos, Deputy Director of National Legislative Service, Veterans of Foreign Wars	93
Prepared statement	95
Weidman, Richard, Executive Director for Policy and Government Affairs, Vietnam Veterans of America	102
Prepared statement	104

APPENDIX

American Federation of Government Employees, AFL–CIO and The AFGE National VA Council; prepared statement	117

Page

Association of VA Psychologist Leaders, Association of VA Social Workers, Nurses Organization of Veterans Affairs, Veterans Affairs Physician Assistant Association, American Federation of Government Employees, National Federation of Federal Employees, National Nurses United, American Psychological Association, and National Association of Social Workers; position paper 119

Johnson, Sharon, MSN, RN, President, Nurses Organization of Veterans Affairs (NOVA); letter 120

Paralyzed Veterans of America (PVA); prepared statement 121

THE FUTURE OF THE VA: EXAMINING THE COMMISSION ON CARE REPORT AND VA'S RESPONSE

WEDNESDAY, SEPTEMBER 14, 2016

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:30 p.m., in room 418, Russell Senate Office Building. Hon. Johnny Isakson presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Tillis, Sullivan, Blumenthal, Brown, Tester, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call this meeting of the Veterans' Affairs Committee of the U.S. Senate to order. Secretary McDonald and Dr. Shulkin, we are glad to have you here today.

We are going to change our methodology just a little bit. We have two votes: one at 2:45 and one following that vote. We are going to run the hearing continuously. The Ranking Member and I are going to waive opening statements so we can go directly to Secretary McDonald to make his full statement for the record. Then, we will go into as much Q&A as we can.

When I have to leave, hopefully there will be somebody here I can turn it over to so we keep the hearing rolling and go right into the second panel and then later into the third panel. So, with your cooperation, we will work with those two votes and make sure we do not have to shut down. If we do shut down, it is only for a couple of minutes.

Let me just welcome everybody again to this meeting of the Senate Veterans' Affairs Committee. We had a great hearing on the innovations taking place at the VA last week, and I think today's hearing will be equally as good because the Commission on Care was a great project that examined the Veterans Health Administration (VHA), its delivery system for our veterans. I think it had a lot of recommendations in it that are very meritorious, a lot of thought-provoking recommendations.

I appreciate the embrace that Secretary McDonald has given to ideas from others that have come in. We have talked a little bit about them, so I know he is going to have a great testimony for us here today. Let me welcome the Secretary of VA, Robert McDon-

ald, to make his testimony, and we will go from there. We welcome Dr. Shulkin to be here for his testimony as well.

STATEMENT OF HON. ROBERT A. MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY HON. DAVID J. SHULKIN, M.D., UNDER SECRETARY FOR HEALTH

Secretary MCDONALD. Thank you, Mr. Chairman.

Chairman Isakson, Ranking Member Blumenthal, Members of the Committee, thank you for this time to talk about VA's ongoing transformation and the Commission on Care's final report. I wish the House had allowed me the same opportunity last week, but neither I nor the veterans service organizations (VSOs) were invited to testify in person.

I ask that my written statement be submitted for the record.

Chairman ISAKSON. Without objection.

Secretary MCDONALD. Thank you, sir.

First let me thank Ms. Schlichting for chairing the Commission. I know it was not easy, but Nancy did an outstanding job in keeping things together.

Overall, I see the Commission's report as validation of the course we have been on for the past few years. There is hardly anything in the report that we have not already thought of or are not already doing as part of our ongoing *MyVA* transformation efforts.

We differ on some details, but we wholeheartedly agree with the intent of almost all the Commission's recommendations—15 out of 18.

We certainly agree on how wrong it would be to privatize VA health care. Privatization would be a boon for some health care corporations, but as seven leading VSOs told the Commission in April, it could threaten the financial and clinical viability of some VA medical programs and facilities, which would fall particularly hard on the millions of veterans who rely on VA for almost—for all or almost all of their care.

There are many things that VA offers that nobody else offers. We have a unique lifetime relationship with our 9 million patients. Nobody else offers that. Our mental health care is integrated with our primary care and specialty care. Nobody else offers that.

VA health care is whole-veteran health care, customized to meet veterans' unique needs, including care for many nonmedical determinants of health and well-being, like education services, career transition support, housing assistance, disability compensation, and many others. Nobody offers that.

Our research innovations made VA a leader in many areas such as prosthetics, spinal cord injury, traumatic brain injury, post-traumatic stress disorder, polytrauma, and telehealth. Nobody else offers that.

If we send all veterans in the community to find care, they would all lose the choice of integrated, comprehensive care tailored for veterans by people who know veterans and are dedicated to serving them. That is what VA is to veterans, and that is why you do not find veterans demanding Community Care as the only choice. The demand for that only choice comes from elsewhere. It does not come from veterans. Veterans know better.

I have tested this during my time as Secretary. When somebody tells me that veterans should only have the choice of the Choice program, I ask them, are you a veteran? By and large, the answer is no. Then I ask, have you talked to veterans about this, and I get the same answer. Then, I probe a little bit more and I found out that beneath the banner of choice are always two things: interest and ideology.

Let's face it, privatization would put more money into the pockets of people running health care corporations. It is in their interest, so of course it makes sense to them, even if it is not what veterans want or need.

Then there is the ideologues. They only deal with the issue in the simplest, laziest theoretical terms: Government bad, private sector good. That is as far as the thinking goes. Thankfully, most members of the Commission were more understanding.

On one point I strongly disagree with the Commission, which is the idea of an independent board of directors for the Veterans Health Administration. I probably do not need to say much about that since the Constitution probably will not allow it, but I will say that a VHA governance board does not make any sense to me, as a business executive. It would only make matters worse by complicating the bureaucracy at the top and spreading the responsibility for VHA so that no one knows who is ultimately responsible.

The fact is, we already have a governance board. Congress is our governance board. And, if Congress works the way it should, nobody would be talking about adding another layer of bureaucracy to VA.

VA is not the holdup on increasing access. We are doing that. We have been doing that for more than 2 years now. VA is not the holdup on expanding community care. We are doing that, too. We submitted a plan to streamline and consolidate our community care programs last October, almost a year ago. What has happened to it?

VA is not the holdup on hiring more medical professionals or getting rid of real estate that costs us much more each year than it is worth, or adding more points of care where they are needed. We currently have eight major medical construction projects and 24 major medical leases needing authorization. They are already funded, but we still need a green light from Congress to move forward.

We are not even the holdup on holding people accountable for wrongdoing. Ask the former VA employee in Augusta, GA, recently convicted of falsifying health care records. He is facing sentencing that could include years in prison and thousands of dollars of fines. All told, we have terminated over 3,755 employees in the past 2 years. We have made sustainable accountability part of our ongoing leadership training.

The Veterans First Act would help us hold people accountable, and we look forward to seeing it brought to the Senate floor for passage. The Senate Appropriations Committee has also approved a budget nearly equal to the President's request, but again, we need to see some follow-through.

The holdup in our very real and ongoing *MyVA* transformation is our need for congressional action. We have submitted over a

hundred proposals for legislative changes that we put in the President's 2017 budget. No results yet.

I detailed our most urgent needs in my August 30 letter to the Committee. They include: approving the President's 2017 budget request to keep up with rising costs and medical innovation; extending authorities to maintain services like transportation to VA facilities in rural areas and vocational rehabilitation; fixing provider agreements to keep long-term care facilities from turning veterans out to avoid the hassle of current requirements; and ending the arbitrary rule that will not let VA's dedicated, conscientious medical professionals care for veterans for more than 80 hours in any Federal pay period.

We also need you to act on modernizing our archaic claims appeals process. Under the current law, with no significant changes in resources, the number of veterans awaiting a decision will nearly triple in the next 10 years from 500,000 today to almost 1.3 million. We submitted a plan to reform the appeals process in June. We developed a plan, with the help of the VSOs, State and county veterans officials, and other veterans advocates. They are all onboard. We just need Congress to get on board.

I am only after what is best for veterans. As you know, I am not running for office. I am not angling for a promotion. I could have taken an easier job 2 years ago but I did not. I answered the call of duty, thinking only of giving veterans the benefit of what I learned at West Point, in the Army, and 33 years in the private sector running one of the most admired companies in the world. I have tried to do that.

Now, 2 years into the transformation process, my only concern is to see it continue. I know Nancy will tell you transformation is a marathon, not a sprint. It will take several years to turn any large organization around. To turn VA around, we must maintain our momentum of change, and we cannot do that without cooperation of Congress and passage of some of the legislation we talked about. That is an absolute certainty.

The Commission, the VSOs, and VA are all in agreement on this: Congress must act or veterans will suffer. That is unacceptable to me and I know that it is unacceptable to you. So, what can we do to break this impasse and get things moving? Whatever it takes, I will do it. Just let me know what it is.

Thank you, Mr. Chairman.

[The prepared statement of Secretary McDonald follows:]

PREPARED STATEMENT OF ROBERT A. MCDONALD, SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS

CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL, AND MEMBERS OF THE COMMITTEE, Thank you for the opportunity to discuss the future of the Department of Veterans Affairs (VA) and the Commission on Care's Final Report. I am accompanied today by Dr. David Shulkin, Under Secretary for Health.

Mr. Chairman, two years ago I was tasked to transform VA for the 21st Century. Since then, VA has established a comprehensive, enterprise-wide transformational process named *MyVA*, which has already increased Veterans' access to healthcare, significantly reduced Veteran homelessness, and begun improving Veterans' experience with VA's benefits and services.

This past January, I came before this Committee and described *MyVA*'s five critical strategies:

1. Improving the Veteran experience,
2. Improving the employee experience—so we can better serve Veterans,

3. Improving internal support services,
4. Establishing a culture of continuous improvement, and
5. Enhancing strategic partnerships.

These five *MyVA* strategies are about rebuilding trust with Veterans, their families and survivors, and the American people. They're a concerted approach to leveraging VA's immense scope and scale so we can give every Veteran an exceptional experience that's easy, consistent, and memorable. *MyVA* is about looking at VA from a Veteran's perspective; doing everything we can to make the Veteran's experience effective at meeting Veterans' needs and earning their confidence. *MyVA* is leaving old, unresponsive ways of doing business behind and changing VA into the high-performing organization it must be to serve Veterans in the 21st century.

At that January hearing, I also spoke about VA's 12 "Breakthrough Priorities." Designed to improve the delivery of timely care and benefits to Veterans, our Breakthrough Priorities are helping VA concentrate efforts on serving Veterans and their families and survivors while aligning resources for success. Eight of the 12 Priorities are about directly improving service to Veterans. Four of the Priorities represent critical enablers to reform internal systems and give employees the tools and resources they need to consistently deliver an exceptional Veteran experience. One Priority is Improving the Employee Experience. For the last two days, I have been at a Leaders Developing Leaders Conference with almost 600 of VA's Leaders. Immediately after this hearing, I am returning to the conference. Developing our leaders and ensuring they have the resources that allow for them to deliver a seamless, integrated, and responsive Veterans experience is critical to our future success.

We are rigorously managing each Breakthrough Priority. One senior executive is responsible for each Priority. A cross-functional, cross-Departmental team is in support. Teams meet bi-weekly with me or the Deputy Secretary to focus on each Priority, discuss progress, identify roadblocks, and find solutions. Weekly updates to Department leadership and our Department-wide *MyVA* Dashboard track progress using established metrics. Meeting these 12 Breakthrough Priorities is a challenge, but we're committed to results for Veterans.

SUMMARY OF BREAKTHROUGH PRIORITIES AND PROGRESS TO DATE

We are building the momentum to carry our comprehensive *MyVA* transformation years into the future. This transformation will have a wide-ranging impact on Veterans, their families, VA employees, and stakeholders. The trust Veterans have in VA has already increased by more than eight percentage points. We also owe it to the American people to be good stewards of the resources allocated to us. As examples of the impact we are having on Veterans, employees, and taxpayers, I highlight the following major accomplishments:

For Veterans, Servicemembers, Families, and Survivors

The most important outcome for Veterans is their success after leaving military service. They should be thriving—receiving the healthcare they need; in meaningful, reliable employment; and secure in their prosperity. For *MyVA*, the outcome we seek is to make access to the care and services Veterans have earned predictable, consistent, and easy. We will gauge how Veterans view their partnership with VA as a measure of the effectiveness of *MyVA*'s efforts. Indicators of progress around the Veterans Experience Priority fall into three mutually reinforcing categories:

1. Trust in VA among America's Veterans.
   - VA has implemented a new trust measurement to gauge Veteran's trust that the VA will fulfill its commitment to our Nation's Veterans. This measure has increased by 7 percentage points since its implementation in December 2015.
   - VA has completed 11,716,685 same day appointments for FY 2016 to date.
2. Customer experiences marked by effectiveness, ease, and positive emotion.
   - In July 2016, 96.36% of appointments were within 30 days of the clinically indicated or Veteran's preferred date; 85.05% were within 7 days; 22.44% were same-day appointments. In July 2016, average wait times for completed appointments were 4.72 for primary care, 6.60 for specialty care, and 2.77 for mental health care.
   - VHA has reduced the Electronic Wait List from 56,271 appointments to 33,373, a 40.69% reduction between June 1, 2014 and August 15, 2016.
   - VHA and the Choice contractors created more than 3.2 million authorizations for Veterans to receive care in the private sector from June 1, 2015 through May 31, 2016. This represents a 7% increase in authorizations when compared to the same period in 2014/2015.
   - Veterans are now able to schedule optometry and audiology appointments directly at 71 VA medical centers without going through primary care for a referral. This not only allows many Veterans to get their eyeglasses and hearing aids

quicker; but also eliminates some demand on primary care. This will be implemented at all VA medical centers by December 2016.

3. Completion of critical customer-centric improvement projects, sponsored by the Veterans Experience team at VA.

• Enrolling in the VA healthcare system is much easier now than it was just a few months ago. Since June 30, when a revamped healthcare enrollment experience was launched on Vets.gov, over 9,200 have enrolled instantaneously online. An additional 850 have enrolled by telephone as a result of process improvements made by our Health Enrollment Center. This includes removal of an actual ink signature requirement and acceptance of an electronic signature. This change has eliminated unnecessary and inefficient back and forth mailings with the Veteran.

4. By the end of this year, every Veteran in crisis will have their call promptly answered by an experienced responder at the Veterans Crisis Line. The VA has partnered with the Departments of Labor, Housing and Urban Development, the U.S. Interagency Council on Homelessness, and other Federal agencies to make substantial progress toward the Administration's goal of ending veteran homelessness in communities across the country.

• Through June 2016, more than 56,500 homeless or at-risk Veterans and their family members have obtained permanent housing or were prevented from becoming homeless as a result of VA's targeted homeless services.

• Since 2010, the number of Veterans experiencing homelessness in the United States has been cut nearly in half, with a 17 percent decrease in Veteran homelessness between January 2015 and January 2016.

5. Expanding the network of Community Veteran Engagement Boards to ensure Veterans' needs in local communities are met

• To date, 80 fully formed boards have been established with a target of 100 by December 2016.

• VA leaders have begun participating more actively in community-based efforts to maximize the collective impact of local services, stakeholders, and Federal/state agencies working together to improve Veteran outcomes.

• The first-ever meeting of community boards from around the country occurred just last week.

For VA Employees

The most important outcome for employees is to feel engaged and empowered to create the highest level of impact every day. Each employee must have meaningful work and a clear view of its benefit to Veterans. Measuring how employees view their experience with VA will reflect the effectiveness of *MyVA*'s efforts. Indicators of progress around the Employee Experienced Priority include:

• Hiring rates in speed of hire shortened.

• Inclusion of elements targeting how to improve employee engagement and customer service in Senior Executive performance plans.

• Policy in place requiring all VA supervisors and employees to have a customer-service standard in their performance plans.

• Completion of Leaders Developing Leaders (LDL) training: This training equips leaders with skills in applying LDL concepts and tools for strengthening employee commitment, building trust and personal accountability, reinforcing principle-based decisionmaking, and improving processes to serve and care for Veterans; working projects or initiatives to make VA more effective and efficient.

– Nearly 80,000 VA leaders and frontline staff from across VA have participated in LDL training thus far.

– LDL Training is cascaded down to frontline staff using materials, messaging, and tools developed and distributed for 2-day, 1-day and half-day modules.

– Over 500 registered LDL projects have been completed or are underway; all aligned with at least one of the 12 Breakthrough Priorities.

– Recent survey data confirms the positive impact of LDL training and participation in projects on employee engagement.

• 83% of employees who have had LDL training with a project state they know how they relate to VA transformation compared to 62% who have no LDL.

• 79% of employees who have had LDL training with a project state they feel valued for the work they do compared to 61% who have no LDL.

• 79% of those employees who have had LDL training with a project state they are witnessing positive changes in VA's culture compared to 58% who have no LDL.

For American Citizens and Taxpayers

Through proper governance and transparent management systems, VA will deliver effective services and benefits, be a good steward of fiscal resources, reliably protect personal information, and effectively anticipate and efficiently adapt to the

future needs of our Nation's Veterans. For example, our Medical-Surgical supply chain will have delivered $150 million in cost avoidance by the end of 2016. These savings are available for redirection to priority Veteran programs and outcomes.

Thanks to the continuing support of Congress, VSOs, union leaders, our dedicated employees, states, and private industry partners, we have made tremendous headway over the past 18 months. Congress has passed some key legislation, such as the Veterans Access, Choice, and Accountability Act and the Clay Hunt Suicide Prevention for American Veterans Act, which gives VA more flexibility to improve our culture and ability to execute effectively. But much more needs to be done.

COMMISSION ON CARE

Mr. Chairman, the direction we have taken and the progress we have made has been largely validated by the Commission on Care in its Final Report. The President and VA find 15 of the18 recommendations in the Commission's report feasible and advisable. Further, after thoroughly reviewing the report, I am pleased to say that 12 of the Commission's 18 recommendations are objectives VA has already accomplished or has been working toward for the past two years as part of the *MyVA* transformation.

I strongly support the Commission's intent that creating a high-performing, integrated health care system that encompasses both VA and private care is critical to serving the needs of Veterans. In fact, VA has outlined our approach to achieve this same goal in our Plan to Consolidate Community Care, submitted to Congress in October 2015. This plan would provide Veterans with the full spectrum of healthcare services and more choice without sacrificing VA's foundational health services on which many Veterans depend.

At the same time, it is critical that we preserve and continue to improve the VA health care system and ensure that VA fulfills its mission. Veteran Service Organizations, having decades of experience advocating for generations of our Nation's Veterans, have made it crystal clear that they believe VA is the best place for Veterans to receive care. Many VSOs fear that the Commission's vision would compromise VA's ability to provide specialized care for spinal cord injury, prosthetics, Traumatic Brain Injury, Post Traumatic Stress Disorder, and other mental health needs, which the private sector is not as equipped to provide. We share their concern and therefore do not support any policies or legislation that will lead to privatization, which I am pleased the Commission did not recommend outright. Privatization is not transformational. It's more along the lines of dereliction of duty.

VA also strongly disagrees with the Commission on its proposed "board of directors" to run the Veterans Health Administration (VHA). Such a board is neither feasible nor advisable for both constitutional and practical reasons. The U.S. Department of Justice has concluded that the proposed structure of the Board would violate the separation of powers. Among other concerns, the Constitution prevents Congress from appointing persons to exercise authority over Executive branch agencies and as such, would prevent the proposed board from exercising the authorities assigned to it by the Commission. The Commission's proposal would also seem to establish VHA as an independent agency, undoing the work of the VSOs in supporting VA as a Cabinet-level department. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health, as well as weaken ownership of the *MyVA* transformation and VHA performance. This could potentially disrupt and degrade VA's implementation of critical care decisions that affect Veterans. The proposed independent VHA agency would also run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans healthcare with the many other services provided to Veterans by the Veterans Benefits Administration and the National Cemetery Administration.

We do, however, strongly agree with the idea of external advice and counsel to ensure that VA is operating with the greatest degree of efficiency and effectiveness for Veterans. At present, VA is served by 25 advisory committees, including a newly reconstituted Special Medical Advisory Group, which consists of leading medical practitioners and administrators, and a newly established *MyVA* Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates. These advisory committees advise VA on strategic direction, facilitate decisionmaking, and introduce innovative business approaches from the public and private sectors. With their help, the Department has begun the process of transforming VHA from a loose federation of regional healthcare systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of healthcare services and additional choice, but without sacrificing VA's foundational health services upon which many Veterans depend.

Although we differ with the Commission on these and other issues and are pursuing alternative approaches where warranted, we agree with the Commission that many changes planned by *MyVA*, recommend by the Commission and strongly supported by VSOs, will likely require resources and remedies that only Congress can provide. These needs are addressed in VA's detailed responses to the recommendations in the Commission on Care's Final Report, which are included as an enclosure to this letter.

VETERANS CHOICE PROGRAM UPDATE

The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) was signed into law on August 7, 2014, and mandated that VA implement a new community care program, the Veterans Choice Program (VCP), to increase timely access to healthcare.

VA increased access to Veterans through an integrated system of care. VHA staff and Choice contractors created over 3 million authorizations for Veterans to receive care in the private sector from October 2015 through July 2016. This is a 42 percent increase in authorizations when compared to the same time period last year. From FY 2014 to FY 2015, Community Care appointments increased about 20 percent from 17.7 million in FY 2014 to 21.3 Million.

Congress mandated that VA implement VCP in 90 days. Implementing a nationwide program in 90 days is unprecedented and led to many growing pains for Veterans, community providers, and VA. During the initial year of the program, VA met with Veterans, community providers, leading healthcare experts, and staff across the country to hear concerns and identify solutions.

In October 30, 2015, VA submitted to Congress our Plan to Consolidate Community Care, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership and clinicians, representing diverse groups and backgrounds. VA has already begun what work we can without legislation to make the plan a reality.

Over the course of the last 12 months, our Choice Provider network has grown by 85 percent. The network now has over 350,000 providers and facilities across the Nation. Over 1.0 million unique Veterans have used the Veterans Choice Program (VCP). Over 100,000 Veterans with 40-mile eligibility used VCP through June 2016. Authorizations for care under the Veterans Access, Choice, and Accountability Act (VACAA) have increased by 81 percent over nine months (October 2015 to June 2016), and VCP authorizations have quadrupled from approximately 301,000 in FY 2015 to almost 1.3 million in FY 2016.

In order to immediately implement changes to the Choice Program, VA brought in new leadership to oversee all Community Care Programs. Under this new leadership, VA quickly began to improve the Choice Program and laid out a plan to drive toward a future that delivers the best of VA and the community.

New programs of this magnitude take time, but VA is making steady progress by implementing immediate improvements to the Choice Program, by developing innovative solutions to improve the community care experience, and by driving toward the future—a single consolidated program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers and VA staff. VA will also continue to strengthen its partnerships with other Federal health care providers, the Department of Defense (DOD) and Indian Health Service, as well as with Tribal Health Programs (THPs), academic teaching affiliates, and federally Qualified Health Centers (FQHCs). DOD resource sharing agreements support the Nation's defense readiness mission, while relationships with academic teaching affiliates align with VA's education and research missions. High-quality providers in IHS, THPs, and FQHCs promote access to exceptional care for Veterans where the live, including rural and medically underserve communities.

In the last two years, we've asked Congress to be our partner as we strive to be the No. 1 customer-service agency in the Federal Government. That is our vision, and we cannot get there without your help. Our Veterans preserved our Nation's opportunity to prosper, and Veterans and their families deserve nothing less than a seamless, unified Veterans experience across VA and across the country. They are counting on us, VA, as well as Congress, to do our part. We need you to continue to partner with us now more than ever. You were there side by side with us as we implemented the VCP. You have been with us side by side as we listened to our Veterans and other stakeholders in providing the needed legislative changes to make choice that much better. Since the implementation of the VCP, VA partnered with Congress to change the law four times, including:

• Removing the enrollment date requirement for Choice, allowing more Veterans to receive community care.
• Redefining criteria of 40-mile eligibility by using driving distance from a primary care physician, increasing the number of Veterans eligible for the program.
• Implementing new unusual-or-excessive-burden criteria, increasing access to care for Veterans who do not meet other eligibility criteria.
• Expanding the episode of care authorization from 60 days up to one year, improving continuity of care and reducing the administrative burden on Veterans and providers.

Additionally, with your help we have made countless VCP contract and program improvements including:

• Executing over 45 contract modifications to improve Program performance.
• Improving timeliness of payments to community providers by removing the requirement that all medical documentation must be received prior to payment.
• Reducing administrative burden for medical record submission for community providers by streamlining the documents required.
• Enhancing care coordination for Veterans, with embedded contractor staff now with VA staff at 14 locations and continuing increases in the number of embedded staff locations.
• Creating dedicated teams of VA and contractor staff that meet regularly to deliver community care improvements.
• Partnering with the community through electronic health exchanges:
  – VHA is connected to 72 of the eHealth Exchange participants. There are 116 participants total.
  – Through these 72 connections, VHA is now connected to 755 hospitals, more than 10,000 clinics, and over 8,400 pharmacies.
  – Total unique enrolled Veteran patients available for information exchange with community partners is now over 590,000.
  – Over 1.3 million Veteran health records are currently available for exchange.
• Over the course of the last 12 months, the Choice Provider Network has grown by 85 percent. The network now has over 350,000 providers and facilities, including over 200 academic hospitals and centers over 50 % of CMS participating accountable care organizations.[1]
• As of May 2016, it takes approximately six days to contact the Veteran, obtain their provider and appointment preferences, and work with the community provider to schedule an appointment compared to 11 days in May 2015.
• Choice contractor call center metrics have continued to improve:
  – Call abandon rate is less than 2 percent.
  – Call hold time is no more than 7 seconds.
  – First call resolution is over 96 percent.
• Over 9 million Veterans have received Choice Cards.
• As of August 1, 2016, 847,451 are eligible based on mileage or hardship.
• As of August 1, 2016, 1,721,909 Veterans are eligible based on wait time.
• As of August 1, 2016, 2,569,360 Veterans are eligible based on mileage or wait time.
• Choice Authorizations have quadrupled from approximately 301,000 in FY 2015 to almost 1.3 million in FY 2016 thus far.

With your help, and with the assistance of our third-party administrators, we have developed and implemented a number of innovative solutions to aid our community care programs. VA community care innovative solutions are part of the Department's continued commitment to improve the community care experience across the country by streamlining and strengthening clinical and business processes. The innovative solutions address a number of topics, example are listed below:

• *Care Coordination:* Alaska VA Healthcare System staff will replace a portion of the intermediary role currently performed by Choice contractor TriWest to make scheduling an inherently VA activity. This business process change is in direct response to concern by Alaska Veterans who reported that calling out-of-state Choice contractors resulted in delays with their care coordination, mostly attributed to time zone differences and a lack of understanding of Alaska's unique geography.
• *Increasing Access Points:* On May 25, 2016, VA Central Office in conjunction with VA Palo Alto Health Care System announced a partnership with CVS MinuteClinic. The program, a VA innovation, focused on the treatment of minor ill-

[1] https://data.cms.gov/ACO/2016-Medicare-Shared-Savings-Program-Organizations/5kdu-cnmy

nesses and injuries, expands access points of care to locations that are closer to Veterans' homes and at hours that are more convenient.

• *Gaining Efficiencies:* VA developed a new tool that it anticipates will expedite medical claims processing. The Productivity Monitoring Tool tracks claims status and monitors the number of claims each employee verifies, distributes, denies, rejects, or sends to payment. It also provides granular information by claim and program type. With this tool, VA can view productivity data by claims processor and identify potential areas for improvement. Additionally, the Provider Rapid Response Team, comprising representatives across VA, Health Net, and TriWest, was established to quickly address community provider inquiries and resolve systemic issues with provider payment processes.

DRIVING TOWARD THE FUTURE

VA cannot accomplish the ongoing transformation envisioned by *MyVA* or recommendations from the Commission without critical legislative changes and funding. VA has aggressively pursued these needed changes and funding with Congress.

More than 100 legislative proposals for Veterans were included in the President's 2017 Budget. Many of these proposals are vital to maintaining our ability to purchase community care. We continue to work to move these critical initiatives forward and are encouraged by the fact that most have been considered in legislative hearings or included in omnibus bills moving toward floor consideration, like the bipartisan Veterans First Act, which passed the Senate Veterans Affairs' Committee unanimously. These bills include some of the provisions of the Purchased Health Care Streamlining and Modernization Act we submitted to Congress in May 2015, such as an enhanced-use lease authority, compensation reform for medical professionals, and a measure of budgetary flexibility to respond to Veterans emerging needs and overcome artificial funding restrictions on providing Veterans care and benefits. These provisions would go a long way toward ensuring the success of *MyVA*, but other important legislative issues still need to be addressed, especially the consolidation of VA's many purchased care authorities and modernization of VA's archaic claims appeals process.

VA is doing all that it can within current law and current funding to better serve our Veterans. But, VA and the Veterans we serve need action by Congress in the remainder of the 114th Congress on a number of issues to continue the transformation of VA and provide the fullest and best-delivered benefits and services Veterans need and deserve. Specifically, Congress must pass a clean version of the President's full budget request; provide more budget flexibility to allow VA to operate more efficiently; act on several critical legislative priorities; and act to prevent the lapse of critical programs. Among the critical initiatives requiring legislative action from Congress are appeals modernization, purchased care modernization, and workforce enhancement. Listed below are VA's top legislative priorities:

Budget

• 2017 Budget—It is critically important to Veterans that VA has full-year funding consistent with the President's Budget request, and that VA not be forced to operate for a protracted period of time under Continuing Resolutions.

Extenders

• Without Congressional action, a number of existing VA authorities will expire before the end of the fiscal year, September 30, 2016, with others expiring at the end of calendar year 2016. Extensions of these authorities are necessary in order for VA to continue providing important services to Veterans. Below are some of the most critical significant negative results of a failure of Congress to act:

– VA would have to largely terminate the Veterans Transportation Service, on which thousands of Veterans rely for access to medical care.
– VA would have to close the Manila VA Regional Office.
– VA's home loan program could be disrupted.
– Vocational rehabilitation benefits for injured Servicemembers would be interrupted.

LEGISLATIVE PRIORITIES

• Appeals Reform

VA is already pursuing changes in staffing and technology to improve the current appeals process, but VA is badly in need of statutory structural changes to appropriately address and fix the current pending inventory of appeals. Our goal is to greatly simplify the appeals process and provide Veterans with a quality appeals decision within one year of their appeal. Legislation proposed in the House and Senate

has been scored as cost-neutral and without legislative action from Congress, the timeline for decisions under the current disability claims appeals system will continue increase to the detriment of Veterans.

Without this much needed legislation, VA projects that Veterans will be waiting an average of 10 years for a final decision on their appeal by the end of 2027.

• Provider Agreements

In order to ensure that Veterans are receiving necessary care through the fullest complement of non-VA providers, VA purchased care authorities must be clarified and modernized. VA and its provider partners who use provider agreements are facing continuing uncertainty, so expeditious action is necessary. VA transmitted the VA Purchased Health Care Streamlining and Modernization Act to Congress on May 1, 2015. As the VA has previously testified, legislation authorizing the VA to purchase this care in certain circumstances through agreements must also be subject to certain provisions of law governing Federal contracts, including providing specific employment protections.

• Workforce Enhancements

The following changes are necessary to recruit and retain critical professionals: Removal of the 80-hour pay period requirement, which is not efficient or appropriate for many medical professionals and is not in line with the private sector and special pay authority for VAMC and VISN Directors is important in order to secure and retain the best talent available in hospital system management.

• West Los Angeles

HVAC and SVAC have advanced bills to facilitate changes for VA's West LA campus that will be of great benefit to Veterans, but we still need legislative action. The Master Plan represents a community consensus after years of litigation, as well as a vision and a model for providing services to homeless and at-risk Veterans. Failure to enact this legislation will halt progress on this important initiative, which has wide support in the community.

• Construction and Leasing

VA needs Congressional authorization for numerous construction and leasing projects across the country to increase Veterans' access to care closer to their homes. Funding has already been appropriated for many of these projects.

• Telehealth

Legislation is pending that will help ensure that VA can guarantee the fullest use of telehealth capabilities in order to provide easier access to VA healthcare, especially in rural areas and across state lines.

Thank you again for this opportunity and thank you for all you do for Veterans. We are extremely grateful for having your support; however, we must work together as the time to act is now. America's Veterans did their duty. They answered the call; we, Congress and VA, must now do our part.

Enclosure
August 2016

DEPARTMENT OF VETERANS AFFAIRS
REVIEW OF THE COMMISSION ON CARE

Over the past two years, the Department of Veterans Affairs (VA) has been working energetically, through its *MyVA* initiative, to transform the Veterans Health Administration (VHA) from a loose federation of regional health care systems to a highly integrated national enterprise, based on a new model of care with VA as both the payer and provider. This model will provide Veterans with the full spectrum of health care services, plus more choice, but without sacrificing VA's foundational health services that many Veterans depend on.

In October 2015, VA delivered to Congress a plan for evolving our current system into a high-performance network based on timely access to foundational services and integration of private-sector providers. Building on more than a decade of working with community partners through multiple mechanisms, this plan would consolidate the various mechanisms, expand our network of providers, and enhance the network's capability to deliver services essential to Veterans' health.

Many of the Commission on Care's (Commission) recommendations are aimed in the same direction and are already being implemented as part of VHA's *MyVA* transformation. VA finds 15 of 18 Commission recommendations feasible and advisable (#1–3, 5–8, 10–16, and 18) and 3 not feasible or advisable (#4, 9, and 17). VA is already implementing changes with the same intent as 12 recommendations (#1–3, 5, 7–8, 10–11, and 13–16); recommends alternative approaches to 2 recommendations to bring them in line with other *MyVA* reforms (#6 and 12); and will work with

the President, Congress, Veterans Service Organizations, and other stakeholders on recommendation #18.

Many of the Commission's recommendations also require action by Congress. VA has aggressively pursued legislative changes and funding that would enable VA to achieve its *MyVA* vision. More than 100 proposals for legislative changes were included in the President's 2017 Budget. VA also submitted to Congress in May 2015 the Purchased Health Care Streamlining and Modernization Act, parts of which have been incorporated into the Veterans First Act in the Senate. Many of VA's proposals, which are vital to maintaining our ability to purchase non-VA care, are pending Congressional action.

Recommendation #1: VHA Care System—"Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which Veterans will access high-quality health care services."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach to achieve the vision described above.

In October 2015, VA submitted to Congress its *Plan to Consolidate Community Care*, which lays out our vision of a consolidated community care program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff. This plan incorporates feedback from key stakeholders, including VHA field leadership as well as clinicians, representing diverse groups and backgrounds.

Immediate steps to improve the stakeholder experience were identified and included in the plan, including reducing unnecessary steps in the processes to enroll and connect Veterans with community care; improving communications between VHA, provider, and Veterans; improving care coordination in the long term for Veterans through improved exchange of certain medical records; and aligning the Veteran's community care journey along five major touch points: eligibility, community care network, referral and authorization, care coordination, and provider claims payment.

Eligibility: The Plan recommends the creation of eligibility criteria to streamline the many different requirements for community care into standard criteria without opening community care to all enrolled Veterans. This is VA's principal point of difference with the Commission on its proposed VHA Care System. VA believes the Commission's recommendation to extend community-care eligibility to all Veterans by eliminating the Veteran Choice Program's (VCP) current time and distance criteria (30 days and 40 miles) is not advisable without Congressional funding due to the expected cost increase and desire to not sacrifice VA's four statutory missions: delivering hospital care and medical services to Veterans, educating and training health professionals, conducting medical and prosthetic research, and providing contingency support to other Federal agencies during emergencies. Many VSOs fear that the Commission's vision would jeopardize VA's ability to provide specialized care for spinal cord injury, prosthetics, Traumatic Brain Injury, Post Traumatic Stress Disorder (PTSD), and other mental health needs, which the private sector is not as equipped to provide. For this reason, VA opposes elimination of the current time and distance criteria.

Community Care Network: VA has since begun developing the requirements for the new community-care network contract, with standards and criteria developed from input by industry, facility staff, and program office staff representing a broad spectrum of needs. These standards and criteria will be included in the draft Request for Proposal (RFP) for the community care network that will open for bid later in calendar year 2016. Legislation is needed to improve Veterans experience by consolidating existing programs and standardizing eligibility criteria.

Referral and Authorization: To ensure that Veterans have access to the full spectrum of health care services, VA will focus on areas in which it can excel (VA-delivered foundational health services) and develop locally defined community partnerships for specialty care as needed. Standards and criteria for specialty care referrals are currently being developed for inclusion in the draft RFP. While the primary care provider will coordinate referrals for specialty care within the integrated VHA Care System, VA should be seen as the prime provider for special emphasis services. For example, VA is the leader in integrating primary care and mental health care and should be seen as the primary care provider for these services. When VA cannot provide a primary care provider, Veterans will be able to select from credentialed providers in the high-performing network.

Care Coordination: The Plan stresses care coordination with a focus on customer service, emphasizing the need for care coordination for Veterans who receive com-

munity care as well as in VA. This coordination would include both the primary care provider staff as well as other VA staff. In cases where VA cannot provide the care coordination for Veterans, the services may be provided through the community care network. In other cases, VA coordinators make more sense. This is true in the Alaska VA Healthcare System, where VA staff will fill an intermediary role currently performed by VCP contractor TriWest to make scheduling an inherently VA activity, in response to local concern that calling out-of-state VCP contractors resulted in delays in care coordination, mostly attributed to time-zone differences and a lack of understanding of Alaska's unique geography.

Provider Claims Payment: VHA is also already working to streamline reimbursement methodologies among its various community care programs and to develop a standardized, transparent process for reimbursing providers in an integrated delivery network. VHA and the Centers for Medical and Medicaid Services (CMS) are identifying CMS innovations in value-based payment methods on a limited basis. Legislation is needed to revise reimbursement rates under the Veterans Access, Choice, and Accountability Act to allow for flexibility from Medicare fee-for-service reimbursement methodologies to value-based methodologies of the future.

Legislation is needed to effectively consolidate existing community care programs, which would reduce confusion among Veterans, community providers, and VA staff. The Commission states that in order to achieve the recommendations, VA must have "flexible and smart procurement policies and contracting authorities." VA strongly agrees and has aggressively pursued legislative changes that would ensure that the appropriate level of flexibility is available to best serve Veterans. In May 2015, VA submitted the Purchased Health Care Streamlining and Modernization Act to Congress. This legislation supports key points of VA's Plan to Consolidate Community Care and would allow VA to enter into agreements with individual community providers outside of Federal Acquisition Regulations, without forcing providers to meet excessive compliance burdens.

VA is also concerned that the Commission's cost estimates do not accurately reflect the likely cost of its proposed system. From a baseline estimate of $71 billion, the Commission estimates that the cost of its recommended option for Veterans' health care for fiscal year (FY) 2019 ranges from $65 billion to $85 billion, with a middle estimate of $76 billion. However, the Commission estimates the cost could increase to $106 billion in FY 2019 if VA is unsuccessful in tightly managing the network and focusing on costs. We appreciate the analysis underpinning the Commission's estimates, but caution that the cost of implementing the Commission's recommendation is likely to be significantly higher, for the following reasons:

- The estimates do not include the substantial investment in information technology (IT) resources that would be required to fully integrate VA care with community care or the administrative/contractual costs of operating the community-delivered services component of the integrated network.
- The estimates assume that VA can realign and consolidate personnel in five years to best provide health care to Veterans, which is an aggressive timeline.
- The estimates do not address the cost of realigning or divesting capital assets as additional care is delivered in the community. While VA agrees in principle with the Commission's recommendation to develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs (see Recommendation #6), we note that the realignment, consolidation, and divestiture of capital assets will require substantial resources and time.
- The estimates are highly dependent on Veteran enrollment in, reliance on, and utilization of VA health care, all of which are difficult to predict, as most Veterans enrolled in the VA health care system have other sources of health care coverage. Extending community care to more Veterans could cause Veterans who now rely on Medicare, Medicaid, or private insurance to use VA care for more of their health care needs because of lower copays or greater convenience, increasing VA's costs.
- Finally, we must caution that the estimates do not reflect the entire VA Medical Care budget as they do not include the cost of programs that are not modeled by the VA Enrollee Health Care Projection Model. These programs include readjustment counseling, non-medical homeless programs, Caregivers, Health Professions Educational Assistance Program, Income Verification Match, CHAMPVA, Spina Bifida, Children of Women Vietnam Veterans, etc. In total, they are estimated to cost $8.2 billion in FY 2017.

Recommendation #2: Enhancing Clinical Operations—"Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach.

VHA is already engaged in processes to make full use of the skills held by VHA providers and other health professionals. VHA is a leader in the use of clinical pharmacists to increase capacity by renewing prescriptions or ordering medication refills independently, after the initial prescription by a licensed physician or nurse practitioner. In addition, many VA clinical pharmacists have a scope of practice that provides prescribing authority and enables them to run pharmacist-managed clinics focused on medication therapy management for chronic diseases. For example, about one third of all prescriptions for the treatment of the Hepatitis C virus are written by clinical pharmacists

VHA has also developed a draft regulation that would standardize full practice authority for advanced practice nurses, to assure a consistent continuum of health care services by the practitioners across VHA and decrease the variability in advanced nurse practice that currently exists as a result of disparate State practice regulations. The proposed draft regulation was published in the *Federal Register*; we are now reviewing comments received. Implementation of full practice authority will increase Veteran access by alleviating the effects of national health care provider shortages on VA staffing levels and enabling VA to provide additional health care services in medically under-served areas. Implementing this policy, as recommended by the Commission, will allow VA to parallel the policies of other Federal agencies, including the Department of Defense (DOD) and the Indian Health Service, as well as many institutions in the private sector.

VHA's Diffusion of Excellence initiative is an operational infrastructure that allows for sharing of promising practices across the enterprise. This model incentivizes and institutionalizes the identification and diffusion of practices nationwide so that every facility has the opportunity to implement the solutions that are most relevant to them. In the first round of submissions, 13 Gold Status Best Practices were selected from more than 250 ideas through a series of reviews and a final "Shark Tank" competition. The next step assigned each Gold Status Best Practice and their originating Gold Status Fellows to Action Teams managed by the Diffusion Council for implementation VHA-wide.

VA seconds the Commission's call for Congress to relieve VHA of bed-closure reporting requirements under the Millennium Act. The Act's arbitrary requirements have not kept up with changes in the Veteran population or the health care environment. Legislation is needed to remove the Act's bed change reporting codified at 38 U.S.C. 8110(d) and the staffing level and service requirements specific to such bed changes under 38 U.S.C. 1710B(b), while retaining staffing and service requirements for all other Extended Care Services. VA would replace the mandated congressional reporting of bed closures with a stronger, clearer, and more stringent internal process to review and if appropriate, approve bed closure proposals.

VA is already moving forward to hire and train more clinical managers and medical support assistants (MSAs). In response to section 303 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146), each VA Medical Center now has a Group Practice Manager (clinical manager). Additional hiring and training of these group practice managers will continue through February 2017. VHA is also developing new training and hiring procedures for MSAs throughout the organization as part of *MyVA*. VA has developed and launched an MSA hiring project called "Hire Right, Hire Fast" and is currently piloting a new hiring procedure that allows for industry-standard bulk hiring of MSAs to hire MSAs within 30 days of a vacancy. Two-week, standardized onboarding training for all new MSAs is also being developed and piloted. Both new processes will begin being deployed nationally this fall.

Recommendation #3: Appealing Clinical Decisions—"Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach, taking into account important differences between the mission and authority of the VA health care system and other federally-supported programs.

VHA is already in the early stages of developing a regulation in response to the Commission's recommendation. This regulation will establish a cohesive baseline national policy for clinical appeals. A clinical appeals regulation will be published for notice and comment in accordance with the Administrative Procedure Act. Recently enacted legislation in section 924 of the Comprehensive Addiction and Recovery Act of 2016 establishes an Office of Patient Advocacy in the Office of the Under Secretary for Health. In addition, in 2015 VHA established the Office of Client Relations to assist Veterans clinical care access concerns.

An interdisciplinary panel will be tasked with evaluating feedback from these offices and other Veteran support resources to improve the overall clinical appeals process, consistent with external benchmarks and factors described by the Commission, Federal regulations and statutes, and sound clinical practice. The resulting recommendations may differ in certain aspects from those envisioned by the Commission, but will undoubtedly be a uniform, fair, world-class clinical appeals process that protects Veterans and is fully compliant with law and regulation. VA's revised process will complement the Veterans Experience Office's efforts to better serve Veterans, make improvements based on customer feedback, and engage the community.

Recommendation #4: Consolidation of Improvement Efforts—"Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center."

VA finds this recommendation neither feasible nor advisable, but is already implementing an alternative approach that institutionalizes continuous improvement as part of VA's *MyVA* transformation.

Health care improvement takes place within a complex socio-technical system with multiple aspects of technology and technical expertise. Placing improvement under an engineering system, such as the Veterans Engineering Resource Center (VERC), may harness the technical aspects of improvement, but it will not provide the balance of critical cultural and people aspects. VA believes doing so would unbalance safety and efficiency and not be successfully transformational.

Ongoing VA transformation efforts have been achieved by specifically aligning VERC assets with enterprise priorities so that appropriate engineering perspectives and skills are interwoven with current organizational priorities. To institutionalize VHA's commitment to continuous improvement, VHA will realign the VERC and the operational improvement arm of Strategic Analytics for Improvement and Learning (SAIL) under the Principal Deputy Under Secretary for Health. This will elevate the health-system subject matter experts who drive transformation in VHA's organizational structure, while continuing to use the VERC to ensure that supporting engineering resources are available across all VA transformational efforts.

Additionally, VA's enterprise approach to improving performance—through Lean Six Sigma (Lean) tools and training, Leaders Developing Leaders training, *MyVA* Performance Improvement Teams, *MyVA* Communities, the *MyVA* Ideas House, and many other initiatives across the VA system—has taught us the value of a central repository for local programs and ideas, both successful and unsuccessful. To that end, VA and VHA have embraced the Integrated Operations Platform (IOP) hub, a knowledge-management technology platform developed by the VERC in partnership with subject matter experts. The IOP consolidates information on continuous improvement activities across VA in key programs, and as a result, best practices and innovation activities are currently visible in one common platform.

VA has invested significantly in developing Lean capacity at local levels so that problem solving is done at the lowest level and with a team of safety, quality, and improvement professionals. This prepares the local facilities to improve their current environment while scanning constantly for emergent new problems.

Recommendation #5: Eliminating Healthcare Disparities—"Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented."

VA finds this recommendation feasible and advisable and is already working to address each of the Commission's concerns as part of VA's *MyVA* transformation.

VA's Office of Health Equity (OHE) was established in 2012 with the mission of championing health equity among vulnerable Veterans. The office developed the Health Equity Action Plan (HEAP) in 2014 in conjunction with the Health Equity Coalition and with concurrence from the Under Secretary for Health. The HEAP is VHA's strategic roadmap to reducing Veteran health disparities. It aligns with the goals of *MyVA* and the VHA Strategic Plan. VHA will make health equity a priority by directing implementation of the HEAP nationwide.

The appropriate placement of OHE within the VHA organizational structure, along with adequate resources, will be considered as a priority component of the broader VHA restructuring addressed in Recommendation #12. This will take into account funding and staffing levels commensurate with the scope and size of Federal offices of health equity established in the Department of Health and Human Services, based on direction in the Affordable Care Act. VA will also identify health equity leaders and clinical champions in each VA District, Veteran Integrated Serv-

ice Network (VISN), and Medical facility who can catalyze and monitor actions to implement the HEAP and further advance the elimination of health disparities.

VA has undertaken systematic actions to identify and address healthcare disparities and inequality. Examples include the development of Hepatitis C Virus Disparities dashboard projected, scheduled for launch by the end of FY 2016; data support and research collaborations with the Quality Enhancement Research Initiative designed to identify health care disparities; establishment of a Population Health office that has developed clinical case registries focusing on the needs of special populations; and establishment of the Women's Health and Lesbian, Gay, Bisexual, Transgender (LGBT) program offices. VA Medical Facilities constitute 20 percent of Human Rights Campaign's Health Care Equality Index participants in 2016, and they were the only facilities to achieve leader status in some States.

Recommendation #6: Facilities and Capital Assets—"Develop and implement a robust strategy for meeting and managing VHA's facility and capital asset needs."

VA finds this recommendation feasible and advisable but recommends alternative approaches as part of VA's *MyVA* transformation.

VA believes that the Commission's recommendation is critical to enabling the successful transformation of the large-scale health care system to a higher-performing integrated network to serve Veterans. Without a strong suite of capital planning programs, tools, and resources, VA will not be able to fully realize the benefits and Veteran outcomes expected from implementing an integrated health care network. VA also strongly agrees with the Commission that greater budgetary flexibility and greater statutory authority are essential to meeting VA's facility needs, realigning VA's capital assets, and streamlining processes to divest itself of unneeded buildings.

VA recommends alternative approaches to two issues:

- Once VA determines its mix of health care services and how they are provided at the market level based on the integrated health care approach, realignment of VA's capital infrastructure framework will be needed. Instead of a realignment process encompassing both assets and services based on DOD's Base Realignment and Closure Commission, VA proposes an independent facilities realignment commission (IFRC) to focus solely on VA's infrastructure needs once the mission services are determined. The IFRC would develop a systematic capital-asset-focused realignment plan for infrastructure needs to be presented to the Secretary of Veterans Affairs and the President for decision, with Congress approving or disapproving the plan on an up-or-down vote.
- With regard to focusing new capital on ambulatory care development, VA proposes a balanced approach to maintain needed infrastructure and other key services (e.g., rehabilitation, community living centers, and treatment for spinal cord injury, Traumatic Brain Injury, polytrauma, and PTSD), while at the same time appropriately investing in ambulatory care in needed markets. The balanced approach would be based on a market-by-market determination of the appropriate mix of services to ensure Veterans have access to needed care.

VA agrees with the recommendation to move forward immediately with repurposing or disposing facilities that have already been identified as being in need of closing. Continued focus in this area is needed and VA is already working toward this goal, subject to the availability of staff and resources.

VA also acknowledges that there will be anticipated challenges in implementing such large-scale realignments and restructuring of VA's footprint. Legislation will likely be required facilitating changes to VA's capital infrastructure to implement a transformation of this nature, including:

- Establishing an IFRC to develop a systematic capital-asset-focused realignment plan.
- Streamlining processes to meet the intent of laws and regulations, such as the National Historic Preservation Act and the National Environmental Policy Act that would make repurposing and divesture more timely and effective.
- Potentially restructuring appropriations to allow for more flexible transfer and reprogramming authority, including potential threshold adjustments.
- Exploring methods (both legislative and administrative) to take advantage of private-sector financing.
- Revising the major medical lease authorization process to align the requirements in concert with practices at other Federal agencies.
- Granting VA authority to retain and utilize proceeds generated from real property divestitures.
- Expanding enhanced-use leasing authority.

Further analysis will be required to determine the specific level of resource investments required to implement the Commission's recommendations. It is clear that significant additional resources will be required. In addition, divestiture of unneeded VA assets is unlikely to generate significant savings because of the upfront resources required to execute the divestiture and minimal market value of the majority of VA's assets. Without the proper resources, tools, and authorities, attempts to divest of assets or streamline capital project execution will not be effective.

Recommendation #7: Modernizing IT Systems—"Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach, understanding that investments in IT will force difficult decisions concerning the allocation of limited financial resources among all VA programs and services, as well as across the Federal Government.

As part of the *MyVA* Breakthrough Initiative to transform VA IT, VA will soon appoint a Senior Executive System (SES)-equivalent position for a Chief Health Informatics Officer (CHIO), reporting to the Assistant Deputy Undersecretary for Health for Informatics and Information, to collaborate with the VA Chief Information Officer (CIO) and the IT Account Manager toward developing a comprehensive health IT strategy and supporting budget proposal. The CHIO and ADUSH will be responsible for prioritizing all health technology programs and initiatives, with strategic technological guidance from the VA CIO and IT Account Manager for health. To comply with the Federal Information Technology Acquisition Reform Act (FITARA), the CHIO does not take the place of the VA CIO, but instead works in concert with IT management to ensure that health initiatives are appropriately prioritized within the portfolio, while the CIO works with VA senior leadership so that all technology initiatives are prioritized holistically, thus ensuring complete Veteran care. VHA and VA's Office of Information and Technology (OI&T) are already collaborating on the vision and strategy for a single integrated Digital Health Platform (DHP).

VA has also established five district senior-executive Customer Relationship Manager positions to work with the local VHA, Veterans Benefits Administration, National Cemetery Administration, and staff office leaders, aggregate feedback for analysis by VHA and OI&T senior leadership, and enhance a continuous feedback loop. The VA CIO recently established the Veteran-focused Integration Process program within the Enterprise Program Management Office (EPMO) to facilitate continuous improvement and constant collaboration.

The Commission recommended that the VA CIO develop and implement a strategy to allow the current nonstandard data to effectively roll into a new system, and engage clinical end-users and internal experts in the procurement and transition process. VHA is currently working with OI&T to ensure that the Veterans Information Systems and Technology Architecture (VISTA) data is mapped to national standards. The new CHIO will be responsible for engaging clinical end-users in the transition to the new DHP. The Under Secretary for Health and the CIO will establish a joint program office responsible for the implementation of the DHP. This process will be focused on delivering and coordinating high-quality care for Veterans.

The EPMO is responsible for portfolio management and has adopted a policy of "best-fit, buy-first" in its Strategic Sourcing function. This ensures that existing best-in-class technology solutions are purchased whenever possible, rather than being developed and maintained by VA. These functions, in combination with the role and focus of the IT Account Manager, will provide the required focus for VHA to implement a comprehensive commercial off?the?shelf IT solution to include clinical, operational, and financial systems.

Recommendation #8: Modernizing Supply Chain—"Transform the management of the supply chain in VHA."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach.

VA believes the components of this recommendation that suggest establishment of a Chief Supply Chain Officer (CSCO) and realignment of all procurement and logistics operations under the CSCO executive position are feasible and advisable, but it recommends an alternative approach to fulfill the Commission's intent. The structural solution recommended by the Commission would not adequately address underlying management challenges associated with organizational complexity and the need to improve integration processes impacting the supply chain. Realignment of VHA's supply-chain structure, including roles and responsibilities of the various VA

Central Office staff offices, health networks, and medical facilities, should derive from and be integrated with the transformation of the overall VHA health care organization structure. The intent of the Commission will be met by addressing alignment issues as the supply-chain breakthrough initiative evolves and is synchronized with VHA's overarching strategies to transform VHA's organizational structure.

As an alternative, the intent of the Commission is already being addressed in an effective manner under the current *MyVA* Breakthrough Initiative to transform VHA's supply chain. This initiative is a more comprehensive approach to fulfilling the Commission's intent and is already driving much needed improvements in data visibility and quality, synchronization of technology deployments, standardization, contract compliance, and training. Already in FY 2016, VHA supply-chain transformation efforts have yielded approximately $45 million in cost avoidance. VHA has also developed a two-year supply-chain transformation stabilization guidance that will put VHA in a far better position to make effective decisions and investments beyond FY 2018 for vertically aligning VHA's management structure and for more efficient sourcing and distribution of all clinical supplies and medical devices. This will increase the availability of supplies for the care of Veterans and result in cost avoidance for American taxpayers.

With regard to the component of the recommendation asking VA and VHA to establish an integrated IT system to support business functions and supply-chain management, although feasible it is more advisable that technology investments beyond those currently in the pipeline should be avoided until such time that a mature supply-chain baseline is established, upon which prudent future IT investment decisions can be based. This is especially important given VA's Financial Modernization System initiative and emerging plans for a new DHP, both of which will impact legacy and contemporary supply-chain systems and interfaces, as well as influence system-improvement alternatives and investment decisions over the next two to five years. Supply-chain system improvements must be integrated and synchronized with enterprise financial and health care system enhancements to achieve efficiencies in service delivery and support analysis of integrated data to meet VHA's current and future needs.

Finally, as suggested, VHA will continue to use VERC capabilities to support the transformation of supply-chain management in accordance with the *MyVA* Breakthrough Priority Initiative #12: VHA Supply Chain Transformation. As a point of clarification, the Commission report is technically incorrect in that the VERC is not leading the *MyVA* supply-chain modernization initiative; rather, the VERC is a highly valued enabling organization engaged by the VHA Procurement and Logistics Office to support the *MyVA* initiative.

Recommendation #9: Governance Board—"Establish a board of directors to provide overall Veterans Health Administration (VHA) Care System governance, set long-term strategy, and direct and oversee the transformation process."

VA finds the Commission's recommendation neither feasible nor advisable due to its unconstitutionality. However, VA believes the intent of the Commission can be achieved regarding the term appointment of the Under Secretary for Health.

The U.S. Department of Justice has concluded that the proposed board of directors, as appointed and with the powers proposed by the Commission, would be unconstitutional for several reasons. Permitting Congress to appoint the board members would violate the Constitution's Appointments Clause (U.S. Const. art. II, § 2, cl. 2), as well as the separation of powers, insofar as congressionally appointed board members would be exercising significant operational authorities within the executive branch. In addition, giving this board authority to reappoint the Under Secretary for Health would violate the Appointments Clause and the separation of powers. Finally, requiring the board to concur with the President in removing the Under Secretary for Health would give the board a veto authority over the President, impairing the President's ability to "take Care that the Laws be faithfully executed" (U.S. Const. art. II, § 3) and violating the separation of powers.

The proposed board would also seem to separate VHA from VA without necessarily insulating VHA from political pressure or improving VHA oversight or operations. The powers exercised by the proposed board would undermine the authority of the Secretary and the Under Secretary for Health and weaken ownership of the *MyVA* transformation and VHA performance, potentially disrupting and degrading VA's implementation of critical care decisions affecting Veterans. The independence granted VHA would run counter to our ongoing efforts to improve the Veteran's experience by integrating Veterans health care with the many other services VA provides through the Veterans Benefits Administration and the National Cemetery Administration. Furthermore, VA is already advised by the Special Medical Advisory Group, which consists of leading medical practitioners and administrators, and by

the *MyVA* Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates with diverse expertise in customer service, strategy development and implementation, business operations, capital asset planning, health care management, and Veterans' issues. These committees already provide VA with outside expert advice on strategic direction, facilitating decisionmaking and introducing innovative business approaches from the public and private sectors.

The Commission correctly notes that frequent turnover of the Under Secretary for Health has had a negative impact on VHA and greater stability in this important leadership position is needed. VA supports a term appointment of the Under Secretary for Health spanning Presidential transitions to ensure continuity of leadership and continued transformation of VHA. Previously, 38 U.S.C. 305 provided for a four-year term for the Under Secretary for Health with reappointment possible, but this provision was removed in 2006. A term appointment could be reinstated, beginning with the current Under Secretary for Health. This is critically important at this juncture given the need to see the ongoing transformation of VHA through to completion. Under Secretary for Health candidates are currently recommended by a commission established solely for that purpose. More analysis is needed to determine length of tenure and timing of reappointment.

Recommendation #10: Leadership Focus—"Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach.

Recent or ongoing actions serving the Commission's intent include:

- VA has established the *MyVA* Task Force to guide VA through the transformation and established a Department-wide *MyVA* transformation office, which has formulated an integrated plan for transformation and is organizing the work on 12 breakthrough priorities.
- Metrics and key performance indicators are in place for each breakthrough priority. Each breakthrough priority has a designated, accountable official who is a member of the senior leadership team and a near-full-time responsible official in charge of driving progress.
- One of the 12 breakthrough priorities in the *MyVA* Transformation is employee engagement, for which we have a comprehensive action plan.
- VA has also established a *MyVA* Advisory Committee (MVAC) consisting of business leaders, medical professionals, government executives, and Veteran advocates. VA leadership meets quarterly with the MVAC, leveraging them as a corporate board from which to seek counsel on the overall transformation.
- *MyVA* has engaged leaders and employees throughout the organization via Leaders Developing Leaders (LDL) (over 54,000 participants to date), VA101 (over 79,000 participants to date), various skills trainings, LDL projects, breakthrough pilots, broad communications to include the *MyVA* Story of the Week that goes out every Friday to all employees, and local initiatives.
- VA established *MyVA* district offices to facilitate transformation efforts throughout VA and also now conducts quarterly surveys of the VA workforce and incorporates this feedback into VA's transformation actions.
- Secretary, Deputy Secretary, and Under Secretary for Health have provided role models for transparency, Veteran focus, and principles-based leadership.
- VHA programs and program offices and the Office Human Resources & Administration (HR&A) representatives have held regular meetings in the past year to discuss a single, benchmarked concept for organizational health and coordinate messaging.
- VHA's National Leadership Council has endorsed personalized, proactive, patient-driven healthcare as one of VHA's strategic goals and strongly supported the formation of organizational health councils.
- Many VHA facilities and networks have some version of an organizational health council already existing.
- All program offices and facilities receive employee survey data annually down to the workgroup level to facilitate action planning and improve employee engagement. Brief pulse surveys have recently been implemented to measure employee engagement at the facility level quarterly.
- VHA's National Center for Organizational Development has use of Prosci change management materials and is pursuing a system-wide license.

Recommendation #11: Leadership Succession—"Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach.

VA is consolidating leadership training behind a model we created as part of our *MyVA* transformation called ILEAD. Previously, VA had multiple leadership models across VA, which led to no common language or culture of leadership, and the models were not customized for VA. The enterprise-wide ILEAD modal will incorporate the principles of "servant leadership" and VA's ICARE core values, aligned with the Federal Executive Core Qualifications. VHA and the VA Corporate Senior Executive Management Office are in the first stages of developing a competency model for VHA's senior leadership positions that will incorporate VA's ILEAD model with the technical competencies essential to successfully leading VHA's complex clinical operations. The VHA senior leader competency models will ultimately cascade down through the organization and be incorporated in its hiring, development, performance assessment, and advancement programs.

VHA has outlined a leadership talent management strategy, benchmarked against the best practices in private industry, and begun initial development of processes and tools to give VHA greater insight and control over its health care leadership succession pipeline. Initial efforts are focused on creating a cadre of leaders to fill future medical center director positions. At the individual level, VHA senior executives serve as mentors to staff members, coaches for VHA leadership development programs, and models through their own leadership behavior.

Current VHA initiatives serving the Commission's intent include:

- VHA made leadership development a priority of its *MyVA* effort, specifically to develop and retain passionate leaders to lead transformational efforts across the Administration.
- Filling key leadership position through a strong succession pipeline is identified as a priority for VHA in the 2016 VHA Workforce and Succession Strategic Plan.
- VHA has fully embraced the LDL philosophy—nearly 30,000 VHA employees have participated in the leader-led cascaded training since it began in September 2015.
- VHA's National Leadership Council has adopted the VA leadership model, which now includes the concept of "servant leader."
- VHA leaders are integrally involved in the development and conduct of its formal leadership development programs. Leaders serve as coaches and mentors to program participants, in addition to personally facilitating sessions on a wide variety of leadership topics.
- VHA established the Healthcare Leadership Talent Institute (HLTI) to provide coordinated focus to VHA's talent management efforts. HLTI links VHA's workforce-planning and talent-development programs through the design and deployment of a set of talent management products and processes, which are in the pilot-testing phase.
- VHA is collaborating with the VA Corporate Senior Executive Management Office in implementing the December 2015 Executive Order on Strengthening the SES. These efforts include building a foundational leadership competency model for VA, instituting an executive rotation program to provide career-broadening experiences outside of each executive's current position, enhancing the SES performance management system, and outlining an SES-level talent-management process for VA-wide implementation.

Recommendation #12: Organizational Structures and Management Processes—"Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decisionmaking at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices."

VA finds this recommendation feasible and advisable but recommends an alternative approach to reorganizing the VHA Central Office (VHACO), consistent with VA's *MyVA* transformation.

VHACO has undergone a stepwise ascent to improving the organizational structure to be more responsive to field requirements through the development of large programs responsible for organizational excellence and developing the future state health care plan. Immediate reorganization would divert attention from key organizational priorities such as improving access to healthcare. Known challenges associated with reorganization (which occurs with the regularity of each Presidential election cycle), are impaired employee engagement, loss of institutional knowledge, and

diversion of attention from critical challenges such as insuring Veterans have same-day access to primary care and mental healthcare services. Legislation would be required to streamline appropriations, and review by oversight bodies would be impacted by the changes described. Finally, the reorganization for VHACO should derive from and be integrated with the transformation of the overall VHA health care organization structure. VHA will initiate a VHACO and VISN organization analysis at the beginning of calendar year 2017.

Recommendation #13: Performance Measurement—"Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies."

VA finds this recommendation feasible and advisable and is already implementing changes as part of VA's *MyVA* transformation, with some modifications in approach.

VHA is consolidating its healthcare operations metrics to provide a consistent, system-wide view of key performance indicators. In October 2015, VHA launched a Performance Accountability Work Group (PAWG) as a governance mechanism for performance measurement at all levels of the organization. The PAWG's first task was to conduct a systematic review of all existing performance measures (numbering over 500), which resulted in a core set of approximately 20 key indicators, aligned to industry-wide approaches. SAIL scoring system is a critical component of these indicators, as well as predictive trigger systems that are the main inputs into a health operations center, which will facilitate centralized quality management.

The leadership of the Office of Organizational Excellence (hereafter, 10E) has undertaken a strategic review across all current business processes to identify realignment opportunities—for instance, focusing ISO 9000 on its original target, which was the reprocessing of reusable medical equipment, and reinvesting the resources that will be freed up to enhance the ability of VERC to support the adoption of LEAN management approaches in support of the Under Secretary for Health's five priorities for strategic action. We have also engaged a senior industry consultant to assist us with the process of executive recruitment and development; created a system-level VHA Performance Scorecard aligned along transformational priorities; simplified the template used for senior healthcare executive performance management plans; and started work to align business functions within the Office of Organizational Excellence to promote a unified approach to performance reporting, performance improvement, and the identification and spread of strong clinical and business practices.

Finally, the Diffusion of Excellence initiative (see Recommendation #2) sources best practices from frontline employees in the field, and brings the combined resources of 10E to support their implementation where appropriate in under-performing VA sites.

Recommendation #14: Cultural and Military Competence—"Foster cultural and military competence among all Veterans Health Administration (VHA) Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health care outcomes."

VA finds this recommendation feasible and advisable and is already working to address the Commission's concern as part of VA's *MyVA* transformation.

VA has implemented training related to cultural and military competence, in some cases by partnering with external stakeholders (i.e., Equal Employment Opportunity Commission, the Joint Commission, Commission on Accredited Rehabilitation Facilities, DOD) and numerous national diversity-focused affinity and advocacy organizations. Examples of this coordinated training include Military Culture Training for Community Providers, Cultural Competency, Generational Diversity, Introduction to Military Ethos, Military Organization and Roles, Professional Stressors & Resources and Treatment Resources & Tools. From April 1, 2015, to July 22, 2016, the last four courses were accessed 2,533, 1,527, 1,172, and 1,070 times respectively. VA will continually assess its cultural and military competence training portfolio for content, target audience, and training modalities to identify additional training needs.

VA Office of Diversity and Inclusion has mandatory training in the area of cultural competence as part of its Equal Employment Opportunity (EEO), Diversity and Inclusion, and Conflict Management training for all VA managers and supervisors and mandatory annual EEO, Workplace Harassment, and No FEAR training for all VA employees. VA also maintains programs focusing on targeted populations, including a LGBT Awareness Program (issues referenced in the Report), Office of

Women's Health Services; Office of Health Equity; and a Center for Minority Veterans.

VHA also has a large portfolio of clinical training programs, including several in the area of cultural and military competence in healthcare delivery. The Office of Health Equity developed virtual patient cultural competency training under the Employee Education Service contract for the Virtual Medical Center project. Presently, military competence training is available to any provider, and they are encouraged to take the training. Providers currently under contract are not required to complete the course, but future contracts will require completion.

Recommendation #15: Alternative Personnel System—"Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector."

VA finds this recommendation feasible and advisable and is already working as part of VA's *MyVA* transformation, with some modifications in approach.

VA supports the Commission's legislative proposal recommendation to establish a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority, provided outside stakeholders support the legislative and policy changes required to create this new system.

VA currently is preparing for consideration a legislative proposal for the FY 2018 budget process to modify Title 38 to give the Secretary the authority to establish a human-resources management system unique to VA.

In the absence of a simple-to-administer alternative personnel system, VA has also proposed modifications to existing statutes to provide some relief to the currently complex personnel system and also help with recruitment and retention. These proposals include establishing an appointment and compensation system under Title 38 for VHA occupations of Medical Center Director, VISN Director, and other positions determined by the Secretary that have significant impact on the overall management of VA's health care system. VA is considering proposals to do the following:

- Eliminate Compensation Panels for physicians and dentists, which have been found to be administratively burdensome.
- Eliminate performance pay for physicians and dentists, which has been found to be extremely difficult to administer.
- Establish premium pay for physicians and dentists to allow flexibility in scheduling and eliminate the daily rate paid to these occupations based on 24/7 availability.
- Modify special rate limitation to increase the maximum allowable special rate supplement providing enhanced flexibility to pay competitively within local labor markets.
- Exempt VHA health care providers appointed to positions under 38 U.S.C. 7401 from the dual compensation restrictions for reemployed retired annuitants.

The VHA Strategic Human Resource (HR) Advisory Committee and Workforce Management and Consulting's Human Resource Development group are proposing a comprehensive VHA H.R. Readiness Program designed to improve the overall operational capabilities of the VHA H.R. community. The program will identify and integrate all existing and available internal and external training resources into a clear, consistent, and logical roadmap to readiness.

Under the *MyVA* program, the Staff Critical Positions Initiative was launched to improve hiring of key leadership and other critical positions throughout VHA. VHA is moving ahead with the "Hire Right, Hire Fast" initiative for MSAs. The initiative is being piloted at a number of facilities and will provide products and guidance in 2016, including additional screening for customer service tools, an interview scoring rubric, job posting templates, H.R. milestone scripts, and much more. These products are designed to increase the supply of MSAs, as well as emphasize the customer service principles and skills needed for success.

VHA has embarked on a Rapid Process Improvement Workshop effort within the H.R. community to examine the hiring process and identify improvement opportunities, to include operational processes and policies. Plans are also under development to establish a centralized architecture to designate lines of authority in setting training requirements, career paths, etc.

Recommendation #16: Effective Human Capital Management—"Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system."

VA finds the Commission's recommendation both feasible and advisable and is already pursuing the following initiatives as part of VA's *MyVA* transformation.

Hire Chief Talent Leader and Grant Authorities: VHA currently has a national search underway for its senior most H.R. executive position. Presently that role does not possess the authority recommended by the commission. It is anticipated that the HR&A transformation program, and the efforts associated with Recommendation 12 in conjunction with the Under Secretary for Health, would work together toward the optimal organization structure for H.R. across VA and within the administrations including appropriate authorities. This process will help clarify the ideal roles and responsibilities of the VHA Chief Talent Leader.

Transform Human Capital Management: As part of *MyVA*, VA HR&A has launched the Critical Staffing Initiative to improve the hiring of key leadership and other critical positions throughout the VA. This effort has been working on near-term improvements to hiring medical center directors and other key medical center leaders. So far, this project has identified and is beginning to implement significant improvements to the hiring process and to proliferate hiring best practices across the organization. VA HR&A is currently planning a process to engage stakeholders across VA to identify next steps for implementing the recommendations outlined in recent study commissioned by VA. A concept paper entitled "VISN H.R. Shared Service Excellence" is also being evaluated. This concept paper incorporates a number of recommendations contained within the white paper noted above, but with specific emphasis on H.R. roles within the VISNs and VA medical centers. The Commission's recommendations will be taken into consideration in the process.

Implement Best Practices: The VISN H.R. Shared Service Excellence paper is heavily weighted toward the sharing of best practices that have been developed in a few highly performing field H.R. organizations. Best practice sharing is also a significant component of the *MyVA* Critical Staffing initiative. Also, the HR&A transformation effort is intended to rely heavily on health care and other industry best practice models.

Develop H.R. Information Technology Plan: The Commission's recommendation addresses an issue which VA's early H.R. transformation efforts are just beginning to address. While there are currently efforts planned and underway to implement H.R. Smart for personnel and payroll records, and USA Staffing to enable the recruiting process (acknowledged by the Commission), VA would benefit from casting these and other anticipated efforts in a more strategic IT plan. Such a plan would better enable implementation and integration prioritization and capital planning.

Recommendation #17: Eligibility for Other-than-Honorable Service—"Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service."

VA finds this recommendation neither feasible nor advisable.

The Commission's own estimates indicate this change would cost $864 million in FY 2019, increasing to $1.2 billion in FY 2033. This recommendation therefore appears to contemplate health care for anyone with another-than-honorable discharge. While VA agrees with the principle of serving this population of Veterans, the cost of doing so makes the recommendation not feasible at this time.

Many Servicemembers with other-than-honorable discharges qualify for health care for service-connected conditions and other benefits under existing authorities. VA will continue to serve this population. VA is also drafting proposed regulations which will update and clarify 38 CFR 3.12 and 17.34 to improve processes and procedures relating to character of discharge determinations and expand tentative health care eligibility for certain former Servicemembers.

These changes will address many of the concerns raised by the Commission. For example, the rules will provide improved guidance about the consideration of mitigating factors such as extended overseas deployments, mental health conditions, and other extenuating circumstances. Also, VBA has, within the past year, updated its manual to streamline its other-than-honorable adjudicative procedures to expedite health care eligibility determinations and improve the Veteran experience by shortening the wait time.

Recommendation #18: Expert Advisory Body for Defining Eligibility and Benefits—"Establish an expert body to develop recommendations for VA care eligibility and benefits design."

VA finds this recommendation feasible and advisable.

Substantial changes in the delivery of health care have occurred since Congress last comprehensively examined eligibility for VHA care through passage of Public Law 104–262, Veterans' Health Care Eligibility Reform Act of 1996, and taking a close look at eligibility criteria in light of current (and projected future) resources and demand makes sense in the context of VA's ongoing efforts to reshape the future of VA health care. VA will work with the President, Congress, Veterans Service Organizations, and other stakeholders to determine the path forward in the tasking of an expert body to examine and, as appropriate, develop recommendations for changes in eligibility for VA health care benefits.

Recommendation 18 also includes a separate and distinct recommendation for VA to "revise VA regulations to provide that service-connected-disabled Veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs." While VA supports the objective, VA already has regulations (38 CFR 17.49) and policy in place giving priority in scheduling to service-connected Veterans and believes these meet and fulfill the Commission's intent.

Chairman ISAKSON. Well, thank you very much, Mr. Secretary. We appreciate your testimony.

Dr. Shulkin, were you going to testify——

Dr. SHULKIN. Yes, sir.

Chairman ISAKSON [continuing]. Or are you here for moral support and hard questions? [Laughter.]

Dr. SHULKIN. Hard questions, Mr. Chairman.

Chairman ISAKSON. Well, I have one question. Then I want to get to the Members of the Committee.

For the Members that just arrived, we are going to go continuously through the votes. I am going to wait until the very last minute to go over and vote on vote one and come back after immediately voting on vote two. Hopefully, between the votes going back and forth we will be able to keep everything rolling throughout the hearing. We have got three great panels, headed off by Secretary McDonald, whom we appreciate for being here.

Secretary McDonald, if you would look at Recommendation Number 1, which I know you have read and you referred to in your testimony, have you got any idea what you would estimate the cost of implementing Recommendation Number 1 from the Commission on Care?

Secretary MCDONALD. Recommendation 1 is about establishing an integrated, high-performing, community-based health care network. In our plan, in October—I cannot remember the exact number; I am sure David will remember it, but we had different levels of cost, depending upon what we decide to take on. We are already in the process of establishing that network.

David, do you want to kind of——

Dr. SHULKIN. Yep.

The Secretary is referring to the plan that we submitted at the end of October 2015, where we currently spend, right now, about $13.5 billion a year on Community Care. That is the combination of Choice and Community Care funds.

In order to make the changes that we suggested, we estimated that we would need $17 billion a year, because we wanted to fix the emergency medicine provision hole that so many veterans get stuck in. We need the investment in infrastructure to do care coordination in an integrated fashion. We think that that is the best use of money for taxpayers, that it is a good—it is actually an efficient plan. The Commission on Care's plan was far more expensive than that.

Chairman ISAKSON. I think it contemplated putting together a network—the VA being a part of a total network with the private sector as well. Is that not correct?

Secretary MCDONALD. Yes, sir, that is correct.

Chairman ISAKSON. I think it probably contemplated also doing that within the contractors we have to date for the two gatekeepers for Choice, but just to issue a single seamless card. Is that correct?

Secretary MCDONALD. Yes, sir, we would integrate the network. It would also include Department of Defense partners, Indian Health Service, and the other Federal partners that we have.

Chairman ISAKSON. This is not a setup, but I would like to hear your answer: is it not true that in the Veterans First bill which this Committee passed out unanimously—that by the provisions in there for provider agreements, we are expanding the opportunity to VA to make that happen and make that possible?

Secretary MCDONALD. Yes, sir.

Chairman ISAKSON. That was the right answer. I just wanted to make sure we did that. [Laughter.]

Secretary MCDONALD. I said in my prepared remarks that we would like Veterans First to get to the floor, that we are happy to help in any way we can to help you get it there.

Chairman ISAKSON. We appreciate your continuous support on that.

My last question——

Secretary MCDONALD. We appreciate the Committee's leadership in putting it together.

Chairman ISAKSON. My last question is really a comment. They have recommendations on IT, working on the IT system in the VA. I am still very interested in hearing how much progress you have made on interoperability of—and the program at Georgia Tech, which I think you all are under contract with Georgia Tech.

Secretary MCDONALD. Yes, that is true.

Chairman ISAKSON. I understand there has been a recent breakthrough that has helped on that.

Secretary MCDONALD. Yes.

Chairman ISAKSON. Can I get a comment on that, Dr. Shulkin?

Dr. SHULKIN. Yeah. Yeah, I would be glad to.

First of all, just as you mentioned, Mr. Chairman, in April of this year we did certify interoperability with the Department of Defense, but under LaVerne Council's leadership we have created a concept of what is called the Digital Health Platform. This is really taking where the industry is to a new level. It is going to increase our ability to have interoperability with community partners, which is one of the recommendations of the Commission on Care.

What you are referring to is Georgia Tech has really a fantastic technology center. We have developed a conceptual prototype for this that I think we are looking forward to sharing with Members of this Committee, that we think is really a path forward to take us to a new level.

Chairman ISAKSON. Good. We appreciate the progress that you are making.

Senator Blumenthal?

HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thanks, Mr. Chairman.

Secretary McDonald, I think in your letter to the President, dated August 6 or August 2, I am sorry, 2016—you indicated that you had concerns about the cost estimates that the Commission put together to reflect various options on the VHA care system model, which ranged, I think, as low as $65 billion to $106 billion in fiscal year 2019, depending on enrollment, network management, and other factors.

I want to say I appreciate that the Commission really devoted itself to seeking to improve the VA health care system, and I certainly appreciate its recommendations, but I wonder if you could explain the VA's concern with those Commission estimates.

Secretary MCDONALD. This is the nub of the issue in terms of the difference between the Commission report and our point of view on the network. I am sure Nancy will comment more on it later.

The question is, how much unfettered access to the private sector do you allow the individual veteran, and who takes responsibility for integrating their health care? We believe that, as the VA, we need to take that responsibility, that when a veteran goes out to the private sector, we still have to own the responsibility for that health care—and the integrator tends to be the primary care doctor—and that if we do not do that, that it results in not very good care and also dysfunctional care because it is not integrated.

It also results in higher-cost care because those doctors that they may go to, first of all, may not be qualified by us as being capable—being high-quality enough to be in that network, and, second, may not follow the standards of cost that are necessary to be part of that network.

Senator BLUMENTHAL. Do you want to comment?

Dr. SHULKIN. Well, I think the Secretary has said it very correctly, Senator, which is we really have differences here with the Commission on Care report on two counts.

One is the quality of care, we believe, is going to be better with VA maintaining the care coordination and the integration role. We believe that we understand the needs of veterans best. And, we do support and we embrace working with the private sector. That is absolutely correct. But, we believe the VA needs to be the care coordinator.

On the cost side, this would be, in my view, irresponsible just to turn people out with no deductibles, no cost-control mechanisms. This would be returning us to the late '80s, early '90s, where there were just runaway costs. So, we think the very best thing for veterans and the very best thing for the taxpayers is to do this carefully in an integrated network, the way that we proposed in October 2015.

Senator BLUMENTHAL. Speaking of costs, the Commission on Care report found that 98 percent of all clinical supplies were acquired using purchase cards, and that 75 percent of what the VHA spends on clinical supplies is made through this purchase mechanism. Only 38 percent of supply orders were made through standing vendor contracts, which presumably would be more effective and efficient. I have been told as well that this same issue may

arise with respect to medical devices and perhaps other kinds of supplies.

That is in stark contrast, as you probably know, to the private sector benchmark of 80 to 90 percent of supply purchases from already existing master contracts with negotiated price discounts, which the VA can do, unlike Medicare—and we are pushing for Medicare to have the same options of negotiation. What is preventing the VHA from using those kinds of master contracts?

Secretary MCDONALD. Nothing. In fact, if you recall the hearing we had on the 12 breakthrough priorities, which you all kindly had here in the Senate—we did not get the same hearing in the House—one of those 12 breakthrough priorities is to set up a consolidated supply chain. Right now, every one of our medical centers has its own supply chain, which, as you have suggested, is nonsensical.

What we can do—what we have seen from our consolidated mail-order pharmacy, where we do have a consolidated supply chain, is our cost advantage is tremendous because of the scale that we have. Also, our customer service is fantastic. We have been rated number 1 pharmacy in the country for six consecutive years by J.D. Power because of that scale advantage.

What we are in the process of doing is building a consolidated supply chain for all of our medical centers. So far, we have avoided about $35 million of cost. Our commitment to you was to avoid $75 million of cost by December. I think we will beat that.

Senator BLUMENTHAL. Thank you.

Thanks, Mr. Chairman.

Chairman ISAKSON. As a courtesy to everybody in the audience and the Members of the Committee, we are going to take a little bit of a different order in terms of questions and testimony, because—to pay Senator Brown back for doing me a great courtesy by being here on time, given he has got a tough schedule, I am going to let him do the next question, followed by Senator Boozman, followed by Senator Manchin. Then, we will take everybody else as they arrive when they come, which will keep the hearing moving as fast as we can.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Boozman is being gracious to let me do that.

Senator BROWN. Thank you, Senator Boozman, and for the work that we have done together on all kinds of issues. Thank you. I will ask two brief questions.

Secretary McDonald, first to you, you correctly note in your testimony that implementation of Veterans Choice went through some initial growing pains, as we all expected. Your meetings with veterans and providers and health experts and others, lay out briefly the challenges and opportunities that you see for Veterans Choice, where we are going.

Secretary MCDONALD. Well, Veterans Choice, as you know, we have made tremendous progress. When you recognize we set up a program in 90 days that affected roughly—and sent out cards to 9 million veterans, we have made tremendous progress. We have also

made changes along the way. Since the original bill, we have now changed the way we define distance, the 40-mile limit. We have changed it from geodesic distance to driving distance. That virtually doubled the number of veterans of being able to avail of Veterans Choice.

We also have made efforts—originally the program was designed where we would simply give a phone number to a veteran and say, go call your third-party administrator. My belief, and I know David's, is you cannot outsource your customer service. So, we are pulling that responsibility back in, the integration-coordination responsibility, and we are now taking responsibility for customer service. We have taken third-party administrator employees and put them into our buildings as a test in order to make that easier for the veteran.

Where are we headed? About 22 percent of our appointments every day now are in the community. There are about a million veterans that rely on the Choice program. There are about 5,000 veterans that only use the Choice program, which is really a strikingly low number, but it demonstrates that most veterans really want the hybrid. Even if they have the Choice program, they want the hybrid of——

Senator BROWN. They really want to know they have the choice. They are generally mostly satisfied with Cincinnati VA or Dayton VA or Cleveland, but they want to know they have that choice, which I think is so important.

Secretary MCDONALD. Thank you.

Senator BROWN. Dr. Shulkin, quickly, are there bureaucratic or legislative hurdles that impede VHA from routinely updating individual facilities' IT infrastructure that is providing VA medical staff and veterans the best care possible? Talk that through with us, if you would, for a moment.

Dr. SHULKIN. I do think that if you ask most of our field hospital directors, they would say that there are challenges. I also think we have seen a really strong direction toward being more responsive to the hospital leaders. Under LaVerne Council's leadership, she has established account executives who now work with VHA, and we are working together to break down some of those barriers.

Just as the Secretary said, and as Nancy said in her hearing last week, this does take time because we are breaking down years and years of barriers, but I think we are headed in the right direction.

Senator BROWN. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Brown.

Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you all for being here. We really do appreciate your hard work.

The Choice program has over a million people participating in it, which I think is a good thing.

Secretary MCDONALD. We do, too.

Senator BOOZMAN. You do not list that as a legislative priority as far as reauthorization. Is it a priority or is it not a priority, or am I—have I misunderstood?

Secretary MCDONALD. We look at reauthorization as part of our program to consolidate care. We believe we did request reauthorization in that October 2015 package that we submitted on the consolidation of care.

Senator BOOZMAN. Good. Well, that is good.

Secretary MCDONALD. So, we do want reauthorization.

Dr. SHULKIN. I would just add—I am sure this is why you are asking, Senator—the program ends August 7, 2017. Without reauthorization, we are going to see us actually go backwards because we have now reached 5 million Choice appointments. That is fantastic and this program should be congratulated.

Senator BOOZMAN. Right.

Dr. SHULKIN. We are just getting it to work. If we could get Veterans First passed through, it is even going to work a lot better. So, reauthorization is absolutely a priority for us.

Secretary MCDONALD. Sorry to take more time on this.

Senator BOOZMAN. No, no, go ahead.

Secretary MCDONALD. Sorry, if you do not mind, but——

Senator BOOZMAN. It is important.

Secretary MCDONALD. August 7 is an important date, but if a woman is pregnant, you know, we really need to know 9 months in advance——

Senator BOOZMAN. Right.

Secretary MCDONALD [continuing]. Of August 7 whether or not—how we are going to care for her. The sooner the better.

Senator BOOZMAN. Right. I guess that was my follow up. It is good to know that you have cleared that up and that it is important. You all truly have done a great job; it has been a momentous task.

Do you have any contingency plans, you know, in regard to August 2017, if the reauthorization—and then also, I think you can really help us at this hearing and in future hearings by helping members understand—not on this Committee but throughout Congress—how important it is to get the reauthorization done.

Secretary MCDONALD. Yeah. We are in the midst right now of renewing our strategies for 2017. Most of our leaders are at the National Training Center right now. One of the things we have brought up is the importance of communicating that August 7 date, but also the 9 months in advance of that. I do think that is critically important.

Dr. SHULKIN. Just to quantify this, we spend about $13 billion a year in the community. As the Secretary said, 22 percent of our care goes out in the community; $4 billion of that is the Choice program. We would have to reduce access to care by about one-third in the community, and that would hurt veterans.

Our contingency plan—we are here to help veterans with the resources that you provide us. We are going to continue that mission, and we will do the very best job possible, but there is no substitute for what you have provided in the Choice program.

Senator BOOZMAN. Good.

Thank you, Mr. Chairman. I do think that is something we really need to work on, to make it clear how important that reauthorization is going to be.

Chairman ISAKSON. That was a terrific question and I appreciate the answer. It gives us our homework to do before that August date next year.

We are going to stand in recess for a moment. Senator Moran is on his way and will continue the hearing. Senator Boozman and I will be back as quick as we can go cast our two votes. We will stand in recess until Senator Moran gets here.

Thank you, Mr. Secretary. [Recess.]

STATEMENT OF HON. JERRY MORAN,
U.S. SENATOR FROM KANSAS

Senator MORAN [presiding]. The Committee will come back to order. I appreciate the courtesy extended to me by the Chairman to be here in between votes.

Mr. Secretary, it is a pleasure that you are here with us as well.

I have a specific set of circumstances that I have addressed to you in a letter and want to follow up in this setting today. I have no doubt but what you and other officials at the VA are sympathetic and concerned and want to resolve the circumstances we find ourselves in with a particular employee at a particular VA hospital in our State.

We have the circumstance—just to set the background for my questions, we face one of the worst examples, in my view, of lack of accountability at the VA with the case of a physician assistant who abused Kansas veterans at the Leavenworth VA hospital and potentially other veterans at other facilities within our State.

He has been criminally charged with multiple counts of sexual assault and abuse on numerous veterans who sought his care and his counsel. He had a criminal record, admitted on his application for State licensure when he was hired. The VA hired him anyway. Clearly, he should never have been hired and should have never been retained as an employee of the VA.

He is a physician assistant. An explanation that I received is that physician assistants are not considered significant risks, or they are a lower risk than other health care professionals at the VA, and so the vetting that should take place did not. What he did in his capacity as a physician assistant is to target veterans who were suffering from post-traumatic stress syndrome, and he used his position at the VA to add to the wounds of war of those who served our country instead of healing them. There are a number of witnesses. Many of them wish to remain anonymous. Criminal, as I said, proceedings have been filed.

Just to give you a flavor, we had—there are two Army veteran brothers who were patients of this individual who felt they had no choice but to go back to this physician assistant for their care and treatment. The quote was, "The fear of losing what I earned versus the fear of being sexually assaulted again, I do not know which one was more important." What an amazing statement for a veteran to reach a conclusion: I do not know whether to go back because I might not get the care I need if I do not.

A victim who asked to remain anonymous in an interview in July 2014, when these charges were filed, said,"It certainly violates veterans' trust. We are dealing with a number of issues, and to have

to come back to the agency tasked with caring for our Nation's veterans is now adding further wounds to the Nation's veterans."

Mr. Secretary, I want to focus in on two aspects of this. Again, I know that your staff has reached out to mine, I assume in response to a letter that I wrote you a few days ago, a few weeks ago. This goes to accountability, something that you and I have had conversations about for a very long time. I want to go to how does somebody get hired with this background? Perhaps even more important, it is troublesome to me that this individual was never fired. After the Inspector General's report, he voluntarily left the VA.

One of the conversations that we have had for a long time is about the ability to fire people at the VA. Of all the circumstances I can think of, I cannot figure out why this would not be one in which a person was fired, as compared to voluntarily retiring, which I assume, among other things, I mean, has a different connotation, a different aura to being fired versus retiring, but I assume it also has different consequences in regard to benefits and this individual's future.

If we could—you had VA officials, leadership here in front of our Committee last week. I got what you would expect for me to hear from them. I am not discounting what they said, but they want a zero tolerance. The VA is committed to a zero tolerance of assault—sexual assault on veterans, staff, or others at the VA. I know that is the case. We want a zero tolerance. But, we have specific instances here in which the hiring process was faulty and the discharge process really did not take place.

Mr. Secretary?

Secretary MCDONALD. Senator, first of all, any accusation of sexual assault, sexual molestation is unacceptable.

As soon as I heard about this, I went to Leavenworth. I was there. I dug through the data. I have different data than you have, so we need to get together and compare our data, because what I understand from my visit and the documents I reviewed is when this individual—when there was an accusation of this individual's potential of having done this, we immediately removed him from caring for patients. We immediately started the procedure to do an investigation and to fire him. He resigned.

Then, we went back and we looked at our hiring process. What I was told at the time—and, again, you have got different data, so I have got to find out why I did not see the data you may have or where you got your data—there was nothing in his file that suggested that this was a risk, that this occurred.

Obviously, you have got different data than I have, because this is not something we would tolerate. Obviously, if this showed up in a person's hiring process, we would not hire them.

Maybe David—do you have different data than I have?

Dr. SHULKIN. No, I think I have the same information you have, Mr. Secretary.

Senator MORAN. Secretary McDonald and Dr. Shulkin, you know, our information comes from the Inspector General—the VA Inspector General, and a significant number of press accounts, I suppose, as well.

A criminal proceeding is now pending in the District Court of Leavenworth County, KS. But, I have seen the application for his licensure in the State of Kansas and he voluntarily indicated on the form that he has a criminal history, which unfortunately the licensure folks did not pick up on either, but that—I assume that was reviewed when this individual, Mr. Wisner, was hired by the VA.

In addition to that, would you tell—are you telling me that when someone resigns you lose your ability to fire them? Are you telling me that he beat you to the punch?

Secretary MCDONALD. If somebody resigns, they are no longer an employee. That is true in the private sector or the public sector. If someone resigns, they have resigned. Now, obviously you have judicial options, which is what is occurring right now with this individual.

Senator MORAN. Well, I think, without—I have no doubt that the facts as I described them are accurate. We would continue to ask you to use this as a learning experience, not only to help prosecute, but so that we send a message to veterans about how careful we are; yet again, it, in my view, goes back to hiring practices and discharge procedure.

Again, I would ask you to respond to my letter in writing so that we can see your response, and then we can have a conversation again.

Secretary MCDONALD. We will certainly respond to your letter in writing. Obviously, we are a learning organization. We do want to learn from mistakes. We want to learn from what is going right. You had the Best Practices Diffusion hearing last week. We will get back to you.

Again, I want to be careful not to use media reports as proof of accusation. Let us let the judicial process play out. We will share with you what we know and we would appreciate seeing the documents that you have.

Senator MORAN. My information—I met with Inspector General Missal. We have had conversations, extensive, about this topic. I can assure you that what I am reporting is not anything but what I was told in that setting.

Secretary MCDONALD. I have not met with Mike on this, so I will——

Senator MORAN. I would ask you if you would ask the VA professionals, the leadership in Kansas, both Leavenworth and the VISN—would you instruct them to have a dialog with me and fully lay out the scenario as they see it to me?

Secretary MCDONALD. Absolutely. I mean, that is their responsibility. We ask each one of our medical center directors to work with their Members of Congress.

Senator MORAN. I thank you, Mr. Secretary.

Secretary MCDONALD. Thank you, sir.

Senator MORAN. The senator from Montana.

HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. I want to thank both the Secretary and Under Secretary for being here today.

This Committee has placed a priority on VA accountability, as I know you have. When we hear stories like Senator Moran just put forth, I know the hair on the back of my neck raises, as it does on yours. Once we get to the facts, I think it is important that the driftwood goes, quite frankly. That is probably complimentary to that person.

It is really important to acknowledge, though, that there are millions of veterans in this country who rely on the VA and Congress needs to be held accountable too. You submit budgets, you submit legislative priorities that allow you to do your job: serve the veterans. It is our responsibilities as Members of this Committee and the members of the U.S. Senate—and the same thing on the House side—to carefully consider those requests and to deal with them as an elected representative, is to do what is best for the veterans of this country.

When that does not happen, it impairs your work and, quite frankly, it hurts the folks who are sitting here in the audience who are veterans. Before you know it, the entire VA system is called into question.

Mr. Secretary, you are the front of the attack, when, in fact, we share more than our share of the responsibility. Do you believe that accountability is a two-way street?

Secretary MCDONALD. I certainly do. I provided, today, one of the most hard-hitting, I think, opening statements I could, saying that we are in the process of transforming the VA. We are seeing effective results. But if we are to continue this, we simply have to get a budget and we have to get the legislation that we have been asking for, for, you know, years.

Senator TESTER. Yeah. We passed the Veterans First Act out of the Committee unanimously 125 days ago. We have yet to deal with it on the floor. It sounds to me like we are going to be leaving town next week, which is crazy—I will just tell you, crazy—that this is something we can get to the floor within 2 days. I would bet we get a unanimous vote out of the U.S. Senate on this bill. But, we are where we are.

I talk to veterans all the time. I know you talk to even more of them. Some of them love the VA, some of them not so much. Would you agree that we have some work to do to get the faith and trust back of many of our veterans out there?

Secretary MCDONALD. We do. In fact, we measure it. In fact, I just got the measure this morning. One of the things we measure—and this is very common in hospitals or people who provide customer service, or veteran services—we measure the effectiveness of the experience, the ease of getting the experience, and the emotion of having it.

I have a chart here that shows that we have made progress. Obviously these are lower numbers than we would like, but we have gone from 47 percent trust in December 2015 to 59 percent in the April-through-June quarter. We are measuring this every quarter. I am not happy. Nobody is happy with 59 percent.

Senator TESTER. Right.

Secretary MCDONALD. But that shows that at least we are making some progress. We have a lot more to make.

Senator TESTER. In terms of greatest concerns identified by the Commission, things like leadership vacancies, staff shortages, a culture of risk aversion, really what are some of the ways that the VA can improve those issue areas?

Secretary MCDONALD. Of our five transformation strategies, the second strategy of improving the employee experience—training employees, giving them the tools they need—right now we have our top leaders offsite in our national training facility, where we are training them. We are training them in tools like human-centered design. We are training them in leadership. We are moving to one consolidated leadership model across the enterprise, which is what great organizations do. We are training them in Lean Six Sigma. We are providing them the training they need.

Then we give them training packets that they take back to their locations and they train their subordinates, and we cascade that training through the organization. That is how you change a culture, and that is what we are in the midst of right now.

Senator TESTER. OK. As you well know, we have talked about staff shortages, we have talked about leadership vacancies. In fact, right now Montana has a temporary director—we do not call her temporary, we call her something else, acting—that is it, acting—VA Montana director, who, by the way, I like very much. I think she is doing a marvelous job.

When I had a conversation with her—oh, it has been 2 or 3 weeks ago, and she holds people accountable very well—one of the things she talked about was that if we are going to get good people into the VA, due process has to be upheld. This is a management person that understands that if people look at the VA and say, I have got no due process rights, somebody can make any accusation at me they want and I can be gone without any argument—that does not help us fill not only leadership positions but also staffing positions, whether it is a nurse, a doc, administrative personnel, appeals person, whatever it is.

Could you talk a little bit about—when we talk about accountability—because I am telling you—you come from the private sector. You understand that if you have got deadwood on your staff, it costs you twice as much money as you are paying for them. Can you talk about how we hit that sweet spot so that people who want to work for the VA, because it is a pretty good outfit——

Secretary MCDONALD. Right.

Senator TESTER [continuing]. Yet understand that if something—if they make a call—if they go against that culture of risk aversion and make a call, somebody has got their back.

Secretary MCDONALD. We are training the organization in what we call values-based leadership rather than rule-based leadership, and we are trying to inspire them. I think we are being somewhat successful, given the quality of the people we are getting on board.

I have changed 14 of my 17 leaders. So, in 2 years, 14 of 17 of the top leaders have changed, and I think we have brought in better-quality people. But, part of this—and I have done a lot of the recruiting myself as you know. You and I went to the University of Montana recruiting, and I have been to over two dozen medical schools recruiting, but our applications are down about 78 percent versus what they were before.

So, the kind of environment and context you are talking about does have a real impact on the quality of the people we get. But—go ahead.

Senator TESTER. Well, I mean, I think that is important to note because, like I said, the issue that Senator Moran brought up is totally unacceptable. I mean, if that is the way it is, it is totally unacceptable.

On the same token, I do know from past life experiences that when you have got somebody out there that is trying to make the right call and somebody can accuse them of something and they do not have any rights, it just goes counter to the whole accountability issue.

Secretary MCDONALD. In my opening statement, Senator Tester, I mentioned that we have terminated 3,755 people in the last 2 years. I also said 14 of my 17 direct reports are new.

In my opinion, the only issues we had around accountability have been the accountability of getting the legislation that we need, which you mentioned, but also the interactions we have had with the Merit Systems Protection Board, which, frankly, we have all agreed that Veterans First would fix.

So, the answer here—I think we already have the answer in front of us. It is, how do we get Veterans First on the floor and passed, because we have all agreed that that is a potential solution.

Senator TESTER. Thank you, Mr. Secretary.

Mr. Chairman, I appreciate your leadership on this Committee a lot, which you know. I have told you that, and I have told you that publicly. You are a class guy. But, damn, we have got to get the Veterans First Act passed. We just do.

Chairman ISAKSON [presiding]. Since we are talking about that subject—and I want to go back to Senator Moran for a follow up in just a second, but let me just comment on that.

For everybody's knowledge and edification in the room, this Committee did outstanding work for over a year-and-a-half on a Veterans First bill that is comprehensive in its nature and, I think, complete in its nature.

Two questions have been asked today. One is about what happens with Choice after August of next year. The other question is how you deal with the Merit Systems Protection Board and accountability in the VA. There are those people in the news media, and some in my party and other places, that have criticized our bill for not being strong enough on the Merit Systems Protection Board and not making Choice permanent.

First of all, we deal with the leadership of the VA in terms of the ability to hire and fire and take them out from under the Merit Systems Protection Board, which is the right thing to do, number 1. Number 2 is the accountability. Because you have that accountability, it will flow from the bottom up because the top is being held accountable. We have been able to get the buy-in necessary to do that.

All of us want to make sure that Choice endures and Choice becomes permanent; none of us want it to run out of funds and go out of business next August, but not passing the Veterans First bill today, which provides for provider agreements in the States with the VA, would be a serious mistake.

People are saying they do not want to do that—some people are saying they do not want to do that because they want to go ahead and get Choice fixed first. When they come up with the $51.4 billion we need to fix Choice first, I am happy to do it. In the meantime, let's expand the opportunity to make the contract agreements on provider agreements, and let's work at the beginning of next year to fix the Choice program so it does not sunset in August but instead is perpetuated around the country, improved and perfected.

I apologize for horning in on that. When I heard my two favorite subjects come up, I just had to make a comment.

Senator Moran.

Senator MORAN. Mr. Chairman, thank you. Thank you for your kindness and consideration of me today and always, and please consider me an ally in your efforts on Veterans Choice first, and particularly the legislation that we would like to see passed.

Mr. Secretary, I am going to run to vote. This is not a—I will not leave this as an open-ended question. I am not trying to get you, but as I thought further about your response to my comments and question, one of the things that I think is true, which you could look into, is you indicated that Mr. Wisner was—as soon as we found out—as soon as the VA found out about him, he was taken away from patient care.

Secretary MCDONALD. Yes.

Senator MORAN. As I understand the facts, he continued to be an employee after that. He was removed from patient care but he continued to work at the VA. The day that he was removed from patient care is the same day that he admitted the allegations, admitted he had a problem, admitted that he dealt with patients in the way that he did. My point would be, that is a moment in which somebody could be discharged, fired, and yet the VA just removed him from patient care and kept him on the payroll. To me, that again highlights this difficulty in getting rid of, in this case, not just bad actors but terrible actors.

Secretary MCDONALD. Well, it sounds to me, Senator Moran, like you have better information than I do, and that you have met with the Inspector General and he has not yet met with me on this issue. I need to find out what he discovered in his investigation. Obviously, if you have the case, you fire them. That is why we fired 3,755 people. You do not tolerate that kind of behavior.

Senator MORAN. Thank you.

Chairman ISAKSON. Thank you, Senator Moran.

I thank the Members of the Committee for being so cooperative to move the hearing forward. I think we will go to our second panel.

Before you leave, Secretary McDonald, I want to thank you and Dr. Shulkin not just for your input today but for your leadership over the last 2 years. I think amazing progress has been made. We have a lot of progress yet to obtain, but I appreciate the leadership by both of you very much. We are here and stand ready to help you anytime we can.

Secretary MCDONALD. Thank you, Mr. Chairman.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

In your testimony, you mentioned that "VA is badly in need of statutory structural changes" to the appeals process. In prior communications to the Committee, VA provided this information concerning how long after enactment a new appeals system should take effect: "The new system should take effect 18 months after enactment. An 18-month delayed effective date would provide VA with the time needed to draft new regulations addressing the new system, update forms and guidance documents, and train staff."

Question 1. Please outline what impact it would have on VA's ability to successfully implement a new appeals system, to process existing pending appeals, and to process new incoming appeals if comprehensive changes to the appeals system were to take effect on the date of enactment. Please include an explanation of how VA would address appeals received after enactment but before VA has had time to draft regulations, update forms, update guidance documents, and train staff.

Response. VA has worked extensively with stakeholders to design a comprehensive new process for early resolution of Veterans' disagreement with VA decisions on their benefit claims. The proposed re-design would impact VA's claim and appeal processing activities and stops the flow of Veterans' appeals into an inefficient system that has been in place throughout much of VA's long history. Moreover, with more than 460,000 appeals in its current inventory, the change in law will require VA to temporarily administer two appeal systems for several years. Recognizing the scope and complexity of this task, and the significant impact that it will have on a large number of Veterans with appeals, VA and its stakeholders have consistently stressed the importance of having an 18-month delayed effective date for purposes of implementing the law without undue risk to the Veterans it is intended to serve. Although the proposed legislation was drafted to address as many of VA's and stakeholders' design features as possible, proper implementation will nonetheless require rulemaking to fill gaps. This is particularly important in the context of implementing a new appeal process that current and future Veterans will use to protect their due process and other rights. In addition to promulgating regulations during the 18-month period following enactment, VA must update its forms and decision notice letters, develop and issue guidance documents, update information technology systems, implement an outreach and communications plan, and hire and train staff. Veterans Service Organizations and other representatives must have time to adapt their operations to these significant changes.

It is imperative that Congress allow VA the time it needs to properly implement the change in law. While VA would attempt to come into compliance with the legislation as quickly as possible if Congress instead made the changes effective on the date of enactment, VA would be faced with the untenable position of doing the work required to implement the law at the same time that is receiving new appeals under the law. Without the opportunity for preparation, the resources that VA would have to expend to come into rapid compliance with the new legislation would have to be shifted from other necessary tasks, which could negatively affect VA's ability to provide services to Veterans. Additionally, if the new framework were to take effect on the date of enactment, it is possible that cases in which the Agency of Original Jurisdiction decision is issued on or after the date of enactment may have to be stayed until basic forms can be drafted and updated and basic processes can be put in place. Also, if there is not adequate time to draft and publish regulations, VA would be forced to implement the new framework based on the statutory language and purpose. There are also significant litigation risks associated with processing appeals in an environment in which there would be questions regarding whether and how some existing regulations apply. These numerous and significant disadvantages to the new framework being effective on the date of enactment, as opposed to 18 months after enactment, would be complicated by VA's continuing obligation to process its legacy appeals inventory. VA does not have unused resources that it can reallocate to such an effort, and the result would likely be several years of poor service to Veterans in both the legacy and new appeals framework.

The language quoted in Chairman Isakson's question is from VA's response to a question for the record in April 2016. VA provided the Committee with draft legislative language reflecting the 18-month delayed effective date in May and June 2016. The delayed effective date provision is included in S. 3328, which states that the amendments made by that legislation shall apply to all claims for which notice of a decision under 38 U.S.C. § 5104 is provided on or after a date that is 540 days after the date of enactment.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN BOOZMAN TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 2. I remain concerned that the VA seems committed to pursuing proprietary software solutions and massive IT overhauls that seem cost prohibitive and will be under development for many, many years. Is the VA considering any commercial off the shelf solutions, to include cloud-based solutions—to bridge the gap until comprehensive software can come on line? Can you provide an update on the status of your self-scheduling app and whether you will compare its effectiveness with proven, commercial solutions?

Response. VA's self-scheduling app, named the Veteran Appointment Request app (VAR app), has completed initial development and is currently in field-testing. National deployment is targeted for the end of 2016. VA has conducted an in-depth evaluation of this app with Veterans. The majority of Veterans that were interviewed about this app reported that they were satisfied or very satisfied with the app; and 100 percent reported that they would recommend the app to other Veterans. VA will continue to monitor user feedback on the app as it is deployed nationally.

At the time development of VAR commenced, there was no available commercial off the shelf (COTS) direct consumer scheduling solution that integrated with Veterans Information Systems and Technology Architecture (VistA), VA's current scheduling package. Accordingly, VA's choice to build our own self-scheduling app was the best option at that time. In the future, should VA replace VistA as its core enterprise scheduling application with a COTS product, VA would, at that time, re-evaluate the requirement to retain the VAR app as our self-scheduling solution. VA is implementing an Enterprise Cloud Brokerage concept to improve interoperability, modernize VA's network, improve security, and enable a more flexible and scalable infrastructure to accommodate future demand.

Question 3. The Commission's report called the VHA's supply chain for clinical supplies, medical devices and related services "inadequate." The report also contrasted it with the success of the VHA Pharmacy Benefits Management Service (PBM), which has taken a systems approach to managing pharmaceutical supplies, logistics, and prescribing. It is my understanding that PBM's success is due in large part to a well-planned and thorough process that includes all affected departments, including the end point of care. Is the VHA looking at lessons learned from the PBM to improve supply chain management in other areas? Is consideration being given to establishing a systems driven, clinically led process for the management of clinical supplies and medical devices (to include surgical instruments)?

Response. The Veterans Health Administration (VHA) Pharmacy Benefits Management (PBM) Program has been successful due to a well planned and executed strategy that involves clinical input at all levels, and has evolved over the past 15 years. The VHA Procurement & Logistics Office (P&LO) is modeling much of its strategy after the PBM program to ensure that clinical input drives the determination of requirements, and management of the supply chain. There are several programs employing this strategy, including the P&LOs Healthcare Commodity Program, Equipment Lifecycle Management Program, and the VHA Healthcare Supply Chain Systems Program. The Procurement & Logistics Office focus is squarely on support for the clinician caring for the Veteran patient.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary McDonald, in Commissioner Schlichting's testimony she discussed that the VA faces ongoing "leadership crisis, confusion about strategic direction, significant variation in performance across the VA health system, and a culture of risk aversion and distrust." You, and Dr. Shulkin have worked hard to restore veteran's trust in the VA through the *MyVA* and Diffusion of Excellent initiatives. How do you ensure that these initiatives continue in a new Administration?

Question 4. This seems to be a critical time for the VA, do you have processes in place to ensure that the progress achieved thus far will be sustained?

Response. VA designed the Diffusion of Excellence Initiative to drive long-term, systematic and cultural changes across VHA that will be responsive to specific changes in Administration or political leadership. In fact, the initiative is designed to conform to the priorities of leadership as they change, promoting and driving consistency in best practices along existing or new priorities. VA has also made system-level changes in incentives that will ensure continuous work in this area as the Ad-

ministration changes. To enable this continuity, VA and VHA senior leaders have put a number of mechanisms in place.

As part of the Diffusion of Excellence Initiative, the Office of the Under Secretary for Health spearheaded changes to the Senior Executive Service (SES) performance framework to incentivize senior leaders at medical centers and regional field networks to identify and replicate best practices locally and regionally. These incentives have resulted in numerous local competitions to identify and spread best practices within different VHA regions. The Under Secretary for Health is also sponsoring a national competition to solicit innovative best practices that improve Veterans' access to, quality of, or experience of health care. The clinicians and staff serving Veterans on the front lines who developed these practices receive support to spread the process improvements to medical centers who need similar solutions. This framework drives leaders to proactively identify best practices at their facilities and promote their replication in other locations. VHA rewards leaders for their ongoing participation in the Initiative. This is just one way the Diffusion of Excellence Initiative is institutionalizing the process throughout the enterprise—and doing so in a way that the will incentivize local leadership to support front-line innovations and best practices. We fully expect these incentives to carry forward into a new Administration.

The Diffusion of Excellence Initiative has also convened a council of senior leaders (both political and career civil service leaders), program office staff, and front line leaders and innovators across VHA to advise on the selection and dissemination of best practices. This engagement of multi-disciplinary and multi-level leaders and staff is one way that the Initiative is enabling 'change champions' who will preserve institutional knowledge, drive culture change, and sustain results despite Administration transitions. The Diffusion Council is highly adaptable, embracing and engaging new leaders and staff as they emerge, and ensuring continual participation from new and relevant stakeholders. The Diffusion of Excellence Initiative is demonstrating this by soliciting a new round of best practices meant to support fiscal year (FY) 2017 *MyVA* Breakthrough Priorities. This solicitation will be released shortly.

The Initiative has also fostered a number of strategic relationships both within and outside VA that provide support and allow the Diffusion of Excellence Initiative to leverage the scale and expertise of existing entities. These relationships will help sustain the Initiative and provide continuity through Administration changes. External strategic relationships forged through the Initiative include the American College of Physicians, private sector leaders who form the Special Medical Advisory Group Best Practices Identification Working Group, and several Veterans Service Organizations.

By design, the Initiative includes partnerships across VHA and VA. These partners include:

- Office of Rural Health;
- Office of Strategic Integration;
- Department of Veterans Affairs Center for Innovation;
- Office of Patient Centered Care and Cultural Transformation;
- Primary Care Operations;
- Quality Enhancement Research Initiative;
- VHA Systems Redesign;
- Veterans Engineering Resource Center;
- *MyVA*;
- VA Veterans' Experience Office; and
- Employee Education System and the National Simulation Center.

Finally, the Initiative will be co-run by the Office of the Principal Deputy Under Secretary for Health and the Office of Organizational Excellence. The Initiative is one of the *MyVA* FY 2017 Initiatives which overlap with the beginning of the new Administration.

The *MyVA* FY 2017 Initiatives build on VA's successes and lessons learned in FY 2016, and are designed to accelerate the Department's transformation. The Initiatives are aligned around the five *MyVA* Strategies:

- Improving the Veterans Experience;
- Improving the Employee Experience;
- Improving Internal Support Services;
- Establishing a culture of Continuous Performance Improvement; and
- Enhancing Strategic Partnerships.

These strategies were shaped by the advice of the President, Members of Congress, thousands of Veterans, the *MyVA* Advisory Committee, leaders of our Veterans Service Organizations, our employees, and many other stakeholders. They

have been supportive and will continue to be supportive of transformational change that improves the Veteran experience.

Improving the Veteran experience means making every contact between Veterans and VA predictable, consistent, and easy. That kind of customer service experience begins with respectfully receiving our Veteran-clients; but it is also based on science. VA has been heavily focused on human-centered design, process mapping, and working with world-class design firms and companies to help make every interaction with Veterans better.

Improving the employee experience is focused on empowering VA employees to serve Veterans, and each other, well. Better service for Veterans is inextricably linked to improving our employees' work environment. The best private-sector customer-service organizations are also among the best places to work and VA has studied their practices to tailor them to our environment.

Improving internal support services means leveraging VA's scope and scale to provide cost-effective and higher quality service to employees and leaders. VA is bringing its Information Technology (IT) infrastructure and financial systems into the 21st century. Our scheduling system dates to 1985. Our Financial Management System is written in Common Business Oriented Language (COBOL), a dead computer language dating back to the late 1950s. This has impeded VA's efforts to serve Veterans. VA is improving its Human Resource Management processes and systems as well.

Establishing a culture of continuous improvement means applying lean strategies and other performance improvement capabilities to help employees improve processes and build VA into a learning organization marked by a culture of continuous improvement.

Enhancing strategic partnerships means continuing to expand partnerships that extend the reach of benefits and services available for Veterans and their families.

VA has chosen Breakthrough and Management Initiatives designed to implement these transformational strategies. A single dashboard is maintained for each Initiative—displaying resources, schedule, dependencies, and the senior leader's assessment and recommendations. A composite dashboard is used to monitor all initiatives as a group—highlighting status for resources, dependencies and schedule. In addition, the composite dashboard displays progress on each Initiative's top-level metric.

Each Initiative is sponsored by executive leaders at VA; they meet bi-weekly with each Breakthrough Initiative's team of accountable and responsible leaders. Progress on Management Initiative is assessed through Monthly Management Reviews, which is an enduring management forum chaired by the Deputy Secretary. In addition, the Secretary or the Deputy Secretary chair a weekly *MyVA* Senior Leader Meeting during which the Department's and Administrations' leaders review progress, discuss accomplishments, share best practices, and gain broader situational awareness.

These strategies are helping VA become the high-performing organization Veterans deserve and taxpayers expect: an organization with sound strategies, innovative leaders and employees designing systems and processes that anticipate and respond to Veterans' evolving needs and expectations. They are timeless, business-savvy principles that will be effective over the long term: the strategies will be as relevant in the next Administration as they have been in this one. Initiatives such as the Diffusion of Excellence will provide benefits, both in FY 2017 and in future years, eventually becoming part of "how VA does business."

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary McDonald, I am pleased to see the Commission's 17th recommendation is to amend VA's current health care eligibility regulation and provide VA health care and benefits to veterans with other than honorable (OTH) discharges, if their overall service is deemed honorable. This issue is critical to ending veteran homelessness given the significant population of veterans with PTSD, and experiencing homelessness also experiencing barriers because of other than honorable discharges. This is why I have cosponsored the Homeless Veterans Services Protection Act with Sen. Murray to exempt homeless veterans from disqualification for related benefits from VA. You state in your August 2, 2016 letter to President Obama on the Commission's report that VA finds recommendation #17 neither feasible nor advisable due to cost ($864 million in fiscal year 2019), due to VA is currently drafting regulations on this issue and that many of this population qualify for care under other authorities.

Question 5. Could you elaborate on when the proposed regulations will be finalized and to what extent it would expand eligibility to this population?

Response. VA's proposed health care regulations regarding tentative eligibility and enrollment for Veterans with other than honorable discharges are still under review within the Department and we regrettably cannot provide a timeline for completion.

Secretary McDonald, in your testimony, you mention that "At present, VA is served by 25 advisory committees, including a newly reconstituted Special Medical Advisory Group, which consists of leading medical practitioners and administrators, and a newly established *MyVA* Advisory Committee, which brings together business leaders, medical professionals, government executives, and Veteran advocates. These advisory committees advise VA on strategic direction, facilitate decision-making, and introduce innovative business approaches from the public and private sectors" (p. 10).

Question 6. Could you elaborate on the internal process VA uses to determine which recommendations are implemented and how they are implemented?

Response. The subject matter experts for each recommendation made by any of VA's advisory committees will review the recommendation and make an initial determination of whether or not VA should concur with the recommendation. If the subject matter experts agree with the recommendation, they then articulate a plan for implementation. These initial determinations and plans for implementation are reviewed by senior VA leadership prior to submitting the Department's formal response to the advisory committee.

Chairman ISAKSON. We will call our second panel.

Our second panel are representatives from the Commission on Care. When I got the Commission's report a few weeks ago on my desk, I took it home for early reading, for lots of reasons. I knew there was a lot of thoughtful input and progress made. I wanted to see what the Commission had to say.

I want to commend the Chairman and the Commissioner present and the other members on the work that you did. A lot of people do not give those private citizens, who volunteer their time to give us good advice, the credit they deserve, but we appreciate very much what you have done.

We are going to hear from both of you today. Our witness to testify first is Ms. Nancy M. Schlichting. Is that the correct pronunciation? OK—the Chairman of the Commission on Care, and Hon. Thomas E. Harvey, Esq., who must be an attorney if he has got "esquire" behind it. Is that right? [Laughter.]

Mr. HARVEY. You nailed that one, Mr. Chairman.

Chairman ISAKSON. We appreciate both of you being here today. We appreciate the work that you did. You will both be recognized for up to 5 minutes each. If you have any printed testimony you want to submit for the record, it will be accepted and printed as is.

Ms. Schlichting.

STATEMENT OF NANCY M. SCHLICHTING, CHAIRPERSON, COMMISSION ON CARE

Ms. SCHLICHTING. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, thank you for the invitation to discuss the report of the Commission on Care, for your support of the Commission, and for the extension of time that you gave us to complete our work.

It has been a privilege and an honor to serve as the Chair of the Commission charged with creating the roadmap to improve veterans' health care over the next 20 years. For the last 35 years I have served in senior leadership roles in large hospitals and health

systems, and for the last 18 years I have been in Detroit, MI, at Henry Ford Health Systems, serving for 13 years as the President and CEO.

My experience in leading Henry Ford, which is a $5 billion, 27,000-employee health system, through a major financial turnaround and navigating our organization through the years of massive job loss in Michigan, population decline, the bankruptcies of our city and major employers while still growing substantially, making major capital investments in our communities, and winning the 2011 Malcolm Baldridge National Quality Award, have prepared me very well for the demands and complexity of the Commission's work.

Our Commission was composed of 15 talented and diverse leaders. We developed several principles to guide our work, including creating consensus and being data-driven, creating actionable and sustainable recommendations, and most importantly, our focus on veterans receiving health care that provides optimal quality, access, and choice.

The independent assessment report you commissioned was invaluable as a foundation for our work. It is a comprehensive, systems-focused, detailed report that revealed significant and troubling weaknesses in VHA's performance and capabilities.

Our work took place over 10 months, with 12 public meetings over 26 days. We sought the broadest input possible, had intense debate and dialog, yet had a unified focus at all times: what is best for veterans.

I believe we have produced a very good report that is strategic, comprehensive, actionable, and transformative. Twelve of the 15 Commissioners signed the report, signaling bipartisan support, and the three who did not sign had divergent views. One thought we had done too much and two thought we had too little transformation.

The VHA requires transformation, which is the focus of our recommendations. There are many glaring problems, including staffing, facilities, IT, operational processes, supply chain, and health disparities, that threaten the long-term viability of the system. Perhaps even more importantly, the lack of leadership continuity, strategic focus, and a culture of fear and risk aversion threaten the ability to successfully make the transformation happen over the next 20 years.

Transformation is not simple or easy. It requires stable leadership, expert governance, major strategic investments, and a capacity to reengineer and drive high performance.

Some of our Commissioners believed in moving VA to a payer-only model. Some believe that government simply cannot run a complex health system and that veterans should have the same choice that Medicare beneficiaries have. Yet we believe VA and VHA, under current leadership, Secretary McDonald and Under Secretary Dr. David Shulkin, are making progress, are aligned with most of our recommendations, and we believe that VHA should be invested in, for several reasons.

One is the model of integrated care delivery; second, the clinical quality, which is comparable or better than the private sector in most metrics; third, the history of clinical innovation, veterans-fo-

cused research, medical education, and emergency capacity; fourth, the specialty programs; and fifth, the role as a safety net provider for millions of complex and low-income veterans that may not or could not be filled by the private sector in many markets. As we know, even with the Affordable Care Act access to primary care and mental health professionals across the country, it is still very challenging.

Our recommendations fall into four major categories:

First, creating a VHA care system which fully integrates VHA, private sector, and other Federal providers, including the DOD and other providers, and that VHA continue to provide care coordination and vet all of the providers in the networks.

Second is the leadership system and governance, and a particular emphasis on continuity of leadership, leadership development, and creating oversight through a board of directors.

Third is the operational infrastructure, focusing on IT, facilities, performance management, H.R. and workforce, supply chain, and diversity and health care equity.

Finally, fourth, eligibility—focusing on other-than-honorable discharge eligibility for health care benefits and eligibility design.

We clearly do not want this report to sit on a shelf, and we ask for your help to make our report come to life through enabling legislation that was included that does require your action.

We are mindful that some of our recommendations have cost implications and we worked with health economists in modeling different options. We do not suggest that Congress has not already made very substantial investments in the system. Rather, we call for strategic investments in a much more streamlined system that aligns VA care with the community.

I would be very pleased to be a resource for the Committee as you continue your work on these issues. I would also look forward to your questions. Thank you very much.

[The prepared statement of Ms. Schlichting follows:]

PREPARED STATEMENT OF NANCY M. SCHLICHTING, CHAIRPERSON, COMMISSION ON CARE

CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL, AND MEMBERS OF THE COMMITTEE: I am pleased to appear this afternoon to discuss the workings, deliberations, findings, and recommendations of the Commission on Care, which I was privileged to chair. And I am delighted to be accompanied by my colleague, Dr. Delos (Toby) Cosgrove, the Commission Vice Chairperson, and the Chief Executive Officer (CEO) of the Cleveland Clinic. I also want to take this opportunity to thank you for your support of the Commission, and your assistance in providing us an extension of time to complete our work.

For the last 13 years, I have served as the CEO of the Henry Ford Health System (Henry Ford), a Detroit-based $5 billion, 27,000-employee organization, which I joined after many years of senior-level executive positions in health care administration. I believe my experience in leading Henry Ford through a dramatic turnaround of its finances and culture and in winning a Malcolm Baldridge National Quality Award and national awards for customer service, patient safety, and diversity initiatives played a role in the President's selecting me to chair this important body. I accepted this position not only because I was honored to be selected, but because I hoped that this commission could make a difference. I believe our report offers that promise.

As you well know, Mr. Chairman, just a little more than two years ago, Congress and the Administration faced a real crisis of confidence in a health system some had once seen as providing the best care anywhere. In 2014, alarming delays in providing needed care, and the scandal surrounding deceptive reporting on patient-

scheduling, led to the enactment of a far-reaching omnibus law that established the Commission on Care.

Congress is to be commended for including in that law provisions that commissioned an independent assessment of VA health delivery and that charged our commission to assess access to care and critical strategic issues. I was privileged to work with a group of commissioners who brought a diverse, rich breadth of experiences and perspectives while sharing a strong commitment to our veterans.

THE COMMISSION'S VETERAN-CENTERED APPROACH

The Independent Assessment, released in September 2015, was invaluable in providing the Commission a comprehensive, carefully-researched, system-focused analysis that both informed our work and provided an invaluable integrated framework for our examination and deliberations.

As we explained in our interim report, early on the Commission adopted a set of principles to guide our work; that identified both how we would proceed and the core values we would honor. Our adherence to those principles proved critical, in my view, to the development of a final report that is value-based and centered on our veterans.

While each of those principles was meaningful and important to our work, let me highlight just a few I think are particularly relevant to our dialog this morning:

- The deliberations and recommendations of the Commission will be data-driven and decided by consensus.
- The Commission will focus on ensuring eligible veterans receive health care that offers optimal quality, access, and choice.
- Recommendations will be actionable and sustainable, focusing on creating clarity of purpose for VA health care, building a strong leadership/governance structure, investing in infrastructure, and ensuring transparency of performance.

I believe you will find that these core principles profoundly influenced and are deeply embedded in the content of our final report.

Our work over a ten-month period—including 12 deliberative and educational meetings over the course of 26 days—was not easy. Our public hearings were wide-ranging; our discussions were frank. Through testimony and dialog, the Commission considered the broadest span of perspectives we could assemble: these included senior VA leaders and VA program and subject-matter experts; stakeholders, including representatives of national veterans service organizations, union and association leaders representing Veterans Health Administration (VHA) employees, individual veterans, Choice Program contractors, representatives of medical school affiliates and associations of behavioral health care professionals; former VHA Under Secretaries of Health and VHA network and medical center administrators; experts in health care and health care economics; and Members of this Committee. Our Commission, with its diverse membership, had spirited discussions, debates, and sometimes difficult deliberations—perhaps not unlike the process that leads to good legislation. Importantly, too, those deliberations were conducted in public sessions, in a process which was stronger for its transparency. Like your own work on this Committee, we were focused on and bound together by the unifying question, "What's best for the veteran?" I believe we have been true to that challenge, and that our report provides actionable, sustainable recommendations—many of which invite congressional action.

Importantly, we discussed at length the challenge of determining what veterans themselves want. To what, we asked, could we look to find the "voice of the veteran?" Time constraints and regulatory requirements ruled out conducting a Commission survey of veterans. But we pursued multiple other avenues and sources to tap and ascertain veterans' views, certainly including your advice, Mr. Chairman, that we engage the veterans' service organizations, who participated fully in our work.

STATUS OF VA HEALTH CARE DELIVERY SYSTEM AND MANAGEMENT PROCESSES

In its sweeping report, the Independent Assessment identified troubling weaknesses and limitations in key VA systems needed to support its health care delivery. Reaching very similar findings, the Commission concluded that—if left unaddressed—problems with staffing, facilities, capital needs, information systems, procurement and health disparities threaten the long-term viability of VA care. Importantly, though, neither the Independent Assessment nor our review called into question the clinical quality of VA care. Quite the contrary. The evidence shows that care delivered by VA is in many ways comparable to or better in clinical quality

than that generally available in the private sector.[1] This is a testament to the high quality of its clinical workforce.

Yet we found a system that faces many grave problems: high among them, an ongoing leadership crisis, confusion about strategic direction, significant variation in performance across the VA health system, and a culture of risk aversion and distrust. Despite the various deep problems facing VHA, our report does not propose shuttering the system or placing its future at risk.

With our focus on what is best for the veteran, the commissioners recognized that the VA health care system has invaluable strengths. It is an integrated health care system with a compelling mission that combines care-delivery, educating health professionals, conducting research, and carrying out a contingency national-emergency mission. VHA has developed and operates unique, exceptional clinical programs and services tailored to the needs of millions of veterans who turn to it for care. For example, its behavioral health programs, particularly their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered the effects of battle or military sexual trauma, or for whom VHA is a safety net. VHA's "wraparound" case-management services meet the most vulnerable veterans where they are to prevent them from falling through the cracks. As the largest national health care system, VHA continues to have the capacity to bring about reforms in the larger health care industry. By way of example, it pioneered bar-coding of pharmaceutical drugs, and championed improvements to patient-safety through systematic identification and review to identify root causes of medical mistakes and "near misses." In working to close access gaps, VA has developed one of the largest telehealth and connected-care operations in the world. While VHA can learn from private sector care, we also benefit from its successes.

TRANSFORMATION

We are clear, however, in our view that VHA must change, and change profoundly, because veterans deserve a better organized, high-performing health care system. Certainly, some elements of such a high-performing system are already in place. VA has high-quality clinical staff, and this integrated health care system is marked by good care-coordination. VHA today, however, relies significantly on community providers to augment the care it provides directly, although those community partners are not part of a cohesive system. VA and VHA are already undergoing substantial change under the leadership of Secretary Robert McDonald, Deputy Secretary Sloan Gibson, and Under Secretary for Health David Shulkin, and it is important to recognize and encourage this change process.

All of our commissioners agreed on the need to transform VA health care. At the heart of that transformation, we call for VA to establish high-performing health care networks that include and that integrate the care provided by credentialed community-based clinicians along with VHA and other Federal providers, and that afford veterans primary care provider-choice, without regard to criteria like distance or wait times. The establishment of integrated care networks—what we refer to in the report as a new VHA Care System—is nothing less than a fundamental change in the model of VA care-delivery. It is a model that will much more closely integrate VHA with its community partners, with an emphasis on coordination of care that is so important to the population VHA serves, one with more chronic illness and behavioral health conditions than the general medical population. High quality care is a critical element, so we propose that VA control network design; set high standards for community-provider participation, to include a credentialing, quality and utilization performance, and military/cultural competence; and tightly manage the networks. Our vision for this transformed system is one that would offer major improvements: improved access to care, care-quality, and choice, with resultant improvement in patient well-being.

Such a system, which Dr. Cosgrove and I would be happy to discuss in more detail, would provide our veterans with the high quality health care they richly deserve. But successful implementation of that recommendation is not only contingent on legislative action but, as importantly, on adoption of other major inter-dependent initiatives proposed in our report. In short, our report—as well as the Independent Assessment—makes very clear that providing veterans access to needed care cannot be achieved by "tweaking" existing programs or mounting a complex new delivery framework on a weak infrastructure platform. Rather, it requires an integrated sys-

[1] VA care has often been cited to be as good as or better than that of private sector. The following paper, identifying about 60 studies by disease type, supports that statement. http://avapl.org/advocacy/pubs/FACT%20sheet%20literature%20review%20of%20VA%20vs%20Community%20Heath%20Care%2003%2023-16.pdf

tems approach that not only redesigns VA's health care delivery system, but re-engineers fundamental internal systems. Transformation will require streamlining key functions such as IT, HR, procurement, facilities-management; investing in IT and facilities; building a strong leadership system; strengthening VHA governance; and reorganizing the relationship between VHA leadership and the field. Clearly, it will take time and will require relentless commitment by all stakeholders.

Let me add that in recommending a transformation of VA health care delivery and the systems that underlie it, we used the term "transformation" advisedly to mean fundamental, dramatic change—change that requires new direction, new investment, and profound re-engineering. Virtually all the commissioners agreed our recommendations are bold, though you have, no doubt, heard isolated voices of disagreement. One view disputes our belief that our report's recommendations would be truly transformative, and says instead that the report proposes only limited reforms and will do little to redirect veterans' health care. At the same time, our work has also been characterized as a "horrendous, anti-veteran proposal." Both critiques widely miss the mark, in my view. Our focus, however, was not on how our recommendations would be characterized, but with developing a report that would result in meaningful improvement in veterans' care. I believe we have laid that foundation.

"PRIVATIZATION"

It is no secret that the Commission debated the merits of so-called "privatization" or of veterans being offered unfettered choice from among all Medicare-qualified providers. It is also no secret that some among the membership are deeply skeptical of government-run health care, and some believe current trends will ultimately lead VA to a payer-only role. Regarding the 20-year horizon to which the Commission was to look, though, we can foresee continued dynamic change in health care. Already, there has been a dramatic increase in outpatient care. We can also speak with some confidence about the potential for explosive growth of telemedicine, increasing emphasis on preventive care, the introduction of precision medicine and the likely proliferation of technologies that permit routine home-based health monitoring of patients with chronic illnesses. But we're also in agreement that the rapid changes overtaking health care make it impossible to accurately forecast further than five years out.

While we cannot fully foresee the medical breakthroughs of the next decades, the Commission did acknowledge important realities:

- Despite profound challenges it must overcome, the VA health system is important to millions of veterans and has great value in providing clinical care, educating health professionals, conducting research, and carrying out a contingency national-emergency mission.
- Millions of veterans will continue to need care in the future that VA provides through critical programs and special competencies that are either unique or of higher quality or greater scope than is available in the private sector.
- Many veterans have complex medical and well-being needs, often greater than are commonly present in the general population.
- As a result, in considering the option of VHA becoming solely a payer, one must acknowledge that health care systems and facilities across this country are generally not equipped to meet many of the unique and complex health needs among the roughly six million veterans whom VA treats annually, particularly those with the highest priority in law: the service-connected disabled and those with limited financial means.
- The difficulties veterans have experienced in accessing timely care in the VA health care system are also relatively common experiences among health care consumers outside VA where national shortages of primary care physicians, psychiatrists, and certain specialists are everyday problems.
- Finally, many private health care systems have not established programs to fully coordinate care—an important attribute of VA-provided care.

This last point has particular relevance to the idea that veterans would be better served if they were simply provided a card or care-voucher that entitle them to get care virtually anywhere at VA expense. That strategy would surely lead to more fragmented care. As described by one highly acclaimed former Under Secretary for Health—

> "Fragmentation of care is of concern because it diminishes continuity and coordination of care resulting in more emergency department use, hospitalizations, diagnostic interventions, and adverse events. The VA serves an especially large number of persons with chronic medical conditions or

behavioral health diagnoses—populations especially vulnerable to untoward consequences resulting from fragmented care."[2]

NEEDED CONGRESSIONAL ACTION

Importantly, our recommendations highlight the critical role we see for Congress. The Commission certainly recognizes that veterans' access to care has long been a high congressional priority. Congress has strengthened the foundation of care-delivery through legislation, provided needed medical-care funding, and conducted important oversight. In creating our Commission, you asked the important question, how can the Nation best deliver veterans' care in the years ahead? Let me highlight some of the critical steps we recommend Congress take:

- Provide VA needed authority to establish integrated care networks through which enrolled veterans could elect to receive needed care from among credentialed providers without regard to geographic distance or wait time criteria;
- Address fundamental weaknesses in VHA governance;
- Provide VA more flexibility in meeting its capital asset and other needs, including—
  - (1) Establishing a capital asset realignment process modeled on the DOD BRAC process;
  - (2) Waiving or suspending the authorization and scorekeeping requirements governing major VA medical facility leases;
  - (3) Lifting the statutory threshold of what constitutes a VA major medical facility project;
  - (4) Reinstating broad authority for VHA to enter into enhanced-use leases; and
  - (5) Easing, for a time-limited period, otherwise applicable constraints on divestiture of unused VHA buildings.
  - (6) Establishing a line item for VHA IT funding and authorize advanced appropriations for that account.
- Create a single personnel system for all VHA employees to meet the unique staffing needs of a health care system; and
- Invest in needed VHA IT funding and facilities.

I'd be happy to discuss any of these in more detail, but let me amplify one point, which our commissioners viewed as foundational. The Commission saw VHA's governance structure as ill-equipped to carry out successfully the kind of transformation required to re-invigorate this health system, which all agreed would be a multi-year process. Continuity of leadership and long-term strategic vision—critical both to implementing a transformation and to sustaining it—cannot be assured under a governance framework marked by relatively frequent turnover of senior leadership and near-constant focus on immediate operational issues. The Commission believed that two fundamental governance changes were needed: establishment of a board of directors with authority to direct the transformation process and set long-term strategy, and change in the process for the appointment for and tenure of the official currently designated as the Under Secretary for Health. Of course, I'd be happy to discuss these and other recommendations in more detail.

COST

Let me emphasize that the Commission's aim was to develop recommendations that are actionable, sustainable, and would realize the vision of improving veterans' access, quality of care, choice, and well-being. We did not set out with the preconceived notion that bold transformational change was needed. Rather we stayed true to our guiding principles and to where our findings led us. Also, we were not constrained by cost considerations, though we did recognize early that the U.S. taxpayer is one of the Commission's stakeholders and we worked with health economists to model different options. Our report includes an appendix chapter that presents estimates of the cost of alternative policy proposals.

We recognized that our recommended option for expanding community care through the establishment of integrated care networks would result in higher utilization of VA-covered health care and, accordingly, in additional costs, in the view of our economists. But we believe adoption of other Commission recommendations and options discussed in our report can help mitigate the increased costs. Projecting costs, as you know, includes elements of uncertainty. Our economists could not esti-

[2] Kenneth W. Kizer, MD, MPH, "Veterans and the Affordable Care Act," JAMA, vol. 307, no. 8 (Feb. 22/29, 2012) accessed at https://commissiononcare.sites.usa.gov/files/2016/01/20151116–02-Veterans_and_the_Affordable_Care_Act_JAMA_Feb2012_Vol307-No8.pdf

mate savings or costs that might result from reducing infrastructure, for example. Similarly, they could not assign costs to needed investment in IT and facilities.

Implicit in our discussions, though, has been the question—should the Nation invest further in the VA health care system? Our report answers that question in the affirmative, even as it underscores the need for sweeping change in that system. We do not suggest that Congress has not already made very substantial investments in the system. Rather we call for strategic investments in a much more streamlined system that aligns VA care with the community.

In my judgment, our report points the way to meeting the central challenge Congress identified in 2014: improved access to care, while offering a vision that would expand choice, improve care-quality, and contribute to improved patient well-being. It is a vision that puts veterans first, not an approach crafted to win buy-in from system administrators or other interests. My long experience tells me that that veteran-centered focus will ultimately improve the service veterans receive while strengthening the system and providing increased transparency and accountability. In my view, this is a vision that merits your support.

I would be pleased to be a resource to this Committee as you continue to work on these issues. I would also be happy to respond to your questions.

Chairman ISAKSON. Thank you very much.

Tom Harvey?

STATEMENT OF HON. THOMAS E. HARVEY, ESQ., COMMISSIONER, COMMISSION ON CARE

Mr. HARVEY. Chairman Isakson and Members of the Committee, Ranking Member Blumenthal, it is a pleasure for me to be here with you today to address the work of the Commission on Care. It is a particular pleasure because for 5 years I sat where Tom Bowman is sitting behind you as Staff Director of the Committee under Senator Alan K. Simpson.

In my personal experience, the vast majority of VA staff at all levels are professional and highly committed to the veterans they serve. Like many of us, I was concerned to learn of the issues that came to light regarding the manipulation of wait times for appointments at the Phoenix VA medical center. I am happy to have been a part of the effort to better understand what had gone awry and to find a solution to those problems for today and into the future.

Service on the Commission has been an interesting experience. The Commissioners brought their varied backgrounds to this venture with one characteristic in common: all of us were committed to assuring that this country's commitment to its veterans was well met. We may have differed on just how best to do that, but the good faith of the Commissioners was palpable. Under the leadership of our very competent Chair, Nancy Schlichting, each Commissioner had an opportunity to express his or her priorities and to defend those should they be challenged.

The final report contains 18 recommendations. Some of these are good ideas. Others strike me as unrealistic. Some are included because one or more of the Commissioners felt very strongly about them. The White House made it clear to our Chair that they would like a consensus report. I signed off on the report in deference to that expectation, even though I had some reservations.

I had had a full and fair opportunity to express my concerns in open session. Among the many things I learned from Senator Simpson was that in negotiations on matters such as these, after all of the give and take you have to be able to take what you can, hold your head high, and declare victory one more time. And that is what I would like to do here.

Over nearly a year that the Commission met, we discussed a broad array of problems within the VA. Many of those were longstanding. We discussed those with senior VA leadership, who themselves recognized that there were issues that were beyond their ability to address. I like to think that by shining the light of discussion on some of those, we may have provided the impetus to the professional staff of the VA to raise such issues.

Some quick statistics regarding veterans and the VA. In 2008, there were 26 million veterans. Today there are about 21 million. In 2008, the budget of the VA was $68 billion. Today it is about $175 billion. In 2008, the VA had 240,000 employees; today about 368,000. The number of veterans is in precipitous decline. We lose about 5 million a decade. Of the total number of veterans, about one-third use the VA for some or all of their health care, many just for prescriptions.

In my written testimony, I highlight some of the specific issues in the report that I had problems with. I would, of course, be pleased to discuss those with the Committee.

What I wish we had done: there are a number of very basic questions that I wish the Commission had addressed. Some of these are things that no one wants to touch, such as why do we have a VA health care system at all? This is something that a number of people ask me.

We need to do something for those who are injured in training or in combat, but the fact is, most of those being treated in the VA system are suffering the same illnesses most of us can expect to experience with the passage of time. There is nothing uniquely veteran about those injuries or diseases, and in most communities there is ample surplus base to treat them in the community hospital.

Some say there are some veteran-specific medical conditions, such as spinal cord injury, blind rehab, Post Traumatic Stress Disorder, and Traumatic Brain Injury. In fact, annually, automobile and diving accidents create more SCI patients than the VA treats. And most of the veterans using the VA system are Medicare-eligible. If they use the community hospital, it can just bill Medicare.

If we are committed to having a VA health care system, who should be eligible to use it? Some people assume that once an individual puts on a uniform they are entitled to free health care for the rest of their lives—no need to worry about health insurance ever again. I do not think this is what we want.

A system was established a few years ago which said that for those with service-connected disabilities, treatment of those disabilities was the first priority of the VA system. Priorities also included veterans of very low income. Is there a better way to articulate eligibility so that the veteran—and, as importantly, the American taxpayer—can better understand what the VA health care system is trying to do, who it is obligated to provide care for?

In reviewing the materials relating to patient scheduling, I was struck by the fact that the gatekeeper for most VA care is a primary care physician. The medical education establishment is just not turning out a lot of primary care physicians, so that is a bottleneck that is only going to get worse. And over the past several years there have been significant changes in the way health care

has been delivered in the United States. That, too, will continue over the next several years.

Was the Commission a success? Several of my colleagues believed that we could only count it a success if the Administration and the Congress adopted the entire document as we presented it. I personally am willing to declare victory with the changes that VA Secretary McDonald, Deputy Secretary Gibson, and Under Secretary for Health Dr. David Shulkin, and their staffs, are now making.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Harvey follows:]

PREPARED STATEMENT OF HON. THOMAS E. HARVEY, ESQ., MEMBER, COMMISSION ON CARE

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. It is a pleasure for me to be here before you today to address the work of the Commission on Care. That pleasure is heightened by the fact that, for five years I sat on the other side of the table as Chief Counsel and Staff Director of the Committee then Chaired by Senator Alan K. Simpson (R, WY). I have also been on this side of the table twice when the Committee considered my nomination to be Deputy Administrator of the Veterans Administration and, in 2005, to be Assistant Secretary of the Department of Veterans Affairs for Congressional Relations.

Mr. Chairman, I particularly want to thank you for placing my name in consideration for appointment by the Majority Leader to serve as a member of the Commission on Care.

In my personal experience, the vast majority of VA staff at all levels have been professional and highly committed to the veterans they serve. Like many of us, I was concerned to learn of the issues that came to light regarding, among other things, the manipulation of wait times for appointments at the Phoenix VA Medical Center. I am happy to have been a part of the effort to better understand what had gone awry and to find solutions to those problems for today and into the future.

Service on that Commission has been an interesting experience. I have known some of the Commissioners for many years. Commissioner Dave Gorman, formerly Executive Director of the Disabled American Veterans, and I go back to my time on the Committee Staff in 1981. Commissioner Michael Blecker and I served as members of the Commission on Servicemembers and Veterans Transition Assistance in the 1990's. Commissioners Darin Selnick and Lucretia McLenny and I served in the Department during my stint there from 2005 to 2008.

The Commissioners brought their varied backgrounds to this venture with one characteristic in common: All of us were committed to assuring that this country's commitment to its veterans was well met. We may have differed in just how best to do that, but the good faith of the Commissioners was palpable. Under the leadership of our very competent Chair, Nancy Schlicting, each Commissioner had an opportunity to express his or her priorities and defend those, should they be challenged.

The final report, ably assembled by a very competent staff under the leadership of Executive Director Susan Webman, and John Goodrich, Executive Officer, contains 18 recommendations. I personally believe that some of these are good ideas. Others strike me as unrealistic. Some are included because one or more of the Commissioners felt very strongly about them. The White House made it clear to our Chair and Vice-Chair, Dr. Delos Cosgrove, that they would like a consensus report. I signed off on the report in deference to that expectation even though I had some reservations. I had had a full and fair opportunity to express my concerns in open session. Among the many things I learned from Senator Simpson was that in negotiation on matters such as these, following all of the give and take, you have to be able to take what you can, hold your head high, and declare victory one more time.

And that is what I would like to do here.

The Department of Veterans Affairs is an immense organization—a behemoth, so to speak. Making changes in such an organization has been described as comparable to making a change in direction of a naval carrier battle group. There are innumerable moving pieces, all of which have to move together in a choreographed fashion. Everything can't happen at once—although in our impatience, we would like that to be the case.

Over nearly a year that the Commission met, aided by the very comprehensive Independent Assessment, we discussed a broad array of problems within the VA. Many of those were long standing. We discussed those with senior VA leadership,

who themselves recognized that there were issues that were beyond their ability to address. I like to think that by shining the light of discussion on some of those, we may have provided the impetus to the professional staff of the VA to raise such issues—and the solutions that they may have been unable to raise previously.

BACKGROUND

In 2014 there were problems at the Phoenix VAMC with regards to scheduling veterans for medical appointments. There have been significant demographic changes in the veteran population with a major migration from the snow belt and the rust belt to the sun belt. It was suggested that several veterans died while waiting for a medical appointment. VA IG found that the VAMC was gaming the scheduling process and keeping duplicate records attempting to show that appointments were scheduled within time guidelines. The IG did not find that the wait times for appointments were causative of the deaths that did occur.

So, in 2014, Congress passed the Veterans Access, Choice and Accountability Act (The Choice Act) which provided, among other things, that if you couldn't get a VA appointment within 30 days, or if the VA was more than 40 miles from your home, you had the choice to get care in the community at VA expense. The Act also provided for a detailed study of many aspects of VA health care and its management and created a Commission on Care to review the study and make recommendations as to what the VA health care system should look like in 20 years. The 15 member commission was bipartisan, with appointments from the leadership of the House and Senate and the President. The Commission's report was issued just after July 4th of this year

MY BACKGROUND

Much of my professional career has been in positions related to serving this country's veterans. I spent five years as Staff Director of this Committee (1981–83 and 1995–96), I also spent three years as Deputy Administrator of the Veterans Administration (1986–89), and for nearly three years was Assistant Secretary of Veterans Affairs for Congressional Relations under Secretary Jim Nicholson (2005–08).

I also served as a member of the Congressional Commission on Servicemembers and Veterans Transition Assistance, then chaired by former VA Secretary Tony Principi.

After law school at Notre Dame (BA, 1963; JD, 1966) I served for nearly five years in the U.S. Army (1966–71) as an infantry officer, two and a half of those in Vietnam. While there, I commanded a company with the 173rd Airborne Brigade and served as an advisor with the Vietnamese Airborne Division. My decorations include the Silver Star and Purple Heart and 12 others for valor and service. I am a Ranger, Senior Parachutist and have the Combat Infantryman's Badge.

I have remained connected to many of the issues affecting veterans through the publications of the VA and of the VSO's. I am a life member of the VFW, DAV and AMVETS.

Other aspects of my professional life include nearly five years with Milbank, Tweed, Hadley and McCloy, a major Wall Street law firm (1972–77), and my selection as a White House Fellow in 1977—and my service in that role as an assistant to Admiral Stansfield Turner, then the Director of the Central Intelligence Agency. Following that I also served in the Department of the Army and of the Navy at the Deputy Assistant Secretary level (1978–81), and as General Counsel of the United States Information Agency (1983–86).

SOME STATISTICS REGARDING VETERANS AND THE VA

In 2008, there were 26 million veterans, today there are about 21 million. In 2008 the budget of the VA was $68 billion, today about $175 billion. In 2008, VA had 240,000 employees, today about 368,000. The number of veterans is in precipitous decline—we lose about 5 million a decade. Of the total number of veterans, about a third use the VA for some or all of their health care. Many just for prescriptions.

SIGNIFICANT FINDINGS/RECOMMENDATIONS IN THE REPORT

VHA Care System (recommendation #1): The Commission recommended that the VA partner with providers in the community so that health care could be available to veterans in the most efficient, cost effective way possible. If there is capacity in the community to offer major cardiac surgery, it doesn't make sense to send a veteran to a VA facility across the country for the same thing. While this seems to make sense, some in the veteran community think that this would be the death knell for the VA health care system which is important to many veterans.

Board of Directors (recommendation #9): I think it is unlikely that Congress will relinquish the authority that it has over the VA and give that to an independent board of directors. Indeed, I would think that the President would not want to relinquish his Executive prerogatives to appoint or discharge individuals directly. Would that be a good idea? Perhaps, if the Veterans Health Administration was a business, but just as it was not adopted after being proposed in the 1999 Commission report, I would expect that it would be rejected now.

BRAC (recommendation #6): A Base Realignment and Closing Commission type of process would be a good idea to enable the VA to eliminate facilities that are under utilized so that resources could be concentrated where the veteran patients are. I understand that there are about 50 VA hospitals with less than a 30% occupancy rate. But, even though there may be very few eligible veterans in a particular hospital's catchment area, there are some. And there are hundreds individuals working at those hospitals. Two senators and one or more Members of Congress will fight to the death to protect those jobs.

Underutilized facilities (recommendation #6): A problem VA has is that on many VA campuses, there are scattered buildings that are not used. Congress has made it virtually impossible to get rid of those, and even if you could, they are in the middle of a campus and would not lend themselves to easy disposal. Many have been designated as historically significant. VA has generally done the sensible thing and just used those for storage which is much less costly than trying to give the buildings to GSA or another government agency.

Family Members (recommendation #18): One recommendation of the Commission is that the VA should allow family members of veterans—or others in the community—to access underutilized VA hospital facilities. They would do this and pay for the services received thereby creating a source of revenue to the facility to complement appropriations.

This is a position particularly espoused by Commissioner Phillip Longman, the author of a 1995 book on VA health care entitled "The Best Care Anywhere." He was recently interviewed for the *Washington Monthly* magazine and took that opportunity to state his support for aspects of the Commission report which he believed would bring us closer to a single payer health care system—true "socialized medicine." Commissioner Longman was recommended for the Commission to the Minority Leader by Senator Bernie Sanders.

Allowing family members to use the VHA system isn't realistic. Look at the patient population of VHA—almost all are male. Many are elderly. We wring our hands about the problem of providing appropriate care to women veterans—and about 9% of veterans are women. I have been faulted for the use of a sample size of one—my wife—in addressing this issue. She is not about to go to the VA for her health care. And don't even talk about pediatrics.

And if we did have family members use the VA system, that would cannibalize the patient population of the community hospitals in the area. I have at times in the past seen the numbers of local hospitals that close each year because they can't operate efficiently. This would exacerbate that problem.

Personnel (recommendation #15): The Commission recommends changing the personnel system so that VA could, among other things, offer salaries competitive with the private sector. A review of the IRS 990 Forms of not-for-profit hospitals gives a sense of what those salaries are. In New York, for example, some hospital CEOs make in the range of $10 million annually. The President of the United States makes $400,000.

Health Equity (recommendation #5): The Commission places an emphasis on "Health Equity," a concept that I had never heard of prior to my service on the Commission. It focuses on the fact that minority veterans (indeed, any minorities) have less favorable health care outcomes than white veterans. This is much more of a social welfare issue than one of direct health care. The fact is, there is a maldistribution of health care resources in the country. Not many doctors want to go to rural areas, Indian reservations, poor inner city neighborhoods, etc. What are the responsibilities of VHA to try to rectify that situation? These seem to me to be societal problems, not a VA problem.

Information Technology (recommendation #7): The VA generally lacks the skill sets to deal effectively with IT needs. It has to contract with consultants to tell it what it needs and then to draft the specifications to meet those needs and then provide the services to make the hardware and software respond to those needs. In the Commission report we are saying that VA should get a commercial off the shelf product that does an amazing range of things, to include electronic health records, scheduling, business applications to effect the payment of non-VA providers and coordinating data among the different VA administrations. The fact is, VHA has spent years trying to develop a scheduling system—and isn't there yet. I think it is really

asking for something well beyond the capability of the VA to accomplish to suggest that it get the comprehensive—and very expensive—IT system we would like them to have.

Veteran Voices: One of our Commissioners bemoans the fact that we haven't done a comprehensive survey of what veterans want. In fact, we have had extensive comment from the VSO community—the group that Congress looks to to articulate the concerns of veterans. The reality is, they claim to speak for veterans and are perceived to do so.

WHAT I WISH WE HAD DONE

There are a number of very basic questions that I wish the Commission had addressed. Some of these are things that no one wants to touch. Such as:

Why do we have a VA health care system at all?

This is something that a number of people ask me. We need to do something for those who are injured in training or in combat, but the fact is, most of those being treated in the VA system are suffering the same illnesses most of us can be expected to experience with the passage of time. There is nothing uniquely "veteran" about those injuries or diseases. And in most communities, there is ample surplus space to treat them in a community hospital. Some say that there are some veteran specific medical conditions—such as spinal chord injury, blind rehabilitation, PTSD and Traumatic Brain Injury. In fact, annually automobile and diving accidents create more SCI patients than the VA treats. Very few VA SCI patients were injured in combat. They were in accidents like so many others.

And most of the veterans using the VA system are Medicare eligible. If they use a community hospital, it can just bill Medicare. VA could consider paying for the Medicare supplement insurance, which would limit the veteran's out-of-pocket expense.

If we are committed to having a VA health care system, who should be eligible to use it?

Some people assume that, once an individual puts on a uniform, they are entitled to free health care for the rest of their lives—no need to worry about health insurance ever again.

I don't think this is what we want. A system was established a few years ago which said that for those with service-connected disabilities, treatment of those disabilities was the first priority of the system. Priorities also included veterans who were just poor.

Is there a better way to articulate eligibility so that the veteran—and, as importantly, the American taxpayer—can better understand what the VA health care system is trying to do, who it is obligated to provide care for?

Where are the VA hospitals? Where are the veterans?

I think that if we look closely, we'll find a real disconnect here. Why is it that the issue of wait time delay first arose in Phoenix? Because a lot of veterans who used to live in the snow belt retired and moved there because of the weather. Thus the greater demand on the VA health care system there. Meanwhile in Canandaigua, NY, the VA maintains a hospital with a 1,700 bed capacity—within an hour driving distance of three other VA hospitals—with (when last I heard the numbers) about 70 patients and a hospital work force of more than 700. There was talk of closing Canandaigua at one time, but it was determined that it couldn't be done because it was the largest employer in the region.

VA HOSPITAL CONSTRUCTION

Every Member of Congress would like a new VA hospital built in his or her Congressional district. The multi-billion dollar construction project will provide construction jobs for five years, and once completed, the hospital will have an annual operating budget of about $250 million. And the hospital will be perceived as a benefit to a number of constituents—a demonstration of the ability to "bring home the bacon."

VA management of most recent new construction projects has been disastrous. With the predicted decline in the veteran population, I would suggest that no new construction be undertaken in the foreseeable future.

PROCESSES

In reviewing the materials relating to patient scheduling, I was struck by the fact that the gatekeeper for most VA care is a primary care physician. The medical edu-

cation establishment is just not turning out a lot of primary care physicians. So that is a bottle neck that is only going to get worse.

There was an op-ed in the Wall Street Journal recently by a retired VA primary care doctor. He observed that many veterans do, in fact, get their primary health care elsewhere, but they want to utilize the VA for their prescriptions because of the very low co-pay. Yet to do that, they have to schedule an appointment with the VA primary care doctor, who then takes the prescriptions from the outside doctor and, assuming they are on the VA formulary, processes them to be filled by the VA pharmacy. He suggests that much of the scheduling problem could be eliminated if the prescriptions from the outside doctor could be processed directly.

General changes coming to health care: Over the past several years, there have been significant changes to the way health care is delivered in the U.S. There is much more reliance on out-patient care rather than in-patient. The Affordable Care Act (Obama Care) and what follows that will mean many more changes to come in the future. In addition, if the decline in the number of veterans continues as it has, by 20 years hence, there will only be about 12 million veterans alive—with a physical plant that was designed to accommodate more than twice that number.

Was the Commission a success? Several of my colleagues believed that we could only count it a success if the Administration and the Congress adopted the entire document as we presented it. I personally am willing to declare victory with the moves that VA Secretary McDonald, Deputy Secretary Gibson and Undersecretary for Health, Dr. David Shulkin, and their staff are now making.

Thank you.

Chairman ISAKSON. Thank you, Mr. Harvey.

In light of the fact that the Committee Members have been so cooperative in shuttling back and forth with votes and other things that have been compromising our time, I am going to continue to deviate from my normal practice and go out of order by not recognizing myself but instead recognize Senator Manchin from West Virginia.

Senator Manchin?

HON. JOE MANCHIN III, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman, for being so kind, as you always are.

Thank you all for being here. I am so sorry I had to go and vote on the first, and missed the Secretary and Under Secretary.

To either one of you, or to both of you, if you would, it is my understanding that the Commission on Care's recommendation include allowing the primary provider to be outside the VA. It was very clear, and I understand they aim to improve access. It worries me that the veteran could receive medical care completely outside the VA with little to no oversight. That is my concern.

In West Virginia we have quite a number of veterans, as you know. Doctors outside the VA network can be trained in military and veteran culture. I am concerned that many are not equipped in dealing with the unique needs of veterans. Is a non-VA doctor able to spot a veteran with PTSD? Are they aware of certain symptoms of toxic exposure? Do they know that veterans may not disclose certain symptoms if they are uncomfortable?

These are all valid concerns. I am speaking—because I go around to my clinics and I go around to the hospitals; I speak to a lot of the veterans. What has been done in the past to the veterans is unconscionable—the wait time and all the stress—and I think everybody recognized that. But when I talk to the veterans, they still want veteran care. They demand it. I have asked them—I said, you know, if you cannot get it, we will get—they say, no, no, they take

care of me here; they know what I need; they know how to treat me.

That is my concern. In the future, how do you see VA striking a balance between making sure a veteran receives access to care in the community and the care received is high quality? How can you say that will happen in the private sector?

Ms. SCHLICHTING. Well, one of the things that is very important about our recommendations is that we are not proposing the current system of having a separation between the private sector and the VA. What we are proposing is a more integrated model.

Senator MANCHIN. Who is going to coordinate that? I mean——

Ms. SCHLICHTING. VA is coordinating that. And VA——

Senator MANCHIN. So, you want VA to be the gatekeeper?

Ms. SCHLICHTING. VA has to vet the network, select the providers that meet very strict criteria. In the report we include several elements of that, including not only their education and their experience, but also their military competency. Of course, about 70 percent of physicians in this country train in VA medical centers, so it is possible that we can create a very well-equipped set of primary care physicians when needed.

We also suggested that every market should be carefully evaluated in terms of access needs. More primary care physicians in the community might be needed in some markets versus others. Where VA has adequate numbers to provide that for veterans, perhaps they would have none.

So, the control of this VA care system that we are proposing is the VA, which includes vetting the networks. It includes having high criteria for participation. It could be different in different markets, based on need.

Senator MANCHIN. Mr. Harvey, I have a question for you.

Mr. HARVEY. Senator, may I just add one other thing——

Senator MANCHIN. Sure.

Mr. HARVEY [continuing]. To address a different part of your question, can people be trained to be sensitive to the veteran experience, and the answer is yes.

I just turned around to Rick Weidman from the Vietnam Veterans of America. I know they have a card—a foldout card that has a number of questions they encourage doctors to ask a person who is a veteran, you know, about the experience——

Senator MANCHIN. Sure.

Mr. HARVEY [continuing]. To elicit some of that——

Senator MANCHIN. OK.

Mr. HARVEY[continuing]. Some of that. There is training available.

Senator MANCHIN. I am sorry to hurry you up. Our clock is running here. [Laughter.]

The Commission on Care's proposal that you all have characterized is a path that will move VA into being more like TRICARE.

I have spoken to a lot of my veterans and everything, and they argue that when CHAMPUS, and then its predecessor TRICARE, started offering more low-cost insurance to military retirees, we started seeing the co-payments for TRICARE beneficiaries starting to rise. They were saying that, you know, it is a "gotcha." They pull you in and then they get you on the other end, making you pay.

I understand that many of our veterans are concerned that shifting care to outside the VA is going to lead to less money going to the VA and less services offered, and more coming out of their pockets to get what we have committed to them. Ten or 15 years down the road, I want us to be able to keep the promise we made to our veterans, especially those with unique injuries like polytrauma, Traumatic Brain Injury, spinal injury, and PTSD.

So, my question to you, Mr. Harvey, do you think the characterization that the Commission on Care wants VA to be like TRICARE is true, and what do you suggest there? What would you suggest Congress consider when thinking about the future of the VA health care?

Mr. HARVEY. Actually, Senator, one of our Commission members dissented from the Commission report largely for these concerns, that if we do this, is this going to be draining money away from the VA, from the VA facilities that are needed? I do not, frankly, have an answer to that. You know, would it be likely that co-payments would increase?

Senator MANCHIN. We can already base this on what has happened previously.

Mr. HARVEY. Yeah.

Senator MANCHIN. If that is the case, I would say, yes, our veterans have, really, reason for concern. They truly should have reason for concern because it is very well we will go down that path.

Ms. SCHLICHTING. If I could comment on that. I do think that it is important to see the balance in the report. While we are suggesting primary care——

Senator MANCHIN. Yeah.

Ms. SCHLICHTING [continuing]. Choice, when needed, within that VA care network, we are also suggesting significant improvements in the operations of the veterans health system.

Senator MANCHIN. My State's biggest problem is opiates, OK? If you have a doctor over here suggesting some sort of opiates and you have the VA trying to wean them off of the opiates we are giving to them, how is that going to—who is going to coordinate that? Who is going to——

Ms. SCHLICHTING. The VA is going to coordinate that.

Senator MANCHIN. Well, I——

Ms. SCHLICHTING. They have to.

Senator MANCHIN. I am concerned about that. It is the biggest problem I have got in my State and it is the biggest problem we have with our veterans right now. You need a single source basically taking care in curing them. If you have a doctor that believes they should be treated by pain—with a pill versus alternate care, you have got serious problems. That is what I am afraid of. I really, truly am.

Ms. SCHLICHTING. Well, the VA needs to have clinical standards for the providers that are part of that VA care network, that are consistent.

Senator MANCHIN. Mr. Chairman, I am so sorry to take a little bit more time than I should have, but I thank you.

Chairman ISAKSON. You are always timely and to the point. Thank you, Senator Manchin.

Chairman ISAKSON. I am going to just ask one question and make one observation.

Recommendation Number 18, Ms. Schlichting, "establish an expert body to develop recommendations for VA care eligibility and benefit design," tell me what that means.

Ms. SCHLICHTING. I think the feeling on the part of members of our Commission was we did not have the time or the focus on eligibility, but many people felt that it was time to do a comprehensive review to really evaluate it as a whole and take a look at eligibility standards today.

There were members of the Commission that felt, for example, that some of the lower-priority categories were not necessary, that the focus should be on service-connected injury, on lower-income veterans. It was felt that that would be something that a separate body could take a look at.

Chairman ISAKSON. So, when you say lower-level veterans, you mean bifurcate the veteran population as to some of them being eligible and some of them not?

Ms. SCHLICHTING. Well, there are several priority categories today, as you know, and the question was, are all those priorities as essential in today's environment?

Chairman ISAKSON. Was there any discussion to expand eligibility beyond just veterans?

Ms. SCHLICHTING. There was some discussion about that as a way of helping to make some of the facilities more efficient.

One example is that with some of the specialty programs that exist within VA, the volumes are very low and there is potentially a challenge of maintaining those programs, and potentially they could become a resource within a community. I think there were a number of thoughts about how to best utilize the capacity within VA facilities and maintain it, and at the same time really look at the total eligibility program.

Chairman ISAKSON. Last, and very quickly, was the eligibility for VA health care for a non-honorably discharged veteran part of that discussion?

Ms. SCHLICHTING. Yes, that was one of the issues we raised as part of our eligibility.

Chairman ISAKSON. Did you make a definitive recommendation on——

Ms. SCHLICHTING. Yes.

Chairman ISAKSON. And that recommendation was what?

Ms. SCHLICHTING. Well, it is included in our findings. It basically outlines that, for other than honorable, they would be put in sort of a tentative category until it could be evaluated. But the idea was to provide the care for veterans that often have reasons for being put in that category that have nothing to do with their service and the honorable service they provided while in the military.

Chairman ISAKSON. So, it would be a case-by-case basis.

Mr. HARVEY. Mr. Chairman, the concern was that if you have a veteran who has had multiple deployments, has served honorably for an extended period of time, comes back to the States and decides he has just had it and acts up and is given an other-than-honorable discharge—not a dishonorable discharge but one of the other categories—perhaps that was, in part, caused by his multiple

deployments—maybe PTSD, maybe traumatic brain injury—so, it would be unfair to leave him out of the VA care system.

Chairman ISAKSON. Thank you very much.

Senator Sullivan.

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman. I want to thank the panel and all the great work that you have done and everybody who contributed to the report.

I am going to begin by thanking Senator Manchin for his passion on this issue with regard to opiates. We are having similar challenges in Alaska. I actually want to thank Dr. Shulkin and Secretary McDonald. We had a big summit in Alaska on opioid challenges and heroin challenges this summer, and we had some very top, top doctors from the VA come up to Alaska for that, Dr. Lee and Dr. Drexler. So, I want to thank both of you.

I want to focus on an area that I did not really see in a lot of the recommendations, but I know it is in there because it is a really important topic. When you talk about the delivery of care, the issue that of course I am very focused on in Alaska is delivery of care in rural communities—extreme rural communities.

Mr. Chairman, I apologize. I know this is a little unorthodox. I am really sorry I missed hearing the Secretary and Dr. Shulkin. I know they are still here, but I would love to, gentlemen, be able to maybe chat at one of the breaks or something on the tribal sharing agreements that are a concern right now, but it relates to this issue.

I was back home in my State, of course, over the summer, like all of us, and in a lot of the communities there just seemed to be a very different approach to delivery of health care in some of the real far-reaching communities in Alaska that are—you know, we do not have roads. We have real unique challenges, given the size and distance.

Some of it relates to how the VA interacts with other health organizations—clinics, tribal organizations—in the far-reaching communities. One of the things that I saw, because I asked everywhere I went—I went to a number of my communities—is there seems to be a very different standard, depending on the community, even depending on, like, veterans sitting next to each other.

I always meet with veterans no matter where I go in the State—try to. Some of them said, hey, no, I can go right down the road to the local clinic or the local Native health organization. Others say, no, I have to fly to Anchorage, or I have to fly to Seattle. That can cost thousands of dollars just to get to these—you know, from some of the different communities in Alaska. Some of them say, then the VA pays for all that and puts us up at a hospital. Others say, no, you are on your own, all literally in the same community.

So, I am just wondering, on this issue, how much have you looked at it and what recommendations you have. Then, more broadly with regard to consistency on delivery, because it does seem very different even in the same communities. Different veterans have very different experiences.

Ms. SCHLICHTING. Well, first of all, I think that what you are describing is the challenge of a veterans health care system, that is

so diverse and covers the entire country, to be able to provide meaningful access in every single part of where veterans live and work.

We felt that that was one of the major driving forces for a more integrated model, so that in communities where VA facilities may not be available, that there is easier access to integrate with existing providers within that community. We also felt that there was a need for better integration with other Federal providers, which could apply certainly within the Native American community across the country.

The consistency of care, frankly, that challenge you describe is true with veterans and non-veterans. You know, in northern Michigan we have access issues. In some areas we have no obstetric services within 200 miles for women who might be trying to deliver. It is a challenge, which is one of the reasons we feel that it is very important to take a local look——

Senator SULLIVAN. Yeah.

Ms. SCHLICHTING [continuing]. In each market to try to provide better access.

The question of why, you know, some veteran has VA pay for it, others do not, that might be an eligibility kind of determination, which I cannot respond to. Really looking at the diversity of markets and how to best provide the care, and particularly when veterans are moving, it is not as if that veteran population is stable.

The facilities available in each market are quite variable as well. Some may have outpatient facilities that can accommodate a lot of needs. Some may not. You know, the need to move from more inpatient to outpatient care is something we are seeing across health care today. So, it is a challenge, but certainly something we had conversations about.

Senator SULLIVAN. And are there recommendations that relate to this in the Commission report?

Ms. SCHLICHTING. The concept of the VHA care system really incorporates some of the questions that you asked.

Senator SULLIVAN. Does it focus on kind of the extreme rural communities?

Ms. SCHLICHTING. Yes.

Senator SULLIVAN. OK.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sullivan.

Are you OK on time, Thom?

Senator TILLIS. Yes.

Chairman ISAKSON. You are OK on time too?

Senator BOOZMAN. Yes.

Chairman ISAKSON. OK.

I am going to go to Senator Blumenthal next.

Senator Blumenthal?

Senator BLUMENTHAL. Thanks, Mr. Chairman. I want to thank you for all the time and energy that you devote into this very, very important work.

To both of you—Mr. Harvey, I think you have raised, in passing, one of the central questions that faces us: why have a separate VA health care system? I think you have heard some answers here, which we see in our daily—literally our daily lives when we visit

VA health care facilities. Not only do veterans want to be with fellow veterans, but there are ways that veterans' care is tremendously enhanced by professionals who see them literally daily, hourly, for the same kinds of wounds, injuries, and so forth.

I might just add, in an area that is receiving more research—there was an article just, I think, yesterday or the day before in the *New York Times* about studies being done on hospitals and measures of their quality, and how, when consumers are better informed not only about the metrics of outcomes but also about how they are cared for, the actual outcomes are better when the emotional or social factor is part of the measurement.

I think in all kinds of ways I see the VA health care system as not—and I think you share this point of view—why should we have it, but it offers the immense opportunity and potential to actually lead the Nation in terms of quality, because it provides that opportunity to really attract the best and the brightest, as it has at certain VA facilities.

The challenges it faces, as I think one of you stated in your testimony, are the same challenges the rest of our health care system does. We need more primary care doctors, more psychiatrists, more equipment at more affordable prices, more pharmaceutical drugs. We can negotiate, but still, rising health care costs are a challenge, which mirrors the rest of our health care system.

What I have not seen so far—and maybe, Madam Chairman, you can talk a little bit about it—consumer protection, making sure that there are policies and procedures designed to monitor the quality of care that veterans receive outside the VA health care system. The metrics and evaluation can be applied to the VA health care facilities, but what about the health care outside the VA walls when there are choices offered, when the Choice program comes into play, in whatever form it may?

Ms. SCHLICHTING. Well, a couple of comments in response to that.

One is that the more unified and integrated the so-called outside providers are within the VA system, I think the greater the opportunity is to really evaluate performance, set clinical standards, and apply the same approach that is within VA to that care that is received in the community. That is a very important and different concept than the Choice program or the traditional ways that VA has paid for care in the community.

Within our recommendations we also suggested that performance metrics need to be very comparable; that we should have, really, the same metrics of performance within the community as within VA, and that those metrics should be a requirement of participation really as a vetted provider within the VA care system.

I think the more that that becomes the model, I think it begins to allay some of those fears about care being provided differently, whether it is the issue of pain management and opioid use or it is other elements of care that are provided.

Senator BLUMENTHAL. Mr. Harvey, did you want to add anything? And thank you for your service.

Mr. HARVEY. The only thing I would add, Senator, is you mentioned—and we addressed this in part of our report—that business of cultural competency of the health care provider understanding

that this veteran has had a particular type of experience, and being sensitive to that.

As I said, perhaps when you were out, I know the VVA has a little card that they suggest using, with various questions to ask the veteran patient to elicit some of the experience, so that as you are factoring this into the diagnosis and, you know, the analysis you are giving as a doctor, you have that as part of that.

That cultural competency and understanding the military background is an important thing that you get through a system like the VA. You are not going to get it at Washington Hospital Center.

Senator BLUMENTHAL. Exactly. Thank you so much.

Thanks, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Blumenthal.

We will have Senator Tillis, followed by Senator Boozman, and then we will go to panel three.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chairman. Thank you all for being here and for your work on the Commission.

Before I get started, I want to thank Secretary McDonald and his team. Mr. Chair, we had meetings last week. Secretary McDonald and a lot of the people that are here were in my office giving me an update on the transformation and the progress on the breakthrough priorities. I think it is great work and I have a lot of confidence in what they are doing.

I have to give special thanks also to Secretary McDonald coming back to my office the following day to give me a report on the Camp Lejeune toxic substances program. I think we are making progress and I appreciate the continued work.

Thank you both for being here. I am going to jump to three of the recommendations where I think the VA may have some concern. I may understand why, but—I am sorry, is it Ms. Schlichting?

Ms. SCHLICHTING. Yes.

Senator TILLIS. Good. I noticed in notes that my staff took—they had one note on discussion about privatization. I never miss an opportunity, when I see a word "privatization" ever mentioned, to mention that I do not believe that the VA should be completely privatized, period, end of story. I do not know of any U.S. Senator who feels like a full privatization is a good idea.

I think that there is an opportunity for veterans to choose whatever—what we should do is create a system that lets a veteran choose whatever pathway is right and necessary to provide timely care, and I believe that we agree with that.

I just say that because anytime I see "privatization," there is somebody that is saying—there is some Senator here that wants to give it to the private sector. I think there is a therapeutic value to some VA presence, veterans being among high concentrations of veterans, and until I see evidence to the contrary I would never support it. On the other hand, I do think there are a lot of opportunities to use non-VA providers in Choice, and that is what we are getting at.

Recommendation 4 has to do with an Engineering Resource Center. I used to work in management consulting. I think that the VA

may have some concerns with this. It probably has less to do with the end result and more to do with the process.

We have got a lot of Centers of Excellence that are sort of emerging. I visited Nashville, where there is a new ICU Liberation campaign. I did a surprise visit, actually—visited with them. They were very hospitable. I was very impressed with the results. It is one of two programs around the State.

So, I think, as a management consultant, I would be less interested in creating other groups and organizations with managers and communications channels and ways to create a web of subject matter expertise and Centers of Excellence that we could leverage. That probably has less to do with the concept and more to do with the implementation, but I will get back with the Department.

Do you have any comments on—either of you—comments on that particular recommendation?

Ms. SCHLICHTING. You know, we have heard, in terms of the response, that perhaps the Veterans Engineering Resource Center—which was the specific component of the VA that we recommended be the center of this performance improvement work—may not be the choice, which is—you know, that is not a—certainly not a big issue for me.

Senator TILLIS. Got you.

Ms. SCHLICHTING. I think the focus clearly is on how to drive a performance-improvement culture throughout VA——

Senator TILLIS. Absolutely.

Ms. SCHLICHTING [continuing]. And focus on clinical and business process improvement.

Senator TILLIS. Yeah, I think that is right.

You know, in Salisbury, NC, there is a great project that they have done, which was Lean process design. That is in my State. I see an emerging number of best practices that we need to execute and proliferate, but in an orderly way to where we are not varying and suddenly creating a hairball of kind of good practices and best practices.

I did want to move to—the board of directors recommendation is probably the one where you do not have me. The reason for that is I feel like that this Committee is the closest thing to a board of directors as we should have. If we add that other layer—I would be interested in your feedback and why you think it is different, but if we add that other layer, then I think we could have VA leadership that get monthly floggings from two different groups, potentially. I do not know that that is necessarily productive. I kind of enjoy our monthly floggings and——

[Laughter.]

Senator TILLIS [continuing]. I would not want to share that with anybody.

In all seriousness, I just think it is something that we should look at and maybe—I will drill down more in the recommendations, but I worry about—if we had that layer down, I think it could be another level of abstraction that could remove the members, particularly the Members of this Committee and maybe the members as a whole, from some of the details that are going on.

I have invested, over the last year, a lot of time with the leadership in understanding the transformation, and I think the more we

learn about it, the more we measure the week-to-week progress, the better off we are going to be. I would have to learn more in the—I have to read more into the recommendation to make sure that it is not putting us further away from that line of sight that I think is helpful. If you have any comment there, please share.

I do not have any remaining time, but I will follow up on Recommendation 17. Let me just put it this way: on bad paper, I think no one—and Senator Blumenthal has been great on this issue—there is no doubt that there are veterans who should probably receive care because the nature of their separation was related to an injury or an event that occurred. Their behavior was actually driven by something that was either a short—maybe a temporary injury or a permanent injury that we just simply did not know. We have talked about it before—shell-shocked, whatever we used to call it in the past.

It is more a matter of the implementation and making sure that it does not disrupt the VA from the things that they are trying to get done with the people who are already in the system who unquestionably deserve care. So, I think we want to work to the same goal. It is more the means rather than the ends.

Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Boozman.

Senator BOOZMAN. We appreciate you all very much, and really appreciate the ideas that you put forth. I think it is very, very helpful.

Ms. Schlichting, in your testimony you talked about the ongoing leadership challenges facing the organization, including a culture of risk aversion, distrust. Separate from your recommendations regarding the board of directors and the Under Secretary's appointments process, I would like to get your thoughts on how VHA can get after the risk aversion and the distrust issues. That is really a very difficult problem.

You might also, as you do that, comment about the—we have heard a lot about the senior leadership conferences and workshops. If you have any, you know, thoughts as to if those are working or not working, or if we need to change those a little bit or, you know, not—also, things like the Diffusion of Excellence. Is that getting down to the "Shark Tank" competitions? Is that getting down to the local level the way it should? Then again, you know, what other steps that we should be taking to try to improve the culture, which is so very important?

Ms. SCHLICHTING. Well, it is a very important question and something the Commission spent a lot of time on. I would just say first that I think Secretary McDonald and Under Secretary Shulkin are making really significant progress.

I think the worry we have is not so much the leadership development work that is going on. It is having continuity at the top for more than a couple of years, because it is very hard to change culture when you do not have a consistent pattern of leadership at all levels, starting at the top.

Our concern was, how do we have more stable leadership, have oversight with expertise? That was the reasoning behind the governing board, if you will, the board of directors, is to have health

care expertise overseeing the transformation process with stable leadership in place. That is how culture begins to really happen in a positive way and people start to take a little bit more risk. There is a culture of safety around speaking up, which is critical, I think, in any transformation. Those were the ideas that we really tried to move forward in our recommendations.

Senator BOOZMAN. And the "Shark Tank," the——

Ms. SCHLICHTING. Yeah, those things are great. I mean, and sometimes they can——

Senator BOOZMAN. The conferences.

Ms. SCHLICHTING. Right. I mean, I think they are fantastic. In fact, I know they are working with Professor Noel Tichy from the University of Michigan, who I know very well. In fact, I have taught in his class. He is terrific. And what Dr. Shulkin has done to really engage the teams I think is fantastic.

Senator BOOZMAN. Good.

Mr. Harvey, you highlighted the long-term challenges the VA has had with IT solutions——

Mr. HARVEY. Yes, sir.

Senator BOOZMAN [continuing]. Particularly as it relates to scheduling. Can you talk a little bit about that? As you mentioned, we have spent, you know, many years trying to get a scheduling system, and spent lots of money. What is your sense regarding the VHA's future willingness to consider off-the-shelf solutions? Again, how do we make progress on this front?

Mr. HARVEY. Well, let me start by saying that we met with the VA's Chief Information Officer, LaVerne Council, and I personally was very impressed. Others that I have spoken to within the VA, who know that part of the world, have been impressed by her competence, her experience. She brings a lot to this.

My concern is that the VA, for reasons that are not entirely clear to me, seems to have just had a terrible time getting IT right. So, what we are now saying is you should do this very complex new system—commercial, off-the-shelf—that will do health records, that will do payment business practices with Choice doctors, it will do coordination with the Veterans Benefits Administration, and it will do scheduling. It will do all of these things.

Proof of concept is something that I would like to see, because I really, honestly, do not think that they are—they would be able to do all of those things right now since, in fact, they have not been able to get the scheduling—just the scheduling, that one part—right.

The VistA system, which is the electronic health records, is an old system. It was one of the newest when it came in. It was the best for a long time, and it has been replaced by other systems. Transitioning to some other system that can do these other things is going to be a huge jump, and you want to do it right because it is going to cost lots and lots of money.

Senator BOOZMAN. OK.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Boozman.

Thanks to both of you for your testimony and for your months of hard work on the Commission. We are going to make sure this is not a dust-gatherer on a shelf, but as a thought-provoker that

results in the perfection we need to bring to the VA. We appreciate your service very much.

Ms. SCHLICHTING. Thank you.

Mr. HARVEY. Thank you very much, Mr. Chairman. Thank you, Members of the Committee.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO MS. NANCY SCHLICHTING, CHAIR, COMMISSION ON CARE

Ms. Schlichting, in the Commission's final report (p. 243), it states that a key source for the Commission was the views of veterans themselves, although the Commission did not conduct its own survey for this report and instead relied on those conducted previously by VSOs and comments through the Commission website.

Question 1. Can you explain why the Commission believed the previous surveys and website comments were sufficient to capture the views of veterans, and explain whether and how their views are representative of all veterans?

Response. We would have liked to have had more veteran input for the Commission's work, but the time necessary and required process for conducting a survey of all veterans made it impossible to complete in the timeframe we had for the Commission. We used what we had available, which included VSO surveys, website comments, and veteran testimony.

Question 2. Relatedly, did the Commission consider conducting its own surveys to capture the views of veterans? If the Committee had conducted these surveys, then how do you think it would have influenced the Commission's final recommendations?

Response. We did consider this, but had to reject it for the reasons stated above. I can't speculate on how it may have changed our recommendations. However, our recommendations were based on the information provided by the Independent Assessment, expert input from the Commissioners, and more than 100 hours of testimony by all key stakeholders, including veterans, VHA employees, VHA physicians, VA leaders, Congressional leaders, healthcare experts, and VSO leaders, and others.

Chairman ISAKSON. We will immediately welcome our third panel, our VSOs, and look forward to hearing from all of them. As our witnesses prepare to testify, let me make an observation, if I can.

On behalf of all the Members of the Committee, and on behalf of the staff of the Committee, I want to tell the VSOs how invaluable your help and support has been over the last 2 years and in the work leading up to Veterans First being developed. We have never had a situation where the VSOs were not ready to come forward with constructive suggestions, and we appreciate your input very much.

Sometimes when you are third on the panel you might think you are an afterthought, but you are not an afterthought. Many of the things we develop here come directly from the testimony that you bring forward. Many of the things we learn that we should have done differently, we learn from you when you correct us. So, we want to thank all of you for being here and we look forward to your testimony.

We will hear from the following individuals:

Mr. Jeff Steele, The American Legion; Joy Ilem, the Disabled American Veterans—and, Joy, we were delighted to have you all in Atlanta, GA, for your annual convention about 3 weeks ago. The Secretary and I both enjoyed being there, and the President was there as well. It was good attendance on the government's part anyway. [Laughter.]

Lauren Augustine, the Iraq and Afghanistan Veterans of America; CDR René Campos, the Military Officers Association of Amer-

ica; Mr. Carlos Fuentes, Veterans of Foreign Wars; and Mr. Richard Weidman, Vietnam Veterans of America.

We welcome all of you to be here, and we will start with Mr. Steele. Is that right that you are Mr. Steele? You are recognized for up to 5 minutes.

STATEMENT OF JEFF STEELE, ASSISTANT DIRECTOR, LEGISLATIVE DIVISION, THE AMERICAN LEGION

Mr. STEELE. Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee, on behalf of our National Commander, Charles E. Schmidt, and over 2 million members of The American Legion, we thank you and your colleagues for conducing this hearing today.

Generally, The American Legion is an agreement with many of the Commission's recommendations. However, the report contains, at its heart, a fundamental flaw which must be recognized and addressed.

Of the three Commissioners who refused to sign the final report, The American Legion is most closely aligned with Commissioner Blecker, who stated in his dissent that, "the adoption of this proposal would threaten the survival of our Nation's veteran-centered health care system as a choice for the millions of veterans who rely on it," a sentiment we have heard today.

The American Legion believes in a strong, robust veterans health care system that is designed to treat the unique needs of those men and women who have served their country. We also recognize that, even in the best of circumstances, there are situations where the system cannot keep up with the health care needs of the growing veteran population requiring VA services; therefore, veterans must seek care in the community.

Thus, we support the creation of fully-integrated health care networks, with the VA maintaining responsibility for the care coordination. These networks must be developed and structured in a way that preserves VA's capacity. Without a critical mass of patients, VA cannot sustain the very infrastructure that supports and makes VA specialized services world class. Providing veterans unfettered choice as to their provider jeopardizes this critical mass.

The American Legion also opposes allowing a complete option of primary care providers within the proposed VHA care system, because we believe the Commission's analysis is faulty. The Commission supports this recommendation based on a Congressional Budget Office (CBO) estimate that was calculated using Medicare rates. The Commission, however, gave no consideration to how Medicare rules would apply to the current quality of care provided to veterans through VHA primary care physicians.

VHA physicians are not restricted as to the amount of time they are able to dedicate to each patient or the number of presentations per patient. Medicare, on the other hand, only provides payment based on 10- or 15-minute consultations, which would deny veterans the full complement and quality of care they are entitled to through their earned benefits. If scored by CBO properly, the cost of this recommendation would be at least triple, if not more, and is thus financially unsustainable.

A better proposal is found in VA's plan to consolidate community care programs. The American Legion supports allowing VA setting up tiered networks. As we understand it, this structure would empower veterans to make informed choices, provide access to the highest possible quality care by identifying the best performing providers in the community and enabling better coordination of care for better outcomes. It rests on the principle of using community resources to supplement service gaps and better align VA resources, and we believe it has the potential to improve and expand veterans' access to health care.

However, as the VA begins to involve more community providers, the issue of how medical malpractice claims are handled becomes increasingly important. As it stands now, if a veteran is injured by a VA doctor, they can file what is called an 1151 claim. One, it will either begin or increase their level of service-connected disability and the injury would be covered by VA for the veteran's lifetime. No such protection exists for contracted care. It is essential to ensure that the current processes under 38 U.S.C. 1151 treats malpractice claims the same regardless of where they receive their care.

Finally, we recognize that the cost for these reforms remain a significant concern. The plan was presented to Congress in late 2015 and was well-received on both sides of the aisle. But, some Members of Congress balked at the costs. Ultimately, we strongly believe that this is a cost that must be met for VA to meet the needs of our veterans.

Mr. Chairman, I cannot conclude without remarking on the broken appeals process. Modernizing VA's archaic appeals process is of the utmost priority and The American Legion's number-one priority.

The House is voting today on Chairman Miller's reform bill. Senator Blumenthal has just come from a press conference where he introduced his reform bill. Senator Rubio also has a bill. There is wide bipartisan and bicameral consensus that the status quo is simply unacceptable and must be reformed. Mr. Chairman, we have worked with you personally and with the Committee. What are we going to do to get this done?

With that, I am happy to answer any questions the Committee may have.

[The prepared statement of Mr. Steele follows:]

PREPARED STATEMENT OF JEFF STEELE, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE DIVISION, THE AMERICAN LEGION

CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL AND DISTINGUISHED MEMBERS OF THE COMMITTEE, On behalf of National Commander Charles E. Schmidt and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to comment regarding The American Legion's position on the Commission on Care and the future of the VA healthcare system.

The American Legion has worked extensively on matters concerning veterans for nearly 100 years. Our work includes all business lines managed and operated by The Department of Veterans Affairs (VA) through sustained physical involvement, review of national policy, and donations of resources, funding, personnel, and experience.

It is with the voice and support of the largest voting block of veterans in the country that The American Legion presents the following analysis and recommendations regarding the report offered by the Commission on Care dated June 30, 2016.

The American Legion acknowledges the Commission relied heavily on the Independent Assessment as per congressional instructions, as well as some limited testimony from VA, Veteran Service Organizations (VSO), and media reports; but the primary foundation for discussion and findings were based on internal discussions among commissioners based on individual filters, experiences, and loyalties; and thus this report is reflective of those individual opinions.

The American Legion will not address the entire report, rather we will highlight the parts we believe have merit for further study or implementation, and those areas where we believe implementation would be detrimental to all veterans seeking healthcare from the VA, whether directly, or through a managed community relationship.

We are in general agreement with most of the Commission's recommendations and are pleased to see they are in line with transformation currently underway at VA through the *MyVA* initiative.

As you know, three of 15 Commission members did not sign the final report, with two commissioners opposing the final report because they felt it didn't go far enough. Commissioner Michael Blecker also did not sign, saying the main recommendation, for the Veterans Health Administration (VHA) Care System, went too far.

The American Legion's positioning on the report places us closer to Commissioner Blecker's. As he explained in his June 29 dissent:

> I cannot agree to the Commission's first and most significant recommendation, establishment of a proposed "VHA Care System." Given the design of this proposed new delivery model, the adoption of this proposal would threaten the survival of our Nation's veteran-centered health care system as a choice for the millions of veterans who rely on it. Although this is only one of many recommendations in the Report, this single recommendation risks undermining rather than strengthening our veteran-centered health care system, and I cannot agree to it.[1]

We also believe that recommendations of more privatization that some are trying to mask as "Choice" fail to take into consideration that veterans already have a myriad of choices, more so than most Americans. Choosing to see a contracted primary care physician as opposed to a VA primary care physician is a choice most veterans using VA health care already have through their private insurance, TRICARE, Medicare, Medicaid or several other options. These "choices" also come with additional expenses to the veteran. Converting VA health care to an insurance payer would increase out-of-pocket expenses for veterans who rely solely on VA for all of their health care needs, and who may not have alternate insurance options.

That said, here are our initial comments on a few of the most important recommendations:

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

This recommendation includes several sub-recommendations. Here we will address two of the most salient ones separately because they each have separate and distinct implications and will require individualized policy and/or legislative modifications in order to accomplish. The overarching theme of this recommendation involves a robust and integrated community care network.

A. The American Legion supports realigning VA's community care program and has provided testimony that discusses its restructuring. In relevant part, we said:

> The American Legion believes in a strong, robust veterans' healthcare system that is designed to treat the unique needs of those men and women who have served their country. However, even in the best of circumstances there are situations where the system cannot keep up with the health care needs of the growing veteran population requiring VA services, and the veteran must seek care in the community. Rather than treating this situation as an afterthought, an add-on to the existing system, The American Legion has called for the Department of Veterans Affairs (VA) to "develop a well-defined and consistent non-VA care coordination program, policy and proce-

[1] http://www.prweb.com/releases/2016/07/prweb13535231.htm

dure that includes a patient centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account.[2]

Over the years, VA has implemented a number of non-VA care programs to manage veterans' health care when such care is not available at a VA facility, could not be provided in a timely manner, or is more cost effective through contracting vehicles. Programs such as Fee-Basis, Project Access Received Closer to Home (ARCH), Patient-Centered Community Care (PC3), and the Veterans Choice Program (VCP) were enacted by Congress to ensure eligible veterans could be referred outside the VA for needed, and timely, health care services.

Congress created the VCP after learning in 2014 that VA facilities were falsifying appointment logs to disguise delays in patient care. However, it quickly became apparent that layering yet another program on top of the numerous existing non-VA care programs, each with their own unique set of requirements, resulted in a complex and confusing landscape for veterans and community providers, as well as the VA employees that serve and support them.

Therefore, Congress passed the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (VA Budget and Choice Improvement Act) in July 2015 after VA sought the opportunity to consolidate its multiple care in the community authorities and programs. This legislation required VA to develop a plan to consolidate existing community care programs.

On October 30, 2015, VA delivered to Congress the department's Plan to Consolidate Community Care Programs, its vision for the future outlining improvements for how VA will deliver health care to veterans. The plan seeks to consolidate and streamline existing community care programs into an integrated care delivery system and enhance the way VA partners with other Federal health care providers, academic affiliates and community providers. It promises to simplify community care and gives more veterans access to the best care anywhere through a high performing network that keeps veterans at the center of care.

Generally, The American Legion supports the plan to consolidate VA's multiple and disparate purchased care programs into one New Veterans Choice Program (New VCP). We believe it has the potential to improve and expand veterans' access to health care.

Network Structure

The American Legion supports allowing VA to set up tiered networks. As we understand it, this structure is meant to empower veterans to make informed choices, provide access to the highest possible quality care by identifying the best performing providers in the community, and enabling better coordination of care for better outcomes. However, it does not dictate how veterans will use the network. The American Legion wants to make clear, though, that we do not support a wholesale option to circumvent the VA infrastructure or healthcare system entirely.

Prompt Pay

We support a provision mandating that all claims be made electronically by January 1, 2019 and an eligible provider should submit claims to Secretary within 180 days of furnishing care or services.

Episode of Care

Provisions ensuring that an eligible veteran receives such care and services through the completion of the episode of care, including all specialty and ancillary services deemed necessary as part of the treatment recommended in the course of such care and services.

Emergency/Urgent Treatment

The American Legion supports requiring VA to reimburse veterans for the reasonable value of emergency treatment or urgent care furnished in a non-Department facility in a final bill.

Conclusion

Ensuring veterans have access to appropriate, timely, high-quality care is critical. VA needs to overhaul its outside care reimbursement programs, consolidating them into a more efficient bureaucracy able to dynamically interact with the network of

[2] Resolution No. 46: (Oct 2012): Department of Veterans Affairs (VA) Non-VA Care Programs

Federal, public, and private providers that are to supplement VA direct provided care.[3]

B. Choice of primary care provider

The American Legion opposes allowing a complete option of primary care providers within the proposed VHA Care System based on the Commission's faulty analysis. The Commission supports this recommendation based on a Congressional Budget Office (CBO) estimate of cost that was calculated using Medicare rates. The Commission, however, gave no consideration to Medicare rules for billing structure and how those rules would apply to the current quality of care provided to veterans through VHA primary care physicians. VHA physicians are not restricted as to the amount of time they are able dedicate to each patient, or the number of presentations per patient. Medicare, on the other hand only provides payment based on a 10 or 15 minute consultation, which then denies veterans the full complement and quality of care they are entitled to through their earned benefits. If scored by CBO properly, the cost of this recommendation would be at least triple if not more, and is thus financially unsustainable. The American Legion finds the recommendation and subsequent analysis by the Commission to be in error and believe that it should not be considered by the Administration.

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The American Legion does not support the creation of a governing board. We do find value in the Commission's discussion and recommendations that point out inconsistent leadership due to rotating political appointments and a leadership vision with a lack of continuity. The American Legion supports appointing a Veterans Health Administration (VHA) leader for a minimum of a 5 year term, with an option for an additional 5 year reappointment. We could also support the same consistency for the Deputy Secretary position.

Congress is also part of the problem here. When Representative Beto O'Rourke addressed the Commission on Care on March 22nd of this year, he noted that part of the problem with VA has been a severe lack of continuity in oversight due to an unwillingness of Members to serve on the VA committees: it's not glamorous, there are real problems to be addressed, and there are no "mission accomplished" banners. Members tend to leave the Committee as soon as they are able—to the point that, on day one as a new congressman assigned to the Committee, he found himself third in seniority on the Democratic side.

The American Legion thinks consideration should also be given to proposals that the Secretary of Veterans Affairs develop and submit to Congress a Future-Years Veterans Program and a quadrennial veteran's review.[4]

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

This proposal to shift all 300,000 VHA employees away from Title Five and onto Title 38 to provide the department with more flexibility in pay, benefits and recruiting is worth serious consideration. While the change would be designed to ease hiring and firing at the agency, the report says the new system should maintain due process appeal rights and merit system principles and we concur.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Included in this recommendation is consideration of the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline.

As the report notes, "closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges."

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[3] http://www.legion.org/legislative/testimony/231623/pending-veterans-affairs-legislation
[4] https://www.Congress.gov/bill/114th-congress/house-bill/216

Appendix C of the report discusses the outline of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas. The American Legion supports further investigation of this proposal.

The American Legion appreciates the hard work from all of the commission members and we look forward to working with this administration and the incoming Congress and administration to ensure veterans are provided with the high level of expert health care that they have earned.

Secretary McDonald's words on the report serve as a worthy stopping point for now: "However, until all veterans say they are satisfied, I won't be satisfied. Nobody at VA will be satisfied, but our progress so far proves that VA's current leadership, direction and momentum can produce the necessary transformation."

CONCLUSION

As always, The American Legion thanks this Committee for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division.

Chairman ISAKSON. Ms. Ilem.

STATEMENT OF JOY J. ILEM, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. ILEM. Thank you, Mr. Chairman, Members of the Committee.

Since the waiting-list scandal and access crisis of 2014, a vigorous debate has taken place about how to best provide timely, high-quality, comprehensive, and veteran-focused health care to our Nation's veterans.

Over the past year, there have been dozens of congressional hearings, numerous investigations, stakeholder engagement, enactment of the Choice Act, a comprehensive independent assessment and, finally, the report from the Commission on Care. All of these efforts were undertaken with the goal of getting to the root of the crisis and transforming the VA so it can better serve our Nation's veterans.

The Commission examined a wide range of ideas, including proposals to privatize and dismantle the VA health care system, but ultimately rejected such radical ideas, instead reaching a strong consensus on a comprehensive set of recommendations for the long-term transformation of VA. DAV supports the Commission's recommendations, as detailed in my written report, but I will focus on a few in my oral remarks that we have concerns with.

We support the Commission's first recommendation calling for the establishment of high-performing, integrated, community-based health care networks, with the VA acting as the coordinator of care. VA and the independent-budget VSOs and the VSO community—many in the VSO community put forth similar plans for integrating community care into VA.

The Commission plan, however, does differ in one crucial aspect, specifically—as mentioned previously—how it would manage the provision of care among VA and non-VA network providers. In order to reach consensus, the Commission recommended a compromise option to let veterans chose non-VA doctors within an established network, even in the cases were VA would have timely access and conveniently located options to meet their needs.

This open-choice option would significantly increase costs, lessen care coordination and quality, and shift resources out of VA, likely

resulting in the downsizing of the health care system. The problem is that if choice is elevated as the most important principle, you are likely to end up with two parallel systems and veterans will have to choose between—rather than an integrated system that is more likely to provide high-quality care and be responsive to veterans' individual needs.

The Commission's economist estimated the open-choice option would increase VA spending between $5 billion and $35 billion annually. Likewise, they noted that there was no clear evaluation of the potential impact that this choice option would have on VA's role as a whole, its ability to deliver comprehensive care and specialized services, or the impact on VA's research, education, and other critical missions.

Additionally, this option, according to the Commission, could shift an estimated 40 percent of the medical care currently provided by VA into the private sector. This reduction in work volume would undoubtedly force VA to cut services and close facilities, thereby depriving many veterans, particularly disabled veterans, of the choice to use VA for all or most of their care.

In order to ensure reliable access as well as high-quality and coordinated care for all enrolled veterans, VA must have the resources to address the many deficiencies identified in the independent assessment, including modernization of VA's IT and infrastructure needs, as well as the flexibility to organize and manage the networks and the care provided.

We also have concern about the recommendations to establish a board of directors to govern the veterans health care system. While we support greater continuity of VA leadership to facilitate better long-range planning, creating a separate and independent governing board for VHA would hinder the ability of the Secretary to coordinate interrelated health care services and benefits programs. Instead, we recommend VA adopt a Quadrennial Review process for improved long-term planning and budgeting purposes, similar to that used by the Departments of Defense and Homeland Security.

In closing, DAV concurs with the majority of proposals put forth in the Commission on Care report and we greatly appreciate the efforts of the Commissioners to find workable solutions to complex problems. We are also pleased that a number of recommendations are already underway, as noted by VA's Secretary in the *MyVA* initiative.

After 2 years of intense discussion and debate, there is a clear path forward and it is now time to take action and start working toward creating a health care system our veterans need and deserve for the future.

Thank you, Mr. Chairman. That completes my statement.

[The prepared statement of Ms. Ilem follows:]

PREPARED STATEMENT OF JOY J. ILEM, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL, AND MEMBERS OF THE COMMITTEE: Thank you for inviting DAV (Disabled American Veterans) to testify on the report and recommendations of the Commission on Care focused on improving veterans health care over the next twenty years. As you know, DAV is a non-profit veterans service organization comprised of 1.3 million wartime service-disabled vet-

erans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Virtually all of our members rely on the Department of Veterans Affairs (VA) health care system for some or all of their health care, particularly for specialized treatment related to injuries and illnesses they incurred in service to the Nation.

Since the waiting list scandal and access crisis were uncovered by Congress and the national media in the spring of 2014, a vigorous debate has taken place about how best to provide timely, high-quality, comprehensive and veteran-focused health care to our Nation's veterans. There have been dozens of Congressional hearings, multiple internal reviews, numerous media investigations, enactment of temporary programs and laws, expert stakeholder input, an independent assessment, and recently a comprehensive report with recommendations from the Commission on Care. Yet despite having diverse perspectives, virtually all of the major stakeholders have coalesced around a common solution: creating an integrated network of VA and community providers, with VA serving as the coordinator and primary provider of care. This transformative approach has been endorsed by DAV, the *Independent Budget* veterans service organizations (IBVSOs) (DAV, the Veterans of Foreign Wars, and Paralyzed Veterans of America), VA Secretary McDonald, key Congressional leaders and the Congressionally-mandated Commission on Care.

Mr. Chairman, with millions of America's veterans continuing to choose and rely on VA, and increasing numbers seeking care every day, it's time to move from debating VA's past problems and start taking actions to create the future VA health care system America's veterans deserve. With the current veterans' "choice" program expected to expire early next year, Congress must now decide whether to extend, expand or modify the current program or move beyond the "choice" paradigm by creating a new model of health care delivery based upon an integrated network of VA and community providers capable of providing care to veterans whenever and wherever needed.

As this Committee is well aware, the Veterans Access, Choice, and Accountability Act (Public Law 113–146) was enacted in August 2014 in direct response to the access crisis and waiting list scandal at the Phoenix, Arizona VA Medical Center and other locations around the VA system. The primary purpose of the Choice Act was to address veterans' access barriers by creating a new temporary choice program that allowed certain veterans to choose community care if they would otherwise be forced to wait more than 30 days for requested care, or travel more than 40 miles to a VA facility to receive requested care. The act also required an outside, independent assessment of the VA health care system, and it established the Commission on Care to study and develop recommendations for VA to improve the delivery of health care to veterans on a longer term basis.

Since its inception two years ago, the choice program has been beset with problems, some caused by the design of the law and others due to the urgent implementation schedule mandated by Congress. As the number of veterans using the choice program has risen, so have the number of problems they have encountered related to timely access, care coordination, appointment scheduling and provider payments. Although DAV and other VSOs supported passage of the choice program as an emergency response to the access crisis, it was neither intended to be nor supported as a permanent centerpiece of VA's health care delivery model. To address technical and implementation challenges with the choice program, Congress enacted two subsequent acts (Public Laws 113–175 and 114–41) but has not made any further legislative changes while awaiting the Commission on Care's final report.

The Independent Assessment mandated by Public Law 113–146, conducted primarily by the MITRE and Rand Corporations, produced voluminous data, information and recommendations about improving health care to veterans. The first and most important finding of the assessment was that the root cause of VA's access problems was a "...misalignment of demand with available resources both overall and locally..." leading to the conclusion that "...increases in both resources and the productivity of resources will be necessary to meet increases in demand for health care..." in the future.[1] Further, despite these deficits, the assessment confirmed what DAV, other VSOs and dozens of independent studies have reported over the past two decades: VA quality of care, on average, is as good as or better than, care in the private sector.

Last year, as mandated by Public Law 114–41, VA developed and submitted a plan to Congress to consolidate non-VA community care programs, including the choice program. VA's plan would create a high-performing network comprised of both VA and certified community providers. Although VA has already begun taking

[1] *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs,* The MITRE Corporation, September 1, 2015, p. B–3.

steps to move forward with a consolidation plan, VA is awaiting Congress to enact enabling legislation to facilitate the new consolidated program that would bring VA's plan to fruition.

Furthermore, the IBVSOs developed a joint Framework for Veterans Health Care Reform that proposed a similar concept of local veteran-focused integrated health care networks. Notably, both the *IB* framework and the VA plan call for VA to remain the coordinator and primary provider of care, with community providers integrated when needed to guarantee veterans timely access to care. This integrated network approach has been publicly supported by dozens of other veterans and related organizations, reflecting the views and sentiments of millions of veterans they, and DAV, represent.

The Commission on Care spent almost a year reviewing the Independent Assessment, hearing from stakeholders and other outside experts, and developing its recommendations to improve health care for veterans. While the Commission considered a wide range of ideas and options, including proposals to privatize VA, and one plan (the "strawman proposal") that called for dismantling the VA health care system over the next two decades. Ultimately, the Commission rejected the radical ideas, instead reaching a consensus on recommendations that hold many similarities to the plans put forward by VA and mainstream veterans organizations. The first and foremost Commission recommendation calls for establishment of "high-performing, integrated community-based health care networks" with VA acting as the coordinator and primary provider of care. Although some important differences are apparent among the integrated network plan proposed by the Commission, the IBVSOs and VA, respectively, call for strengthening the existing VA health care system by incorporating community providers into integrated networks. Moreover, each proposal maintains VA as the coordinator and primary provider of care, and each views the use of community providers and choice as a limited means to expand access in circumstances in which VA is unable to meet local demand for care.

After two years of spirited and passionate debate about the future of veterans health care, we envision a clear path forward that builds on the strengths of the existing VA system, while expanding access by seamlessly integrating the best of community care to ensure no veteran must travel too far or wait too long for care. Congress and VA must now begin the steps to finalize plans and move forward with the evolution of veterans health care. Equally important, both Congress and the next Administration must make a commitment to ensure that the resources necessary are provided to complete this transformation.

While we agree with most of the Commission's recommendations to strengthen the leadership, management and operation of the VA health care system, some remain of concern to us, and are explained below.

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Based on National Resolution No. 238 calling for reform of VA health care, adopted by delegates to our most recent National Convention, DAV supports the overall structure and intent of this recommendation to create an integrated care network model. However, DAV does not support the Commission's recommended option to allow veterans to choose any primary or specialty care provider in the network even when VA is able to provide the requested care. This open choice option would result in less coordinated care, worse health outcomes, lower the overall quality of care and result in significantly higher costs that could ultimately endanger the overall VA system of care that millions of veterans rely on, particularly veterans who were injured or made ill during military service.

As the Commission report states, "veterans who receive health care exclusively through VHA generally receive well-coordinated care . . . [whereas] . . . fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers."[2] While veterans' individual circumstances and personal preferences must be taken into consideration, decisions about access must first and foremost be based on clinical consideration, rather than on arbitrary distances or waiting times. However, in order to ensure consistently reliable access as well as high quality care for enrolled veterans, VA must retain the ability to coordinate and manage the networks. As the Commission's report states, "Well-managed, narrow networks can maximize clinical quality . . ." and, "Achieving high quality and cost effectiveness may constrain consumer choice."[3]

[2] Commission on Care Final Report, June 30, 2016, p. 28.
[3] Commission on Care Final Report, June 30, 2016, p. 29.

Furthermore, the Commission's recommended option to allow every individual veteran to determine which VA or non-VA providers in the network they would use could affect access for other veterans and would lead to increased costs. The Commission itself recognizes the likelihood of higher costs for networks under their recommended option, cautioning that, VA "...must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources..."[4] In fact, the Commission's economists estimate that the recommended option could increase VA spending by at least $5 billion in the first full year, and that it could be as high as $35 billion per year without strong management control of the network. The Commission also considered a more expanded choice option to allow veterans the ability to choose any VA or non-VA provider without requiring them to be part of the VA network. Economists estimated such a plan could cost up to $2 trillion more than baseline projections over just the first ten years.

While we agree that the VA health care system must evolve by integrating community providers into its networks, VA must retain the ability to coordinate care and manage workload within the networks. In general, the networks must have the ability to expand to include community providers if veterans face access challenges or VA is unable to provide sufficiently high quality care. However, the size, scope and design of local networks, as well as clinical workflow, must be directed by VA based on a demand-capacity analysis in each market in order to assure quality and adequate access to care.

DAV is particularly concerned about the Commission's projection that more than 40% of the medical care currently provided inside VA facilities could shift to non-VA network providers if this recommended option is implemented.[5] (Note that the "40% estimate is derived from the Commission's estimate that 60% of the 68% of care that is eligible for community care under the recommended option would shift.) If such a large transfer of patient care workload from VA facilities took place, it would have a dramatic impact on VA's ability to maintain a critical mass of patients necessary to safely and efficiently operate its current programs and facilities. An outflow of workload of this magnitude would undoubtedly lead to a number of facilities cutting services or closing, thereby depriving veterans of the option to receive all or even any of their care from VA providers in certain locations. Such downsizing or elimination of VA as an option would be particularly devastating for severely injured, ill and disabled veterans who rely on VA for comprehensive, integrated and specialized care.

Furthermore, we are alarmed that the Commission report specifically states that no consideration was given to whether its recommended option would weaken or diminish VA's medical and prosthetic research, academic, and national emergency preparedness missions, which continue to be vital aspects of the VA health care system overall. In particular, the VA research program helps to ensure that veterans receive the most current, safest and most effective treatments available for service-related conditions, and help to advance the standard of health care both within VA and beyond. The report also explicitly states that the Commission did not consider whether a sufficient number of private providers would be willing to take on additional patient loads from VA at Medicare reimbursement rates, how such a shift from VA to private providers would affect underserved communities, or how reduced patient workload within VA facilities would affect the quality of care of veterans remaining in the VA system.[6]

In addition to these concerns, it is critical to emphasize that the creation of seamless integrated community networks cannot be accomplished quickly or without a significant infusion of new resources to develop and deploy a modern Information Technology (IT) and management infrastructure necessary to successfully operate the networks, particularly to achieve seamless scheduling, care coordination and provider payment functions. DAV and our *IB* partners have repeatedly documented the shortfall in appropriations for medical care, appropriate staffing levels, infrastructure, IT, and other critical elements of VA's health care programs over the past decade, all of which helped to precipitate the access crisis. Now that there is a consensus about how to move forward to reform, strengthen and sustain the VA health care system, it is imperative that Congress take decisive action to ensure that sufficient funding to accomplish this new mission be provided.

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[4] Ibid.
[5] Ibid, p. 31.
[6] Commission on Care Final Report, June 30, 2016, pp. 32–33.

We agree with the Commission that networks should be, "...built out in a well-planned, phased approach..."[7] in order to ensure that the potential secondary impacts discussed above are avoided or reasonably mitigated. Furthermore, it is imperative that before and during the development of these networks, VA should regularly consult and collaborate with local and national veterans organizations and leaders, as well as other key stakeholders and community partners to gauge progress and properly address legitimate concerns.

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

DAV agrees with the recommendation to streamline and strengthen VA's facility and capital asset program management and operations. We also agree with the recommendation to give VA greater budgetary flexibility to meet its facility and capital asset needs, particularly overcoming Congressional budget scoring rules that have complicated VA's ability to open new leased clinic space. We also agree that VA needs to have the ability to realign its health care resources to address changes in the veteran population, demographics, location and health care needs, as well as evolving health science and technology. However, we do not agree that it is necessary or advisable to create an inflexible process, similar to the BRAC process, which has been employed to close military bases. The development of integrated community networks must be based on dynamic demand and capacity analysis, which would include modeling of the need to expand, contract, or relocate VA facilities. Local stakeholder input would be essential to ensure that local health care coverage would not be negatively affected by any facility realignment. DAV and our *IB* partners also believe that expanded usage of public-private partnerships should be explored as another way to address VA's infrastructure needs.

However, even with these reforms, significant increases in infrastructure funding will be necessary to address VA's access challenges. The Independent Assessment mandated by the Choice Act, found that the, "...capital requirement for VHA to maintain facilities and meet projected growth needs over the next decade is two to three times higher than anticipated funding levels, and the gap between capital need and resources could continue to widen."[8] Without change, the estimated gap will be between $26 and $36 billion over the next decade. For Fiscal Year (FY) 2017, DAV and our *IB* partners recommended $2.5 billion for all VA infrastructure programs; however, the Administration requested only $1 billion. Over the last several budget cycles, Congress also failed to address this growing problem or provide necessary resources for VA to meet all of its infrastructure maintenance and modernization plans. To complicate matters VA has lacked expertise to efficiently manage its Capital Assets Program resulting in significant cost overruns on several projects. While certainly a need exists to maximize savings from closing unused or underutilized facilities, the Commission's report points out that these savings are estimated at only $26 million per year, an amount that would not begin to make up for the shortfall in infrastructure spending required to maintain the remaining VA system. Also, under budget formulation policies, any such savings from closed or downsized facilities most likely would be lost to VA. Unless Congress and future Administrations begin to provide realistic funding levels to repair, maintain and replace existing VA health care infrastructure, these reforms will be significantly challenged.

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

While a board of directors in commonplace in the private sector hospital setting, DAV does not support the recommendation that would eliminate the VA Secretary's control of the VA health care system and give it to an unelected, independent Board of Directors that would be less accountable to the President, Congress, veterans and the American people. Separating veterans health care services from other veterans benefits and services would result in a loss of comprehensive and coordinated support for veterans, particularly those injured or ill from their service. In our opinion, creating another layer of bureaucracy between veterans and the VA health care system would create more problems than solutions. We appreciate the Commission's interest in recommending greater stability and continuity of leadership; however; we believe better means are available to accomplish these goals without undercutting VA's uniquely integrated system of services and benefits.

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[7] Ibid, p. 4.

[8] *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs,* The MITRE Corporation, September 1, 2015, p. K–1.

Rather than create an inherently political and bureaucratic layer between veterans and their health care system, these same purposes could be accomplished through the establishment of strategic planning mechanisms currently being used by the Departments of Defense and Homeland Security. Specifically, we propose that VA be required to undergo a Quadrennial Veterans Review (QVR), similar to the Quadrennial Defense Review (QDR) and Quadrennial Homeland Security Review (QHSR). The QVR, similar to its counterparts, would establish a national strategy to guide the creation of Federal policies and programs for veterans, and would be timed to overlap with Presidential administrations to provide continuity and insulation from political influence.

In addition, similar to the Departments of Defense and Homeland Security, there should be established a Future Year Veterans Program (FYVP) that would establish five-year resource needs and projections that VA would need in order to implement the policies and programs set out in the QVR. VA should also fully convert its budgeting and spending systems to a Planning, Programming, Budgeting and Execution (PPBE) system also used by the Departments of Defense and Homeland Security in order to assure accountability in how VA allocates it resources to meet immediate, short-term and long-term strategic goals. Establishing new planning and budgeting functions could provide VA stability and continuity in a more practical, effective and feasible manner than trying to establish a semi-independent governance board.

In addition, consideration should be given to overlapping the terms of the Under Secretary for Health and other senior VA leaders with Presidential elections, to provide additional stability and continuity, and to insulate these officials from political influence.

ADDITIONAL COMMENTS ON COMMISSION ON CARE RECOMMENDATIONS

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

DAV generally supports the intent of this recommendation but notes that additional funding would be essential for VA to hire new support staff discussed by the Commission. We also note the recommendation to eliminate bed reporting requirements under the Millennium Act is unclear.

We believe the oversight afforded by this Act is important; however, given changes in the veteran patient population, their health care needs, and the manner in which health care is delivered today, reinstating or maintaining the existing comparison year of 1998 [for bed levels] for a number of important programs would not produce information useful for Congressional oversight, veterans service organizations, and for others with interest in VA capacity.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-funded programs.

DAV supports the recommendation to create a fair, transparent and timely process to appeal clinical decisions, and we have testified before Congress on this concept. We would emphasize the importance of including veteran patients and veterans advocates during the development of this procedure.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

DAV supports the recommendation for VHA to adopt a model of continuous improvement and to share and standardize best practices in accordance with our Resolution No. 244, which calls for VA to maintain a comprehensive health care system for enrolled veterans, endemic to which is continuous improvement and the advent of best practices. We also agree that the three Veterans Engineering Resource Centers should play a more prominent role in the maintenance and improvement of such a system. Currently, VA employs numerous clinical researchers and operates several centers of excellence, health services research and development centers, and other centers devoted to continuous improvement, quality enhancement, patient safety and other factors affecting the model of care for veterans' health. Each has its own history, mission and proven accomplishments that have and continue to serve veterans. In addition, because systems engineering, as with other systemic change approaches, has limitations particularly in complex network-based adaptive systems, such limitations should also be considered when implementing this recommendation.

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

DAV supports the recommendation to more effectively address health care equity issues in VA's ethnic and minority populations. We refer the Committee to DAV's 2014 report, Women Veterans: The Long Journey Home, which details the barriers and program inequities that women veterans face. Our report offered specific recommendations to remedy these challenges.

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

DAV supports the recommendation to modernize and give VHA functional control over its IT systems in accordance with our recommendations in the *IB*. To assure full coordination of the proposed integrated networks will require full implementation of new IT systems and complete interoperability across VA and network providers. We would again note that significant time and dedicated resources will be required to achieve this goal.

Recommendation #8: Transform the management of the supply chain in VHA.

DAV generally agrees with this recommendation. We would note in consonance with our recommendations in the *IB* that some supply and acquisition programs and services are critically important to seriously disabled veterans, such as those affecting the procurement of certain types of prosthetics and sensory aids. Careful consideration must be given to balancing national standardization concepts with local flexibility to meet the unique needs and preferences of veterans who need these specialized services to address their disabilities.

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

DAV supports this recommendation and we note our specific support for VA's *MyVA* initiative that is underway and already beginning to address these concerns.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

DAV supports the intent of this recommendation on the basis of our recommendations in the *IB* dealing with the need for reforms in VA's human resources management programs, and again note that VA's *MyVA* initiative and other new leadership initiatives are beginning to address these issues.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decisionmaking at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

DAV generally supports the intent of this recommendation; however, transformation of this size and scope impacting the entire VA health organizational structure will have far reaching effects and must be carefully evaluated to mitigate any adverse consequences while achieving the overall goal.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

DAV generally supports the intent of this recommendation, although we would emphasize that not all performance metrics could or should be identical to those used in the private sector due to the unique nature of the VA health care system and the significant differences between patient cases mix in VA facilities versus those in private care. Health care outcomes and patient satisfaction could be measured consistently between VA and private providers; however, metrics related to cost, value or efficiency are less likely to provide meaningful comparisons because of differences in how VA and private systems are funded, the role of private health insurance, the primary-preventative model of VA health care and the interconnection of VA's complementary psych-social services and benefits—none of which generally exist in private care. VA should continue to develop and optimize metrics that

provide meaningful feedback about its unique health care model, as well as help develop new benchmarks that both VA and the private sector can use to strengthen health outcomes and performance measurement.

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

DAV generally agrees with this recommendation. In terms of providing military culture competency, VA providers are generally well-trained, though there remains room for improvement. As networks are developed, ensuring some level of military/veteran cultural competency to non-VA providers will be critical, although they may never possess the same level of immersion or understanding about the impact of military service as VA providers who work full-time inside a veteran-focused environment. We would also agree that non-VA providers should be expected to deliver the same level of veteran-focused care as VA providers. For example, all providers treating veteran patients need to ask about their military history and possible toxic exposures and be knowledgeable about medical conditions generally associated with certain wars or military conflicts.

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

DAV recognizes that the current laws governing VA personnel issues are complex and may need to be amended. We also recognize the need to strengthen VA's ability to recruit, hire, retain and be competitive with the private sector. However, we do not have a formal position on whether the creation of an alternative personnel system would be the best way to accomplish these goals.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

DAV fully supports this recommendation on the basis of our human resources management concerns expressed in the *IB*.

Recommendation #17: Provide a streamlined path to eligibility for health care for those with other than honorable discharge who have substantial honorable service.

DAV supports this recommendation on the basis of our National Resolution No. 226, adopted by delegates to our most recent National Convention, which calls for a more liberal review of other than honorable discharges for purposes of receiving VA benefits and health care services in cases of former servicemembers whose post-traumatic stress disorder, Traumatic Brain Injury and military sexual trauma or other trauma contributed to their administrative discharges characterized as other than honorable.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

DAV does not believe a new commission or task force is needed to make adjustments to veterans health care eligibility or benefits design. The Secretary already possesses tools to control access through enrollment decisions, and Congress retains complete discretion to modify eligibility requirements, to adjust the health care benefits package or other benefits through the legislative process.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you and other Members of the Committee may have about the Commission's report and VA health care reform.

Chairman ISAKSON. Thank you, Ms. Ilem.

Ms. Augustine?

STATEMENT OF LAUREN AUGUSTINE, SENIOR LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Ms. AUGUSTINE. Chairman Isakson and Members of this Committee, on behalf of Iraq and Afghanistan Veterans of America and our more than 425,000 members and supporters, thank you for the opportunity to share our views on the Commission on Care Report.

There are few issues more important to the healthy transition home for our generation of veterans than ensuring a veteran-centric, exceptional, and sustainable VA. We know from our member research that our members are increasingly turning to the VA for health care.

In our most recent survey, 29 percent of our members reported using the VA exclusively, up 6 percentage points from the previous 23 percent. Those using the VA in combination with other insurance is currently 63 percent, up 5 percentage points. As more veterans return and as we face the challenges of physical and mental injuries, we need to know that the VA will deliver for us. We must get this right.

The Commission on Care report was intended to map out a path to that VA, and in general is pointed in the right direction. IAVA agrees that we need to reform VHA. Our analysis of each recommendation is detailed in our testimony submitted for the record. Today's remarks will focus on IAVA's general analysis of the report as well as three of the 18 recommendations. We have six general comments on the report.

One, the report is presented as a series of independent recommendations. It fails to acknowledge that the success of implementing a single recommendation likely depends on the execution of others and will also require extensive time and resources to execute effectively.

Two, the report fails to consider how these recommendations to VHA will impact the VA as a whole, particularly VHA's ability to continue coordinating with VBA and NCA.

Three, the report fails to analyze the impact of recommended VHA reforms on VHA's ability to conduct research and train future clinicians.

Four, the report does not acknowledge the challenges faced by VA due to the misalignment of demand, resourcing, and authorities.

Five, the report failed to take into account reforms and programs that the current VA Secretary has already planned and/or implemented.

Finally, six, the report recommendations are broad and can be left somewhat open to interpretation.

As for the specifics of the recommendation, IAVA broadly agrees with most of them and VA's response to the report, but we would like to focus the remainder of today's remarks on Recommendations 1, 9, and 17. Specifically, IAVA opposes external primary care providers, IAVA opposes the creation of a board of directors, and IAVA supports a streamlined path to eligibility for other than honorable discharges.

On Recommendation 1, IAVA supports an integrated network of care that includes community providers, led by VA primary care providers, managing the veterans' care. However, Recommendation 1 is too broad, lacking critical pieces of analysis and with a fatal flaw: the external primary care provider. It also assumes that community providers will be available and able to absorb the demand created by integrating such a network.

On Recommendation 9, IAVA understands the reasoning behind the establishment of a board of directors and decrees that conti-

nuity in leadership is critical to long-term reform. However, we echo the concerns raised by many, including the VA, and do not support this recommendation in an already burdensome bureaucracy.

On Recommendation 17, IAVA strongly agrees with the need to provide a streamlined path to health care eligibility for those with other than honorable discharges who have substantial honorable service.

Those with other-than-honorable discharges can be among the most vulnerable in our veteran population. Awarding temporary eligibility to these individuals will allow for access to critical services without delay in health care, due to the current process for determining eligibility. However, it is important to stress that, with this change, will be a resource burden on the VA that will require Congress to support. With increased demand comes increased need for resources.

To close remarks today, I would like to reiterate several key points. One, reforming VHA into a truly 21st century health care system will require significant coordination between the next president, VA, Congress, VSO partners, and the veterans we all serve. Two, these changes will also require a significant financial investment that should not come at the expense of cutting existing benefits. And, three, again, these changes cannot be siloed within themselves but must be part of a comprehensive plan to be effectively implemented.

Thank you for your time and attention.

[The prepared statement of Ms. Augustine follows:]

PREPARED STATEMENT OF LAUREN AUGUSTINE, SENIOR LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL AND DISTINGUISHED MEMBERS OF THE COMMITTEE: On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members and supporters, thank you for the opportunity to share our views on the recently released Commission on Care Report. The Commission on Care was created by the Veterans Choice, Accountability and Access Law of 2014 and was charged with providing a framework for designing the Veterans Health Administration (VHA) for the next 20 years. IAVA appreciates the opportunity to have the voices of this Nation's newest veterans heard as we discuss the long term future of veteran health care.

Overall the Commission on Care report has put forward thoughtful analyses and recommendations for reforming VHA. IAVA broadly agrees with many of the recommendations, but also has reservations with a few, which are outlined in detail in this testimony. Further, we have an overarching concern with the lack of consideration for how these recommended changes to VHA will impact the Department of Veterans Affairs (VA) as a whole, particularly VHA's ability to continue coordinating with the Veteran Benefits Administration (VBA) and National Cemetery Administration (NCA) as well as its ability to continue leading in health research and clinician training.

Regardless of the specifics of each recommendation, one thing is certain: Reforming VHA into a truly 21st century healthcare system will require significant coordination between VA, the larger administration, Congress, VSO partners, and the veterans we all serve. This coordination must be done in a bipartisan, veteran-centric manner that understands transformative change requires resources. IAVA encourages Congress to listen to the needs of the VA and fund any necessary changes at adequate levels without cutting existing critical benefits, like the GI Bill.

GENERAL ANALYSES

1. *The report fails to consider how these recommendations to VHA will impact the VA as a whole, particularly VHA's ability to continue coordinating with the the VBA and NCA.* One of the most unique aspects of the VA is its ability to offer wrap-

around services to the veterans in its care. VHA is not only responsible for health care, but also oversees critical programs like suicide prevention and veteran homelessness. Over the years, the necessary coordination between VHA, VBA and NCA has continually improved. While not perfect, the cross-coordination of the these administrations is critical in maintaining VA's ability to provide these wrap-around services and fully support the veteran. This report does not address this critical need for coordination and how coordination would be impacted if these recommendations to VHA were implemented, but it must.

2. *The report fails to analyze the impact of recommended VHA reforms on VHA's ability to conduct research and train future clinicians.* Seventy percent of physicians receive some level of professional training from the VA. VA also trains over 20,000 nurses and nearly 35,000 people in other health related fields annually. This, combined with the robust research program that has led to groundbreaking discoveries in prosthetic development, spinal cord injuries, mental health injuries and burn care, expands VHA's impact in the community beyond any simple health care provider. These additional roles are critical aspects of the VHA footprint that were not accounted for in the development of the Commission on Care report. The impact of implementing these recommendations on these additional critical VHA roles must be taken into account.

3. *The report does not acknowledge the challenges faced by VA due to the misalignment of demand, resourcing and authorities.* The Independent Assessment of VA conducted by the Mitre Corporation found that a misalignment between demand, resourcing and authorities is one of the critical challenges of the VA to execute effectively on its mission. This report does not address this challenge. As the writers of the *Independent Budget* point out, at its current state VA is underfunded and cannot meet demand. Budget approval rests with Congress; only they can properly align demand and resources. And such substantial reform efforts, while needed, will require proper and realistic resourcing. IAVA would again echo our concern of recent Congressional efforts to pay for new services and benefits at the VA by cutting existing benefits and make a strong recommendation that this method not be used to fund transformative change within VHA.

4. *The report is presented as a series of independent recommendations; it fails to acknowledge that the success of implementing a single recommendation likely depends on the execution of others and will also require extensive time and resources to execute effectively.* The Commission on Care report puts forward a number of recommendations that will require time and resources to implement, and yet the challenges inherent to such a long-term, resource-intensive process are not addressed. Further, the report outlines a series of independent recommendations, but does a poor job of showing their interconnectedness. For example, an integrated network of care cannot be built without an updated technology platform and infrastructure to support the network. Yet these, and the costs associated with them, are not mentioned in the recommendation to create an integrated network of care. This lack of integration gives a false sense of overall cost of implementing this plan. It also fails to emphasize that in many cases, if one recommendation is adopted without others, the overall plan to improve VHA will fail. It is critical to recognize that while these recommendations are presented as stand-alones, many will be intertwined and one cannot be fully achieved without others.

5. *The report failed to take into account reforms and programs that the current VA Secretary has already planned and/or implemented.* The Secretary conducted an extensive internal assessment of the VA when he was initially appointed to the position in 2014. As a result, he has put into action the *MyVA* initiative, which addresses many of the points raised by the Commission on Care report. The report does not specifically address this initiative or take under consideration potential redundancies of the recommendations of the Commission report.

6. *The report recommendations are broad, contradictory at times, and can be left somewhat open to interpretation.* This presents a challenge as leadership and the makeup of Congress changes. The broad and contradictory nature of the report does not provide clear and concise direction and the intent of the Commission in making these recommendations might be lost to political leanings.

ANALYSES OF REPORT RECOMMENDATIONS

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as VHA Care Systems, from which veterans will access high-quality health services.

IAVA Analysis: IAVA recognizes that the VA cannot fulfill its mission alone and a fully integrated network of care that includes community providers will be essen-

tial to achieving this mission. We also agree with the need for an integrated model that requires patients to consult with a primary care provider to receive specialty care services and removes the arbitrary eligibility criteria enacted by the Choice Program. However, we disagree with primary care services being available outside of the VA, even if it is limited to within the community network. While well-intentioned, IAVA is concerned that a broad interpretation of this recommendation creates a framework whereby VHA as an institution can slowly be phased out. Furthermore, IAVA is not convinced the primary care providers outside the VA could effectively treat the whole veteran and effectively help veterans navigate the VA. A veteran's primary care provider needs to be the quarterback of their care; they've got to be central and fully integrated into the team.

Additionally, the budget assessment for this recommendation makes a number of assumptions that may or may not hold true. First, the economic analysis does not include cost assessments for upgrading the IT platforms to support a truly integrated network, costs associated with the needs of the physical infrastructure of facilities nor additional administrative costs to support this new model.

Although not specifically addressed, this recommendation also assumes that community providers will be available and able to absorb the demand created by integrating this network. The model estimates as much as 60 percent of VA care shifting to the community network (from 34 percent currently). This will likely create a large demand on a community medical system already struggling to meet the demand of existing civilian patients (a challenge already realized by VA Choice providers). Finally the implementation of such a system does not take into account the impact on research and training, and could have a severe negative economic impact if not mitigated.

Overall, IAVA supports an integrated network of care that includes community providers, with integration of VA primary care providers managing the patient care and an overall resource estimate that considers additional costs needed for administrative support, IT systems and infrastructure required to support the network. We find this recommendation well intentioned, but too broad, lacking critical pieces of analysis, and with a fatal flaw: the external primary care provider.

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, improved data collection and management.

IAVA Analysis: There is a growing shortage of physicians and the healthcare community will need to be open to expanding responsibilities for all health professionals. IAVA agrees with the need for VHA to more effectively engage its professional staff and ensure that clinicians have the support staff, both clerical and clinical, they need to use their time more efficiently and effectively to treat patients. We also agree that data integrity and collection must be a priority.

Recommendation #3: Develop a process for appealing clinical decisions that provides the veterans protections at least comparable to those afforded under other federally-supported programs.

IAVA Analysis: IAVA has no strong opinion on this recommendation. IAVA does support the intent to convene an interdisciplinary panel to further assess and offer recommendations regarding revising the clinical appeals process to ensure the veteran is receiving a judicious and uniform process when appealing a clinical decision.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

IAVA Analysis: IAVA has continually recognized that one of the challenges at VHA is sharing best practices across the VHA system of care. Under the leadership of Secretary McDonald and the Undersecretary for Health, Dr. Shulkin, VHA continues to try and identify innovative solutions at the local level and bring these to the greater VHA community. However, streamlining these practices has been a challenge. We concur with the intent of this recommendation, VHA must establish an effective way to identify these transformative programs and share them across the VA in a streamlined and efficient way. However, we are not confident that the Veterans Engineering Resource Center is the appropriate entity to meet this intent.

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the cause of the problem and ensuring VHA Health Equity Action Plan is fully implemented.

IAVA Analysis: IAVA agrees that VHA should adopt as a primary mission the elimination of health care disparities among the veterans it serves. As the report

states, minority populations are growing in the U.S. as a whole, and also within the veteran community. For VA to fully recognize its mission to serve veterans, it must be focused on serving all veterans.

IAVA has recently focused on improving services to women veterans. Women veterans are a minority group, but they are not homogeneous. Women veterans are a very diverse population. We agree with the report's findings that the VA prioritize and fully resource serving minority populations. Additionally, we agree that while VA has improved its focus on understanding these populations through research, more must be done. There is an overall lack of data on vulnerable populations and a lack of data on how VA is doing to support these populations. This data gap must be closed. In doing so, VA will have the tools to finally address the needs of these populations in a data-informed way.

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

IAVA Analysis: As the Commission on Care report recognizes, the VHA infrastructure is in dire need of attention. The average facility is 50 years old, resources for updates are nowhere near adequate and the ability for VA to conduct needs assessments of its facilities and act on those assessments are hindered by Congressional oversight. IAVA agrees that the VA must have more flexibility to meet its facility needs. We also recognize the growing importance of ambulatory care needs, while balancing the availability of inpatient facilities

Additionally, we feel it is imperative to recognize the current challenges for VA to enter into agreements with health care partners to share space, equipment or personnel. Current law makes it nearly impossible for these private-public partnerships to be entered into, and in order for VA to implement recommendation one of this report, an integrated network of care, this capability is essential.

IAVA also agrees that there could be resources gained by empowering VA to make these critical facilities decisions. There are a number of legislative changes that can be made to address the critical infrastructure needs of the VA. It will be imperative that Congress work with the VA to make these needed changes a reality.

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business practices.

IAVA Analysis: IAVA recognizes the VA IT system will be a critical component of an integrated system of VA care. Currently, the IT system is woefully outdated and does not afford the possibility of this integrated system. The current care in the community programs and providers do not interface with VA in a streamlined manner, making care disjointed. Further, the report points out that a lack of standard clinical documentation and a standardized electronic health records (EHR) across all facilities makes record sharing across facilities and from facility to veteran very difficult. IAVA agrees with these findings. In order for VHA to provide a streamlined, high quality and timely level of care, the IT system must be brought into the 21st century. VHA must have a detailed strategy and roadmap to achieve this level of IT and it will require the support of Congress to fulfill its vision.

IAVA has advocated not only for an update to the VHA IT system, but also the development of an interoperable EHR between Department of Defense (DOD) and VA and within VA. This is critical to providing patient service to the military/veteran population. It is is also required by law and past due. However, with an integrated network, the need for interoperability will go beyond the VA and DOD and include its community partners.

We are concerned that the priorities of VHA's IT needs are getting lost in the Office of Information and Technology and agree VHA needs an IT advocate working to meet the IT needs of VHA. However, we believe this would also benefit VBA and NCA and they too should have IT advocates.

Finally, we agree that the budget cycle as it stands now makes it very difficult for VHA to plan for and execute on IT needs, and concur that VHA's IT budget needs should also be on a two year cycle with VHA's advance appropriations cycle.

Recommendation #8: Transform the management of the supply change in VHA.

IAVA Analysis: This is beyond the scope of IAVA's expertise and therefore we take no position. However, we support any mechanisms that could improve efficiencies and allow for resources to be reallocated elsewhere in VHA with these improved efficiencies.

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy and direct and oversee the transformation process.

IAVA Analysis: IAVA understands the reasoning behind this recommendation and agrees that continuity in leadership is critical to long term reform. However, it can be very difficult to impose private sector practices (Board of Directors) on a public sector entity (VHA) because of the nature of that public sector entity.

In an attempt to increase accountability in VHA, establishing a board runs the risk of the opposite effect. Particularly with the establishment of the board through various political appointees, the board risks becoming another entity where inaction becomes the norm because of opposing viewpoints. Additionally, as described the board has no fiduciary control; Congress will continue to be the final oversight authority. IAVA is concerned that the addition of the board adds another layer to the already burdensome bureaucracy. A board of directors without fiduciary responsibility effectively becomes an advisory board, and VA already has one, and arguably multiple, of those established through the *MyVA* Board and the VSO community.

We understand the Commission's concerns over continuity of senior leadership roles such as the Undersecretary of Health and are willing to consider a longer term of appointment for the Undersecretary of Health, but believe that this requires further analysis on the impact on VBA and NCA. More generally, with a change in governance structure such as this recommendation, there must be considerations as to how this impacts the coordination between VHA, VBA and NCA.

There is also further consideration to be made as to the role that VSOs, Congress and other informal advisors already play in this capacity.

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to reform VHA culture and sustain staff engagement.

IAVA Analysis: As the report recognizes, the cultural and organizational health of VHA must be positively transformed before the VHA can function at its greatest potential. IAVA strongly agrees that in order to build a healthy culture, VHA must instil greater collaboration, ownership, and accountability among its employees. We applaud the strong dedication found among VHA employees and continue to advocate for policies and opportunities that best strengthen and support the VA's workforce.

We agree with the report's recommendations that stress a systems-oriented, leadership-supported, and flexible approach to cultural transformation. However, IAVA is concerned that this cultural transformation must be conducted throughout all of the VA and not exclusively siloed within VHA. Given the strong inter-agency cooperation at the VA and the need for VA leadership at its highest levels to support these goals, implementing the changes suggested by the report must be done across the whole VA.

Additionally, the concept of the transformation office has the potential to help drive and focus the suggested cultural changes. However, we would need to understand the specifics of how the transformation office would function, how it would disseminate policies and training, and how it would be able to support local and national change to understand if such an office would be a more effective model of change than the current system. Since the report also directs this new transformation office to report directly to the suggested governing board, we would echo here our concerns detailed under the analysis of recommendation nine.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

IAVA Analysis: IAVA overall agrees that VHA does not have a strong plan in place for leadership development and growth and this is critical for the continued success of VHA. Under Secretary McDonald, the need for leadership development has been recognized and is one of many areas where IAVA is excited to see progress already being made.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decisionmaking at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

IAVA Analysis: IAVA supports streamlining VHA and empowering staff to make decisions, but in empowering the staff VA must ensure they have the right tools and metrics to make informed decisions. IAVA supports reducing redundancies and sim-

plifying organizational structure, but also want to ensure that in simplifying vital processes are not lost.

We have also supported the VA Secretary's request for more budgetary authority to make these critical decisions and route resources to where the need rests. We understand the need for a health care system to have that additional flexibility, but that must be carefully balanced with ensuring vital programs continue to be funded.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

IAVA Analysis: IAVA broadly agrees with the need for VHA to streamline and focus its organizational performance measures and establish the same in a personnel performance measure system. These metrics must be clearly defined, measurable, and speak more to the need for meaningful measures tied to safety, quality, patient experience, operational efficiency, finance and human resources (as indicated in the Independent Assessments). We also see value to tying these metrics to private sector measures given recommendation one to create and integrate the network of care, but hesitate to rely too much on the private sector measures given that VHA also has its own unique aspects that might warrant some measures outside of the private sector. Additionally, this is another area being addressed by the VA Secretary's *MyVA* transformation plan.

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers and staff to embrace Diversity, promote cultural sensitivity and improve veteran health outcomes.

IAVA Analysis: IAVA completely agrees that military cultural competence is critical for all who provide care to veterans. A recent RAND report that looked at military cultural competence among community mental health providers defined this not just as knowledge and comfort with the military culture, but also knowledge of evidence-based practices to treat mental health injuries and ability to practice these techniques. It's critical to recognize that competence applies at all levels, from the individual greeting as the veteran walks in the door, to the provider treating the patient. All VA staff must be trained in this. Additionally, providers and their support staff must understand the specific health indicators for this population to better serve them. IAVA supports all of the recommendations in this section specific to asking about military health history and awareness of all veteran groups, including providing quality care for women veterans and the LGBT community. This will be a critical requirement for any community providers that are adopted into the VHA network, whether it be the current care in the community programs, or some future iteration.

Recommendation #15: Create a simple to administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management and supports pay and benefits that are competitive with the private sector.

IAVA Analysis: IAVA is an active advocate for a dedicated focus on VA staffing. Specifically at VHA, we agree that attracting talent to VHA will be critical at all levels of the staffing hierarchy, and so competitive salaries and hiring incentives will be critical in doing this, as well as expediting the hiring process. We also recognize the tradeoff of moving from a Title 5 to a Title 38 hiring structure, including potential impacts on the diversity of the hiring pool. We recommend that should this recommendation be considered, this concern be addressed and then monitored if the recommendation is implemented. Given that VA serves a unique and diverse population, we want to be sure that the staff that serves this population maintains that same diversity.

We also agree that VA H.R. should take a more proactive approach in developing leaders within VHA. We encourage VA to consider how VA H.R. can balance the needs to meet regulatory requirements, but more importantly emphasize professional development and fostering leaders among the VA ranks, as well as improving morale and hopefully as a result, retention.

Any discussion on improving VA personnel systems must also include a discussion on increasing accountability at the VA. While a vast majority of VA employees serve veterans in an exemplary way, there are also those who discredit the VA through underperforming or plain negligent acts. Being able to jettison these employees in an expedited manner while also protecting whistleblowers and rewarding those that do serve in an exemplary way are the keys to restoring VA morale.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds and assign expert resources to achieve an effective human capital management system.

IAVA Analysis: In order to achieve recommendation 15, recommendation 16 must also be a priority. To reform the personnel hiring and H.R. administrative systems, leadership must be in support and must prioritize it.

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

IAVA Analysis: IAVA agrees with this recommendation. Those with Other-Than-Honorable (OTH) discharges can be among the most vulnerable in our veteran population. They are at a higher risk for suicide and homelessness, and often as a result of their discharge status may have no VA resources available to them. Community programs often mirror the eligibility criteria of the VA, and so even these resources may not be available to them. They become stuck in limbo, possibly needing help for an injury sustained while in service, but not able to obtain that help because they are not eligible due to their discharge status. For some, the injury obtained during service might have even contributed to the OTH discharge received.

Awarding temporary eligibility to these individuals will allow for access to critical services without delay in health care due to the current process for determining eligibility. However, it's important to stress that with this change will be a resource burden on the VA that will require Congress to support. With increased demand comes increased need for resources.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

IAVA Analysis: This remains a critical issue within the veteran community and updates to VA eligibility have not been addressed in 20 years. It is past time to do so. IAVA agrees with the recommendations to form a body to review these criteria and develop recommendations to meet the needs of all veterans.

Again, IAVA appreciates the opportunity to outline our review of the Commission on Care. Change is necessary, and working together we know the VA and the health care it provides can be strengthened to provide the highest quality care for veterans in this Nation's history. IAVA looks forward to continuing to work alongside this Committee, Secretary McDonald and our fellow VSO partners to evaluate and implement changes necessary to best achieve this goal.

Chairman ISAKSON. Thank you, Ms. Augustine.

Ms. Campos.

STATEMENT OF CDR RENÉ A. CAMPOS, USN (RET.), DEPUTY DIRECTOR OF GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Commander CAMPOS. Chairman Isakson, the Military Officers Association of America appreciates this opportunity to give our views on the Commission on Care report.

MOAA was particularly grateful for the open and collaborative process Commissioners established in order to receive information and feedback from veterans themselves, as well as the VSOs and MSOs representing this constituency.

Overall, MOAA supports most of the Commission's findings and we are pleased to see many of the report recommendations incorporate the changes that Secretary McDonald and VSOs have been advocating for since the implementation of the Commission on—since the Choice Act.

In responding to the report, I would like to put right up front that we want to see the exhaustive work of the Commission and the critical legislation proposed by the Congress and Administration be enacted this year. The panels before us have already discussed that: the budget, the Veterans First Act, and appeals mod-

ernization, those particular ones. Let me focus on three specific recommendations, though.

First of all, MOAA supports establishing high-performing, integrated, community-based health care networks. While VA alone cannot meet all the health care needs of veterans, the system does provide a foundational platform on which to build. And that is clearly stated up front in the report.

MOAA believes a new system needs to preserve well-known programs and competencies in VHA's mission in the areas of clinical, education, research, and national emergency response. These are integrally related to the broader VA mission and American medical system.

MOAA is pleased the Commission recognized VA's primary role in coordinating health care and helping veterans navigate the system. That said, though, VA must retain responsibility for managing VA's health—veterans' health information and patient outcomes to ensure quality and continuity of care services.

Second, MOAA agrees with the Commission's recommendation to create an integrated and sustainable culture of transformation where all the programs and activities are aligned and leaders at all levels of the organization are responsible and accountable for improving organizational health and staff engagement. Such transformation requires modernizing VA's leadership and human capital management system across the enterprise. Such improvements will require the necessary funding and authorities to make that happen.

As with many of our VSO partners, MOAA supports the concept of a longer-term appointment for the Under Secretary of Health. We, however, are not supportive of establishing a board of directors. MOAA believes Congress' role of oversight is essential and adequate in holding VA accountable, and Congress must continue to be the veterans' strongest advocate.

Finally, MOAA aggress with the Commission's proposal to establish an expert body to develop recommendations for VA care eligibility and benefits design. The Commission recommends that VA revise its regulations to provide tentative health care eligibility for those with other than honorable discharge. The Commission believes that VBA's adjudication process in determining characterization of discharges takes far too long and is very strictly interpreted, preventing veterans from getting the care they need sooner rather than later.

Instead, MOAA recommends that Congress direct VA to provide more information on the current scope of the problem—what the process is, what the potential costs, and the impact of—and what the impact would be on VHA if this recommendation was implemented.

In conclusion, MOAA appreciates the Senate and the House Committees on Veterans' Affairs' unwavering leadership and focus on improving health care for our veterans.

In closing, I would like to just share a quote from one of our veterans in the field, who articulates what MOAA's perspective is on VA health care. I quote,"I will tell you that our VA has a very solid reputation. And despite what is heard in the national press, I know, from both personal experiences and from experiences I have

heard from others who use the VA in Durham, we are very fortunate. The VA medical center works well and the staff is committed to its mission."

When I walk through the VA medical center in Durham, I am struck with two things. The first is how complex it must be to manage such a facility. The second is what I see in the faces where nowhere—faces of people who have nowhere else to go. The VA is there for them.

MOAA believes this VA medical center is the rule rather than the exception in VHA. It is our view that we must leverage these best practices and invest in this type of culture across the system. Our veterans and their families deserve no less.

I thank you for this opportunity and look forward to your questions.

[The prepared statement of Commander Campos follows:]

PREPARED STATEMENT OF CDR RENÉ A. CAMPOS, USN (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL, AND MEMBERS OF THE COMMITTEE, the Military Officers Association of America (MOAA) is pleased to present its views on the Department of Veterans Affairs (VA) Commission on Care Report under consideration by the Committee today, September 14, 2016.

MOAA does not receive any grants or contracts from the Federal Government.

EXECUTIVE SUMMARY

On behalf of our 390,000 members, MOAA appreciates the Congress' vision in establishing an independent commission to look at how best to organize and deliver health care in the VA Health Administration (VHA) in the 21st Century.

After reports of secret waiting lists at the VA medical center in Phoenix, Arizona, MOAA urged President Obama to establish an independent commission in order to make immediate and long-range systemic changes necessary to provide the best quality care and support services to our Nation's servicemembers, veterans and their families.

After 10 months of intense deliberations, public meetings, testimony, and extensive inputs from experts across the country, including MOAA, the federally-directed Commission on Care issued its final report on June 30, 2016.

MOAA was particularly grateful for the open and collaborative process commissioners established in order to receive information, feedback and viewpoints from veterans themselves, as well as from veteran and military service organizations representing this constituency.

Overall, MOAA supports most of the Commission's findings, and we are pleased to see many of the report recommendations incorporate the changes Secretary McDonald and veterans service organizations (VSOs) have been advocating for since the implementation of the Veterans Access, Choice and Accountability Act of 2014 (Choice Act).

While much more remains to be done, we appreciate the Commission's sincere effort to strike a balance of sustaining and improving VA health care delivery while enhancing civilian care opportunities.

Along with our VSO partners, we look forward to working with the President, Congress and the VA to translate the Commission's recommendations into effective action.

The following section provides MOAA's views and concerns on selective issues and recommendations for your consideration.

COMMISSION ON CARE REPORT ANALYSIS AND RECOMMENDATIONS

MOAA believes Chairperson Nancy Schlichting's statement on the final report released on July 5, 2016, is an excellent characterization of the current system and provides a compelling reason for why immediate reform is needed.

"The system problems in staffing, information technology, procurement and other core functions threaten the long term viability of VA health care system and that key VA systems do not adequately support the needs of 21st century health care," stated Schlichting, CEO of the Henry Ford Health System. "The Commission found that no single factor can explain the multiple systemic problems that have frus-

trated VA efforts to provide veterans consistent timely access to care. Governance challenges, failures of leadership, and statutory and funding constraints all have played a role. As the Final Report states, however, 'VHA has begun to make some of the most urgently needed changes outlined in the Independent Assessment Report (Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs Report, published January 1, 2015), and we support this important work."

MOAA supports the following key elements of the report recommendations:

Redesigning the Veterans' Health Care Delivery System

- Establish high-performing, integrated community-based health care networks to be called "VHA Care System (VCS)" to include VA facilities and Department of Defense (DOD) and other federally-funded providers and facilities.
- VCS networks retain existing special-emphasis resources and specialty care expertise (e.g., spinal cord injury, blind rehabilitation, mental health, prosthetics, etc.).
- Community providers must be credentialed by VHA to qualify to participate in community networks, ensuring providers have the appropriate education, training, and experience.
- Highest priority access to health care would be provided to service-connected and low-income veterans.
- Eliminate the current time and distance criteria for community care access (30 days/40 miles).
- VCS should provide overall health care coordination care and provide navigation support for veterans.
- Veterans would choose a primary care/specialty care provider in VCS—specialty care requires referral from the primary care provider.
- VHA should increase efficiency and effectiveness of providers and other health professionals by improved data collection and management, adopting policies to allow them to make full use of their skills.
- Eliminate health disparities by establishing health care equity as a strategic priority.
- Modernize VA's information technology (IT) systems and infrastructure.

While VA alone cannot meet all the health care needs of veterans, the system does provide for a foundational platform upon which to build. The Commission acknowledges the importance of this foundation up front in the report:

> "VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement."

MOAA believes the new health care system delivery model needs to preserve well-known programs and competencies in VHA's mission areas of clinical, education, research, and national emergency response—all critically important elements and capabilities integrally linked to the broader VA mission as well as the American medical system.

The report does note however, that while care delivered in VHA in many ways is comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility because of operational systems and processes, access, and service delivery problems.

Specialty programs and resources are unique and distinctive capabilities which set VHA apart from the private sector in its ability to deliver critical and specialized medical services. This is particularly true in the areas of behavior health care programs, integrated behavioral health and primary care through its patient-aligned care teams, specialized rehabilitation services, spinal cord centers, and services for homeless veterans—core competencies and capabilities which should be expanded, enhanced, and shared across government and private sector health systems.

These unique medical capabilities, combined with other government (DOD and other Federal health systems) and private sector partners to create high-performing networks of care, would allow VHA to more effectively assimilate its system of care through integrated community-based health care networks of the VCS. Such change would result not only in greater system optimization, but also better serve our veterans.

MOAA is pleased the Commission recognized VA's primary overall role in coordinating health care and helping veterans navigate the system whether care is delivered in VA medical facilities or through community providers. Though the new system would allow veterans the option to choose a primary care provider (PCP) from all credentialed PCPs across the system, and all PCPs would be responsible for co-

ordinating veterans care, MOAA believes VA must retain ultimate responsibility for veterans' health care and managing health information and patient outcomes to ensure quality and continuity of care and services.

Like many VSOs, we support the elimination of the current time and distance criteria for community care access (30 days and 40 miles). Implementation of the Choice Act using the current restrictive and arbitrary eligibility criteria has created problems that require a fresh look at what the standards should be in the new VA health system.

MOAA is also supportive of refocusing health care benefits to allow service-connected, disabled and low income veterans' higher priority. Additionally, VHA must eliminate existing health disparities by making health care equity a strategic priority. The report outlined a number of racial and ethnic health inequities in the system. More must be done to institutionalize cultural and military competency and eliminate system disparities as we move forward in the transformation.

Similarly, MOAA agrees with the Commission's approach to allowing health care providers and professionals such as advanced practice registered nurses to work to their full licensure potential. This is already being done in many states and government health agencies, including the Defense Department, and offers a positive solution for addressing VHA's suboptimal productivity levels. MOAA has strongly advocated for such change as a means to help expand current system capacity and capability.

Further, the report highlighted the need for VA to invest in transforming its antiquated, disconnected IT systems and infrastructure to improve veterans' health and well-being. MOAA agrees such an investment in a comprehensive electronic health care information platform is foundational to VA's ability to establish, operate and sustain a health system equal to or better than what is found in the private sector.

This platform must be interoperable with other systems within the network, enabling scheduling, billing, claims, and payment. It should be easy for veterans to access their own information so they can better manage their health. Years of underfunding VA IT and financial management clinical, administrative, and business systems has prevented VA from evolving and innovating to remain relevant and agile as private sector medicine and patient health needs change over time.

GOVERNANCE, LEADERSHIP, AND WORKFORCE

MOAA agrees with Commission recommendations to:

- Develop and implement a strategy for cultural transformation.
- Reform and modernize VA's leadership and human capital management systems to recruit, train, retain, and sustain high quality health care professionals and executive-level leaders.
- Create a simple-to-administer alternative personnel system.
- Transform the organizational structure of VHA and reengineer business processes.

Cultural transformation across the VA enterprise is imperative and it starts at the top with effective leadership. VA's last major transformation occurred in the mid-1990's. Former Under Secretary of Veterans Health, Dr. Kenneth Kizer told commissioners, "Today's VHA is intensely, unnecessary complex, and lacks a clear strategic direction, and is hampered by overly top-down management at VA's Central Office (VACO), where the staff size more than doubled in a five year period between fiscal years 2009 to 2014 as a result of centralizing a portion of field operations functions to VACO."

Of all government agencies, VHA has one of the lowest scores in terms of the organizational health and has repeatedly appeared on the Government Accountability Office's (GAO) high-risk list. GAO has documented well over 100 outstanding systemic weaknesses covering a wide-range of management and oversight problems in the VA health care system, including insufficient oversight of employees and leadership.

While the VA has a reputation for having a highly dedicated staff focused on serving veterans, VHA is often perceived by employees as being very bureaucratic, driven by politics and crisis, and having a risk-adverse culture, with little connection to leadership. These findings from the Independent Assessment are persistent and prevalent across the system even though VA has undertaken a number of initiatives in recent years to address the culture of the environment.

MOAA agrees with the Commission's recommendation to create an integrated and sustainable culture of transformation where all programs and activities are aligned, and leaders at all levels of the organization are responsible and accountable for improving organizational health and staff engagement.

Such transformation must also include reforming and modernizing VA's leadership and human capital management systems across the enterprise. Currently VHA lacks a comprehensive system for leadership and employee development and urgently requires a workforce management and succession planning strategy for attracting, training, retaining, and sustaining high quality health care personnel and executive-level leaders.

MOAA urges the Committee to support improvements to the Department's leadership and human capital management systems by providing the necessary funding and authorities needed to implement the report recommendations. The VA needs the financial incentives and hiring authorities to attract outside leaders and experts who want to serve in VHA, to include temporary and/or direct hiring of health care management graduates, senior government and private sector health system leaders and experts to stabilize the current workforce and to remain competitive in the health care market.

Additionally, VHA must embrace a systems approach to transforming its organizational structure and reengineer business processes to align with the VHA mission, eliminate unclear, duplicative functions, and clarify roles and responsibilities at VACO on down to field offices and medical facilities. VHA needs a more simplified organizational structure, performance measurements, and processes for business operations—the current operating system is unnecessarily complex, confusing and cumbersome.

The Commission proposes one model for streamlining VHA structure to reflect the structure used in large private-sector hospital systems. MOAA believes this should be a priority to eliminate duplication, consolidate program offices, and create a flatter and more sustainable structure.

Eligibility. MOAA agrees with the Commission proposal to establish an expert body to develop recommendations for VA care eligibility and benefit design.

The criteria for determining health care eligibility has not changed in 20 years even though VA's health system has seen tremendous change during this time. Current criteria are outdated and confusing to veterans and VHA staff and are inconsistently administered across the system.

The report also spotlighted "that nothing in law or regulation assures service-connected, disabled veterans of priority of care." The new system must assure priority to these as well as other vulnerable segments of the veteran population.

MAJOR AREAS OF CONCERN

MOAA has some concern about Commission proposals to:

- Establish a Governing Board of Directors to provide overall VCS governance, set long-term strategy, and direct and oversee the transformation process.
- Provide a streamlined path to eligibility for health care for those with Other-Than-Honorable (OTH) Discharge who have substantial honorable service.

The Commission recommends an 11-member board which would be accountable to the President, having decisionmaking authority to establish long-term strategy and implement and oversee the transformation of the new health system.

The Board of Directors would also provide recommendations to the President for appointment of a Chief of VHA Care System (CVCS) for a five-year term (could be reappointed for a second term). The CVCS would report to the Board and function as a chief executive officer of VHA. The idea is to provide longer-term continuity in VHA operations and prevent disruption in leadership that often comes with political transitions.

As with many of our VSO partners, MOAA supports the concept of a longer-term appointment for the Under Secretary of Health to ensure continuity when changes in leadership occur in the Executive and legislative branches, but would not be supportive of establishing a Board of Directors. MOAA believes Congress' role of oversight is essential in holding VA accountable in caring for veterans, and Congress must continue to be veterans' strongest advocate. Establishing a Board of Directors would usurp Congress' role, add an additional level of bureaucracy, and in our view, likely slow progress and hinder transformation.

Finally, the Commission recommends VA revise its regulations to provide tentative health care eligibility to former servicemembers with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances (e.g., Traumatic Brain Injury or post-traumatic stress that likely contributed to their OTH discharge).

MOAA understands the Commission's concern about VA's strict interpretation of what is truly dishonorable service and agrees the ambiguous and subjective application of regulations resulted in disparities in adjudicating veterans' cases. MOAA has supported establishment of boards to review and upgrade discharges in such cases

where appropriate. VA estimates there are over 700,000 OTH cases, and it would cost upwards of $846 million to implement the Commission's recommendation, but acknowledges the true size of the population and costs are unknown.

VA also acknowledges the need to streamline the Veterans Benefits Administration's characterization of discharge adjudication process when veterans apply for benefits. The current process is not standardized and is taking far too long for decisionmaking, preventing veterans from getting the care they need sooner rather than later. While VHA has established partnerships with community organizations to help link non-eligible veterans to care outside the system, more needs to be done to address these disparities. MOAA recommends Congress direct VA to provide more information on the current scope of the problem, potential costs and the impact on VHA of such changes before implementing the Commission's recommendation.

CONCLUSION

MOAA appreciates the Senate and House Committees on Veterans' Affairs unwavering leadership and focus on improving health care for veterans.

MOAA is confident that collectively we can achieve dramatic transformation in VHA which will serve our Nation, veterans and their families for decades to come. While it will take a significant commitment and investment by government and non-government communities, we believe reform is possible and achievable. Our veterans and their families deserve no less.

MOAA thanks the Committee for considering the important findings and recommendations in the report. Our organization looks forward to working with the Congress, the VA and the Administration to reform and modernize the VHA system of care.

Chairman ISAKSON. Thank you, Ms. Campos.

Mr. Fuentes, welcome back.

STATEMENT OF CARLOS FUENTES, DEPUTY DIRECTOR OF NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. FUENTES. Thank you, Mr. Chairman. On behalf of the men and women of the VFW and our Auxiliary, I would like to thank you for the opportunity to present our views on the Commission on Care's final report.

The VFW thanks the Commission. I would like to echo our friend, René here on their willingness to involve us in the process. The VFW believes that the Commission has made some meaningful suggestions on how to improve the health care VA provides veterans. The VFW urges Congress and VA to consider the recommendations we have supported and alternatives to the ones that we oppose.

We strongly support the Commission's recommendation to improve the VA clinical appeals process. Due to the lack of system-wide processes, veterans have experienced vast differences when appealing clinical decisions, often delaying the care that they have earned and deserve.

The VFW members have firsthand experience with the pitfalls of the fragmented VA clinical appeals process and believe it must be reformed to ensure veterans receive an appropriate response to their grievances. This includes the ability to provide evidence to support their appeals, which many VISNs do not permit.

The VFW also supports amending VA's current health care eligibility recommendations to ensure veterans with other than honorable discharges have access to the lifesaving care they need and deserve.

The VFW also supports the Commission's recommendation to establish high-performing, integrated, community-based networks

which leverage the capabilities of the private sector and the public sector to meet the needs of veterans in each community.

The VFW is glad to see the Commission also agrees that VA must remain the coordinator of care for veterans. It must develop systems and processes to help veterans make informed health care decisions. Doing so is vital to ensuring veterans receive high-quality and coordinated care rather than fragmented care which leads to lower quality and threatens patients' safety.

That is why the VFW opposes the Commission's proposal to give veterans a list of primary care providers and hope that they are able to find one willing to see them. Veterans in need of primary care must be offered the opportunity to discuss their preferences and health care conditions with a nurse navigator, who can help them find a provider who fits their preferences and clinical needs.

The VFW also opposes the Commission's recommendation to establish a governance board of political appointees to determine when and where veterans receive their health care. VA needs strong leadership, not more bureaucracy.

However, we do agree that an exemplary Under Secretary of Health should continue to lead VHA regardless of political changes in Congress and in the White House. But instead of precluding the President from replacing an Under Secretary for Health, Congress and VA must evaluate ways to make the position more attractive to executives with experience running successful health care systems.

That is why we were pleased with Dr. Shulkin accepted the nomination. But he is not the typical person who has occupied that role. Dr. Shulkin is the first non-career VA employee to be confirmed as Under Secretary for Health since Dr. Ken Kaiser, who led the largest and most successful health care transformation in VA's history. Congress and VA must ensure that the position of Under Secretary for Health attracts more candidates like Dr. Kaiser and Dr. Shulkin, not career VA employees who seek to protect the status quo.

The VFW also supports most of the Commission's recommendation regarding capital infrastructure. We agree that waiving budgetary rules and improving VA's enhanced-use authority will enable VA to expand access.

However, the VFW cannot support a BRAC Commission. The VA SCIP process already addresses the issues of unused property. It is Congress who has failed to remove these properties. The reason Congress has failed to act is the same reason it would fail to act under a BRAC-style process: local pressure from the veterans community.

The solution is to develop the better communication plan with the impacted veterans and develop a replacement plan that ensures veterans do not experience a lapse in access to care. Veterans' fear of losing VA care drives Congress's inaction, and no commission or board will fix that.

Mr. Chairman, thank you for the opportunity to testify, and I am happy to answer any questions you may have.

[The prepared statement of Mr. Fuentes follows:]

PREPARED STATEMENT OF CARLOS FUENTES, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: On behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliary, thank you for the opportunity to offer our thoughts on the Commission on Care's final report.

The VFW thanks the Commission on Care for their hard work and extensive deliberations on how to improve the health care and services a grateful Nation provides its veterans. In particular, we thank Chairperson Nancy Schlichting for her work to build consensus among the commissioners and for her willingness to work with the major Veterans Service Organizations (VSOs) in order to gain an understanding of what veterans like and want to see improved in their health care system.

While the VFW does not support every recommendation made by the Commission, we certainly believe the Commission accomplished its mission to propose bold transformation that can improve access to high quality care for our Nation's veterans. The VFW urges Congress and VA to act on the recommendations we support and consider alternatives to the ones we oppose.

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Similar to the *Independent Budget*'s "Framework for Veterans Health Care Reform," the Commission recommends developing high performing, integrated and community based health care networks that leverage the capabilities of private and public health care systems to meet the health care needs of veterans in each community. The VFW is glad to see the Commission also agrees that VA must remain the coordinator of care for veterans and must develop systems and processes to help veterans make informed health care decisions. Doing so is vital to ensuring veterans receive high quality and coordinated care, rather than fragmented care which the Commission agrees results in lower quality and threatens patient safety.

That is why the VFW opposes the Commission's proposal to give veterans a list of primary care providers and then find one willing to see them. The VFW does not believe it is necessary to trade quality care coordination for choice. Veterans in need of a primary care provider must be offered the opportunity to discuss their preferences and clinical needs with a VA health care professional to determine which provider (including private sector, VA and other public health care providers) best fits their preferences and clinical needs. This would ensure veterans make informed choices and receive care tailored them.

The VFW is also concerned that the Commission's recommendation on how veterans would navigate its proposed community delivered service (CDS) within the Veterans Health Administration (VHA) care system ignores the Commission's key findings regarding care coordination. Instead of fully leveraging the nurse navigators "to help veterans coordinate their care in VA and in the community," as the Commission describes as a possible supplement to its CDS recommendation, it calls for private sector primary care providers to coordinate the care veterans receive and leaves veterans to fend for themselves when scheduling appointments with community specialty care providers.

While we agree that a veteran's primary care provider must have visibility of all the care a veteran receives at VA and in the community, we strongly believe VA, not the primary care provider, must serve as veteran's medical home. This includes helping veterans schedule appointments with specialty providers when they receive a referral from their primary care provider, which would ensure veterans receive care that fits their preferences and clinical needs. This also includes consolidating a veteran's medical history into one electronic health care record that is accessible by the veteran's VA and community health care providers.

In an effort to alleviate demand on its primary care providers, VA is moving toward direct scheduling for certain specialty care, such as optometry and audiology. The VFW agrees with VA that certain types of care may not require a primary care consult and believes VA must have the ability to waive primary care referral requirements for such specialties. Such waivers must also apply to veterans who receive care through community care networks, which further exemplifies the need for VA to serve as the medical home for enrolled veterans.

Counter to the Commission's recommendation, the VFW does not believe that the majority of eligible care would shift from VA facilities to the community care networks. VFW surveys and direct feedback from veterans indicate that veterans would

like to receive more of their care from VA health care professionals who know how to care for their service-connected conditions. In the VFW's "Our Care" report from September 2015, we found that 53 percent of veterans prefer to receive their care from VA providers, which is higher than VA's reported reliance rate of 34 percent. VFW surveys of veterans who are eligible for the Choice Program under the 40-mile rule, which affords them the option to receive private sector care without a referral from a VA provider, also indicate that the majority of veterans continue to prefer VA providers despite having unfettered choice.

However, the VFW is very concerned that open networks could lead to veterans receiving care from providers that are available instead of the ones they prefer. The VFW has heard from veterans who use the Choice Program that they would prefer to go to VA, but their local VA facilities do not provide the services they need, or they would have to wait too long for an appointment.

The VFW fears that VA and Congress would interpret such veterans' use of private sector care as their preference for private sector care, when in reality they would have preferred to receive VA care, but private sector care was their only option. Doing so could lead to more resources being directed to community care networks and further depleting resources VA is given to expand access to the care veterans prefer. That is why the VFW believes continuous evaluation and adjustments to community care networks, as recommended by the Commission, must be based on veterans' preference, not simply utilization of networks.

Regardless if care is delivered through community providers or VA medical facilities, VA must remain the guarantor of care to ensure such care is high quality, veteran-centric and accessible. That is why the VFW strongly supports the Commission's recommendation that VA require community care network providers to report quality, service and access metrics. The VFW also believes veterans who receive care through community care networks must be afforded the same patient rights and protections they receive at VA medical facilities.

The VFW also supports a phased implementation of integrated networks with ongoing management and evaluation, national strategy and local flexibility to ensure veterans' needs are met. However, the VFW opposes the Commission's recommendation of establishing a board of directors, as discussed in our views of recommendation number nine, and believe management and implementation of integrated networks must be overseen by a multidisciplinary team of VA subject matter experts with direct and consistent guidance from local VA health care professionals and VSOs, similar to the approach VA used to develop its plan to consolidate community care programs and authorities.

CLINICAL OPERATIONS

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

The VFW supports the recommendation to develop training programs for medical support assistants (MSA) to ensure VA health care providers devote more time to treating veterans rather than administrative tasks.

While training is important, VA must also address the high turnover in MSA and entry level positions at the local level. VA has developed an expedited hiring process for MSAs as part of the *MyVA* transformation. The VFW fully supports this initiative, but believes VA must have statutory authority similar to the VA Canteen Service, which is exempt from title 5 hiring requirements and can directly hire entry level employees to fill high turnover positions.

The VFW does not take a position on the recommendation to grant full practice authority to advance practice registered nurses. The VFW defers to VA in determining the most efficient and effective scope of practice of its providers. However, we will hold VA accountable for providing timely access to high quality health care, regardless if such care is provided by an advance practice registered nurse or a physician.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

VFW members have experienced firsthand the pitfalls of VA's clinical appeals process. The VFW agrees with the Commission that a well implemented clinical appeals process is necessary to improve patient satisfaction, ensure veterans obtain medically necessary care, and mitigate disagreements between veterans and their health care providers. Currently, veterans who disagree with clinical decisions by their health care provider can appeal to the medical center's chief medical officer,

who is reluctant to overturn a decision made by VA health care providers. A veteran is then able to appeal to the Veterans Integrated Service Network (VISN) director, who rarely overturns a decision made by a medical center chief medical officer. The VISN level decision is final, unless a veteran appeals to the Board of Veterans Appeals, which is not a viable option for veterans who require time sensitive medical treatments.

Due to the lack of a system wide clinical appeals process with national oversight, veterans have experienced vast differences when appealing clinical decisions between multiple VISNs. That is why the VFW strongly agrees with the commission's recommendation to convene an interdisciplinary panel to revise VA's clinical appeals process. Such a panel must ensure veterans have the ability to provide justification or evidence to support their appeals, which many VISNs do not permit. Veterans must also have the ability to appeal clinical decisions above the VISN level.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

The VFW agrees that improving employee experience is a vital aspect of reforming the VA health care system. The majority of VA employees take pride in their jobs and continuously identify ways to improve efficiency and productivity. However, such employees have not been given the tools or the processes to identify problems and make changes. That is why the VFW supports efforts to identify and disseminate best practices and recognize innovative employees who improve the care veterans receive.

HEALTH EQUITY

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The VFW supports this recommendation and agrees that health disparities based on social and economic differences have no place in the VA health care system. The VFW has heard directly from women veterans that VA employees have confused them for caregivers and spouses, or have challenged their veteran status because of their gender. Veterans of all races, backgrounds, and genders have sacrificed in defense of this Nation and must be treated with the respect and dignity they have earned and deserve.

The VFW strongly supports building cultural and military competence among all community care network providers and employees. It is important that veterans receive care from providers who understand their health care needs and are familiar with the health conditions associated with their military service. This includes providers in VA medical facilities and private sector providers who participate in community care networks. By providing cultural competence training, VA would improve health care outcomes and ensure veterans receive care that is tailored to their unique needs.

FACILITY AND CAPITAL ASSETS

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital asset needs.

The VFW agrees with most of the recommendations provided regarding capital infrastructure.

We agree that waiving congressional rules requiring budgetary offsets for a period of time and expanding the enhanced-use lease authority will allow VA to enter into needed leases, without accounting for the cost of the entire lease in the first year. However, suspending this offset requirement for a few years will leave VA in the same position it finds itself in today if Congress does not find a long term solution to VA's leasing authority. VA also needs broader authority to enter into enhanced-use leases agreements. Public Law 112–154 reduced VA's authority to allow for only adaptive housing. Returning it to its prior authority will allow VA to lease more of its unused or underutilized property, while still contributing to the mission of VA.

The VFW also agrees that reevaluating the total cost of minor construction projects is needed. Currently, VA will submit multiple minor construction projects that appear to be related for a single facility. This is evidence that either the $10 million cap on minor construction projects needs to be increased or VA needs the authority to bundle multiple minor contracts for the ease of planning and appropriating several minor projects at one time without violating the $10 million cap. Regardless of whether the cap amounts are adjusted, underfunding will continue to

place much needed construction projects in competition with each other. Congress must fund VA construction accounts to a level where projects to expand access are not in competition for resources for new facilities or eliminating safety risks in facilities VA must maintain.

The Commission recommends that a board analyze and make recommendations regarding VA's infrastructure needs and the CDS networks. The VFW believes that most of the functions of this proposed commission are already being carried out by either the Strategic Capital Infrastructure Plan (SCIP) or the Federal Real Property Council (FRPC). The VFW believes that the current roles of SCIP and the FRPC would need to be expanded to include the evaluation of community care on the overall capital planning process. SCIP analysis should be expanded to include the feasibility for public-private partnerships and sharing agreements with other public and community provides. This would fulfil the idea of better leveraging community resources to expand VA's capacity and capabilities.

The VFW does not agree with the Commission on Care's BRAC realignment commission. The SCIP process already addresses the issue of under/unutilized property, and it is Congress that has failed to act to remove these properties. The reason they have failed to act is the same reason they would fail to act under a BRAC-style recommendation—local pressure from the veterans' community would cause them to vote "no." The solution is to develop better communication with the local veterans' community and present the replacement plan that will occur when their VA hospital is closed. Veterans' fear of losing VA care drives Congress' inaction, and no commission or board will fix that without improved communications.

INFORMATION TECHNOLOGY

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

The VFW agrees that VHA must have a chief information officer (CIO) to focus on the strategic health care information technology (IT) needs of the VA health care system. VA Assistant Secretary for Information and Technology LaVerne Council has discussed the need for a senior level employee to oversee VHA IT projects. The VFW agrees that the VHA CIO must work closely with VHA clinical and operations staff to ensure IT systems meet the needs of their users, but continue to report to the Assistant Secretary for IT to ensure interoperability with Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA) systems.

The VFW agrees that the lack of advance appropriations for VA's IT accounts has hindered VA's ability to properly fund IT projects, specifically ones associated with VHA which is funded under advance appropriations. That is why the VFW has continuously called for Congress to provide advance appropriations for all of VA's budget accounts. We thank this Committee and the House Committee on Veterans' Affairs for enacting legislation to authorize advance appropriations for VA's medical services and mandatory accounts to ensure veterans can continue to receive care and benefits during a government shutdown, but it is vital that VA's remaining accounts, including IT, community care, research, NCA, VBA, Inspector General and VA's four construction accounts receive advance appropriations to ensure VA can fulfill its mission to veterans.

The VFW does not have a position on whether VA should purchase a commercial off-the-shelf (COTS) electronic health care system. However, the VFW agrees that VA should turn to COTS products when such products are financially beneficial and lead to improved services for veterans, but VA must have the authority to develop homegrown products when necessary.

SUPPLY CHAIN

Recommendation #8: Transform the management of supply chain in VHA.

The VFW supports this recommendation to reorganize and standardize VA's supply chain to leverage economies of scale. This recommendation is similar to one of Secretary Robert McDonald's *MyVA* priority goals aimed at building an enterprise-wide integrated medical-surgical supply chain that leverages VA's scale to drive an increase in responsiveness and a reduction in operating costs, which the VFW fully supports.

This transformation must rely on local level feedback and buy-in to succeed. While each medical facility cannot continue to dictate where their medical supplies are purchased, they must be given the opportunity to request specific supplies or products if needed in order to provide the best quality care. This is similar to non-formulary requests for prescriptions that are not on the VA's formulary. The transformation must also consider whether specific products are preferred or clinically

needed by veterans, such as prosthetics equipment that may cost more, but lead to a better quality of life for veterans.

BOARD OF DIRECTORS

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The VFW opposes this recommendation. The VFW believes VA needs leadership, not management by committee. Similar to the Commission on Care, the governance board would include political appointees, the majority of whom would be civilian health care executives and veterans who do not use the VA health care system. How, when and where veterans receive their health care cannot be determined by appointees who do not have a vested interest in improving the care and services veterans receive.

Additionally, the VFW believes that a governance board would result in more bureaucracy. VHA's budget requests would still need to be approved by the Office of Management and Budget and appropriated by Congress. This recommendation also fails to resolve the misalignment between capacity to provide care and the demand on its programs that is highlighted in the Commission's report. The VFW recommends reforming the congressional appropriations process to ensure VA receives the resources it needs to meet veterans' health care needs, instead of creating more bureaucracy and further limiting how much care VA is able to provide.

A number of reform ideas have been discussed to address this issue. One proposal is to make VA's health care accounts mandatory spending. Doing so would exempt VA health care accounts from discretionary budget caps which have limited VA's ability to expand access and implement needed reforms. Another proposal is to provide VA a true two-year budget by authorizing VA to transfer advance appropriations to its current year budget to cover budget shortfalls. However, such ideas have not been given proper consideration by Congress. The VFW believes it is time to consider innovative reforms to the VA health care appropriations process.

This Committee, the House Committee on Veterans' Affairs, the Secretary of Veterans Affairs and the President must continue to provide oversight and management of the VA health care system with or without a governance board. Thus, a governance board would mean that VHA leadership would have additional management and reporting requirements which would only serve to further stymie the needed transformation process.

Instead of creating more bureaucracy, Congress must build on Secretary of Veterans Affairs Secretary Robert A. McDonald's *MyVA* Advisory Committee, which has helped Secretary McDonald generate and improve the innovative programs VA is implementing under the *MyVA* Transformation Initiative. While VA has 24 other advisory committees, the *MyVA* Advisory Committee is unique because it serves a purpose similar to that of the proposed governance board. It is composed of leaders in health care, business, and the veterans' community, who review and comment on VA's operational, business, and organizational plans. The VFW urges Congress to make the *MyVA* Advisory Committee a permanent statutory committee to ensure future secretaries can benefit from the expertise of a board without impeding the Secretary of Veterans Affairs' authority to properly manage VA.

The VFW agrees that VHA needs high quality and sustained leadership. We agree that an exemplary Under Secretary for Health should be allowed to continue to lead VHA despite political changes in Congress and the White House, but we do not believe the President should be precluded from replacing the Under Secretary. To ensure consistent leadership, Congress must evaluate ways to make the position of Under Secretary for Health more attractive to health care executives with extensive experience running successful health care systems. The VFW was pleased when Dr. David J. Shulkin accepted the nomination to replace Dr. Robert A. Petzel. That is why we intend to ask the next president to give Dr. Shulkin the opportunity to continue serving veterans, should he so desire. However, Dr. Shulkin is the exception. He is the first non-career VA employee to be appointed as Under Secretary for Health since Dr. Kenneth W. Kizer, who led the largest and most successful transformation of the VA health care system's history. Congress needs to make certain the position of Under Secretary for Health attracts more candidates like Dr. Kizer and Dr. Shulkin, not career VA employees who seek to continue the status quo.

LEADERSHIP

Recommendation #10: Require leadership at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

The VFW supports this recommendation. As discussed above, employee experience is vital to restoring veterans' trust and confidence in their health care system. Secretary McDonald is in the process of addressing this recommendation by transforming VA from a rules based culture to a principles based culture that empowers VA employees to do what is right, instead of fearing reprisal for not following every rule. Several veterans have reported improvements in the culture at VA medical facilities, but more work is still needed.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

The VFW supports this recommendation. We agree with the importance of succession planning and the need for robust structured programs to recruit, retain, develop and promote responsible and high performing leaders. Specifically, the VFW strongly supports the recommendation to adopt and implement a comprehensive system for leadership development and management. VA employees must be prepared and willing to fill vacancies in leadership positions to ensure VA is not required to rely on temporary leadership to run its medical facilities.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decisionmaking at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

The VFW generally supports this recommendation. We agree that the VA central office and VISN office staff have grown too rapidly and that fragmented authorities, lack of role clarity and overlapping responsibilities impacts VA's ability to deliver high quality and efficient health care. Specifically, the VFW agrees that VHA must consolidate program offices to create a flat organizational structure to streamline VHA's current cumbersome and duplicative organizational structure.

The VFW understands the Commission's recommendation that Congress should reduce the number of VA appropriations accounts. While it is essential for Congress to use its power of the purse to influence VA programs, Congress must do so effectively and not impede VA from fulfilling its mission. For example, the Military Construction and VA Appropriations Act recently passed by the House and being considered by the Senate limits VA's VistaA Evolution project to $168 million, but requires VA to meet certain requirements before the funds become available. While the VFW understands the need for such reporting requirements, we believe VA must have the flexibility to use such funds immediately. Withholding such funds only serves to further delay VA's plans to modernize its electronic health care record.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

The VFW supports this recommendation. It is important to develop a performance management system that effectively measures outcomes and holds VA leaders accountable for improvements.

However, the VFW does not believe such performance measures need to be identical to those used in the private sector. VA performance measures must adopt best practices from the private sector, but they must also acknowledge VA's unique mission and the fundamental differences between private and public health care systems.

DIVERSITY AND CULTURAL COMPETENCE

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veterans' health outcomes.

The VFW strongly supports this recommendation. As discussed above, cultural and military competence training of providers would ensure veterans receive care that is tailored to their unique needs.

It is particularly important to build cultural competency among community care providers who do not have experience caring for veterans or may not be aware of best practices when caring for veterans with service-connected wounds and illnesses. A study by the RAND Corporation found that only 13 percent of private sector mental health care providers are ready and able to provide culturally competent and evidence based mental health care to veterans. The VFW believes VA must leverage the capacity of the private sector to provide mental health care to veterans, but it must also ensure veterans who use community care receive high quality and veteran-centric care by providing military competency training and sharing best practices with community care providers and ensuring such practices are adopted.

WORKFORCE

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

The VFW supports this recommendation. VA must be able to recruit, train, retain and discipline a high performing workforce. The VFW agrees that civil service laws and regulations that govern how government employees are hired, how much they are paid, and how they are disciplined were not designed to support a high performing health care system. VA must have a personnel system that eliminates barriers to hiring and retaining high quality employees.

We agree with the Commission that Congress must afford VA employees appropriate due process to appeal disciplinary actions. The VFW has also supported a number of accountability measures considered by this Committee, including S. 2921, the Veterans First Act, which would expand the Secretary's ability to remove or demote employees for poor performance or misconduct. Overall, the process that is taken to remove or demote VA employees who commit malfeasances must ensure such employees are no longer allowed to collect a paycheck or harm veterans, but protect good employees and whistleblowers from being wrongfully terminated or retaliated against.

The VFW also agrees with the need to improve VA's student loans reimbursement programs. However, VA is already authorized to reimburse health care professionals up to $120,000 over five years of student debt, which is similar to the National Health Service Corps' loan repayment plan program. While the VFW would support increasing the amount VA health care professionals may receive, it would not make VA more competitive when hiring or retaining high quality employees, because local facilities are not given enough funds to fully utilize this program. For example, the VFW heard from a VA nurse that her medical center is given $80,000 per year for the education debt reduction program. These means the facility could reimburse three providers the maximum allowed amount of $25,000 or divide the $80,000 amongst its dozens of providers and render the retention incentive ineffective. To properly utilize this incentive, Congress and VA must properly fund this program.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

The VFW supports this recommendation. We often hear from VA medical facilities that they struggle to hire needed staff because of the cumbersome human resources (HR) process. Specifically, the outdated and ineffective rules and regulations that govern when and how VA can recruit possible candidates puts VA at a disadvantage when competing with the private sector to recruit high quality health care professionals.

Secretary McDonald has made some progress in addressing this issue by deploying rapid process improvement workgroups which identify and resolve regulatory barriers that adversely impact the hiring process and improve an applicant's experience when applying for VA jobs. However, the VFW agrees with the Commission that VA H.R. systems and processes must be prioritized and improved. It is unacceptable for VA H.R. professionals to be required to operate 30 disparate IT systems. When H.R. is unable to do its job efficiently, VA medical facilities are not able to fill vacancies quickly, which leads to access problems that negatively impact veterans. It is also deplorable that VA's cumbersome H.R. rules and processes impede its ability to remove or demote wrongdoers.

ELIGIBILITY

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an Other-Than-Honorable discharge who have substantial honorable service.

The VFW fully supports the recommendation to amend VA's current health care eligibility regulation and provide VA health care and benefits to veterans with other than honorable (OTH) discharges, if their overall service is deemed honorable. Under current law, a veteran who meets other eligibility criteria and has a discharge that is other than dishonorable is eligible for VA health care. However, VA's process for determining which veterans are considered to have an other than dishonorable discharge is flawed, and generally results in veterans who have anything less than an honorable discharge being denied benefits.

This is a particular concern for veterans who served honorably in combat, but were administratively discharged upon returning home due to relatively small infractions, like missing formations or being charged with alcohol-related incidences. VA regulations do not consider discharges for minor offenses as dishonorable, if such veteran's service was otherwise honest, faithful and meritorious.

Unfortunately, VA's process for determining eligibility is not consistent and often fails to properly account for a veteran's entire service. In their recent report, "*Underserved: How the VA Wrongfully Excludes Veterans with Bad Paper*," Swords to Plowshares, the National Veterans Legal Service Program and the Veterans Legal Clinic at the Legal Service Center of Harvard Law School found that instead of granting OTH veterans the health care and benefits they have earned, VA has lumped them in with bad conduct and dishonorable discharges, which are reserved for servicemembers convicted of wrongdoing at a court martial—thus resulting in 90 percent of OTH veterans being denied the benefits and services they have earned.

Without access to VA health care, those suffering from service-related mental health injuries are left on their own to deal with their mental health symptoms, making recovery nearly impossible. The VFW supports amending VA's regulation to ensure veterans with OTH discharges who committed minor infractions but otherwise completed honorable service, receive full eligibility for health care and benefits. Additionally, VA must also ensure veterans who present to a VA medical facility with a medical condition that requires urgent or emergent medical attention, such as a veterans who shows signs of suicidal ideation, are not required to undergo a cumbersome character of discharge review before receiving lifesaving care. Veterans who are later determined to be ineligible for VA health care must be transitioned to other health care options, but veterans cannot be denied lifesaving care simply because VA rules require a flawed and time consuming character of discharge review process.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefits design.

In every past evaluation and change to the eligibility criteria for health care, access to care was increased to unserved populations of veterans, or eligibility was realigned to conform with an updated delivery model. With those two facts in mind, and understanding that the development of an integrated health care system will deliver care under a different model, the VFW supports the idea of studying access barriers based on current eligibility criteria while ensuring service-connected, homebound and catastrophically disabled veterans do not incur barriers or delays in services or care. Additionally, the VFW would oppose any proposal to increase the health care cost shares for veterans.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you or the Committee members may have.

Chairman ISAKSON. Thank you, Mr. Fuentes. We appreciate it.

Last, but certainly not least, Vietnam Veterans of America, Mr. Weidman.

STATEMENT OF RICHARD WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

Mr. WEIDMAN. Thank you very much, Mr. Chairman, for allowing us to be here today. I will deviate because much of the material I might have covered in a summary has already been covered by

my distinguished colleagues to my right. So, I will concentrate just on a couple of things that we consider to be really important.

The first has to do with Recommendation Number 17 and the Administration's non-concurrence with it. We understand their position, but it is really up to the Congress, at the first opportunity, to get emergency appropriation so we can move ahead to those people who have an OTH, or other-than-honorable discharge, most of them as a result of administrative procedures—never had access to counsel, never had a full record of court-martial, but rather were just pushed out as they were seen no longer to be useful.

Vietnam veterans, we have a long history with that because that happened to many people at the end of the Vietnam War and even as it was going on. For kids—and I say "kids"—who enlisted at 18 and got sent to Vietnam at 18½ or 19 and came home—they were on a 3-year enlistment, and the military service did not want them when they came home. They did not want to be there and they copped an attitude because of the experience in the boonies in Vietnam, so they got in trouble: sign here, son, and you can go home. So, they did, which has ruined many of their lives.

Unfortunately, that pattern is still going on today from Fort Carson to bases in Texas to right here at Fort Belvoir, where people are being unfairly pushed out and labeled as "other than honorable" simply because there is somebody in either NCO Corps or in the Officer Corps who has taken an active dislike to them.

VVA has been very concerned about this ever since our inception. Many of us have been active in discharge upgrade services before VVA was founded, and we continue to be concerned with this thing. It has become more difficult over the years to get discharges upgraded, even when an objective person looking at it agrees absolutely that that discharge should be upgraded and they should have their benefits restored.

We have filed several class action suits against DOD, and we certainly were assisted by former Senator and Secretary of Defense Chuck Hagel's memo. That has opened the door. With the lawsuit pressing, instead of a success rate of 4 percent, it has gone up to 45 percent before the Army Board.

In terms of separation, the Secretary of the Navy, Secretary Mabus, has issued a directive that has helped dramatically in having Marines who should have their eligibility restored, and as well as Navy people. What we need is for Secretary Fanning and the Secretary of the Air Force to do the same thing.

What is needed is to make sure that we have the money that is added into the budget as these things take hold. This is a group of people who are most at risk for suicide, particularly the younger ones; the older ones have already done so. It is something that the passage of the final DPAA, to make sure that the Fairness to Veterans Act is included in that, would be a huge step. I would stress that the leadership of this Committee, which we—on so many issues we greatly appreciate, Mr. Chairman, you and your colleagues and the Ranking Member's efforts, needs to be turned to getting an emergency appropriation so VA can be ready to handle it.

The last, which is really merit—the thing I would just touch on, instead of going into detail because of limits of time, is the whole

procurement recommendation. Given the 8 to 0 Supreme Court decision handed out at the end of June in *Kingdomware* v. *VA*, it is—I cannot—everybody in this room knows how rare it is to have an 8–0 Supreme Court decision.

They were absolutely clear about what must be done. The question is whether VA does it. Instead of concentrating on rearranging the structure, we need to look at what they are doing and how they are doing it, including the excessive reliance on the delegated authority for the Federal Supply Schedule.

I will close there, Mr. Chairman. Once again, I deeply appreciate, on behalf of all of us at VVA, the sound leadership from this Committee, of both you and Senator Blumenthal. Thank you.

[The prepared statement of Mr. Weidman follows:]

PREPARED STATEMENT OF RICK WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

GOOD AFTERNOON, CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL, AND OTHER SENATORS OF THIS DISTINGUISHED COMMITTEE. On behalf of VVA National President, as well as the members of Vietnam Veterans of America (VVA) and our families, I thank you for affording VVA the opportunity to testify today regarding the recommendations of the Commission on Care, and what the Department of Veterans Affairs has been doing to improve access for eligible veterans to avail themselves of the generally excellent health care that the VA provides.

Let us begin with some facts:

- The Veterans Health Administration, the VHA, is an integrated managed care network, the largest in the Nation. Long before the "scandal" that led Congress to enact the Choice Act, a provision of which established the Commission on Care, the VHA availed veterans of care by community providers, when necessary or appropriate.
- VA medical centers provide for the most part "one-stop shopping" for primary and specialty care, something that is not afforded at most private-sector hospitals and healthcare facilities.
- The commission, you should note, acknowledges that the quality of care in VHA facilities is good to excellent and is in many areas superior to care from private hospitals or medical centers.

Certainly, however, VVA does not quibble with the mission of the commission: to enhance and improve a healthcare delivery system that will "provide eligible veterans prompt access to quality health care."

To the commission's credit, commissioners rejected the idea of privatizing VA healthcare. They nixed the idea of unfettered "choice," of giving eligible veterans the option of going to any private-sector healthcare providers of their choosing, with the VA footing the bills and being transformed, in effect, into a source of income. They would scrap the time and distance criteria for access to community care (30 days and 40 miles), one of the provisions of VACAA, the Veterans Access, Choice, and Accountability Act.

The commissioners tripped up, however, in conceptualizing an entirely new governance structure, and in sublimating VA, healthcare facilities into an expansive community context dubbed the "VHA Care System." Yes, VA clinicians should refer veterans to outside providers when and where appropriate to improve access as well as to provide care that VA clinicians are unable to deliver. However, no, the VA should not cede, as the commission recommends, the role of primary care clinician to non-VA personnel; this would be a critical misstep, undermining the integrity and managed care the VA offers.

"Foundational among the changes" the commission seeks is "forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system." This concept is mistaken. The governing board that the commission envisions as necessary to achieving a "bold transformation" ignores reality. Their "Board of Directors" would be a paper tiger that, without the power of the purse, can only recommend, not appoint or institute, thus making it a board of advisors. And veteran service organizations and veteran leaders in effect already function as an informal board of advisors on both the national and local levels—consider the *Independent Budget*, for instance. The VA would have far fewer perceptional problems if it acknowledged this and worked in concert with VSOs as a matter of course, seeking

and embracing our input at the beginning of a process, not pro forma near its conclusion.

Not all of the commission's recommendations veer away from logic and viability. There is, certainly, a need for strong, sustainable leadership at the top, locally as well as nationally. In fact, it has been the failure of leadership that has gotten the VA into hot water with you in Congress and in the media, with individual veterans and the public, in the first place.

In addition, as you are aware, the commission's recommendations for transformative change in healthcare delivery are not intended as an immediate palliative; rather, the charge of the commission was to envision what the VA healthcare delivery system should look like in 20 years, and to provide a blueprint on how to get there.

Before I offer VVA's analysis of each of the commission's 18 recommendations, I do want to publicly praise the efforts of the commissioners for the sense of purpose they brought to the task. In addition, I want to particularly applaud the strong and steady leadership of commission chair Nancy Schlichting, and the commitment and expertise of the staff who I know labored long and hard to produce the commission's final report.

REDESIGNING THE VETERANS' HEALTH CARE DELIVERY SYSTEM

The VHA Care System/Recommendation #1

The fundamental problem with the commission's conceptualization for the future of VA healthcare delivery commences in the language of this initial recommendation, which calls for "... community-based health care networks" that will "integrate health care within communities." This would essentially fold VA-provided health care into a wider community-oriented network of providers.

The Veterans Health Administration already is an integrated managed care network that does in fact avail veterans of care by community providers when called for. Individual failures in medical practice as well as access to care, when they occur, have been highlighted in the media which, for the most part, do precious little investigative reporting on systemic problems in VA health care delivery. (Nor do they cover many of the positives in VA health care, e.g., making every veteran patient afflicted with hepatitis C eligible to receive the medication that can now cure this potentially fatal disease.) Now, the illumination of issues revolving around management and medical practice fulfills the oversight and investigations responsibility of Congress. Many times, however, the glare of the spotlight focuses on specific problems, enlarging them, undermining the basic integrity of the VA healthcare system and the clinicians, administrative and housekeeping personnel who are its essence. Problems in other healthcare facilities throughout the Nation are not subjected to partisan political punditry, are far less transparent, and do not trigger the same public scrutiny and condemnation as VA health care does.

Perhaps more basic to the relationship between clinician and patient is the assumption that most veterans want to choose their primary and specialty healthcare providers. This precept is fundamentally flawed. If a veteran needs to see a specialist, s/he often has little ability to divine on their own who to go to and must rely on the recommendation of their primary care provider. In the brave new world envisioned by the commission, the veteran can "choose" to see the "credentialed" specialist of his/her choice. Does anybody really think that this will enable a veteran to get same-day service from a busy clinician? Alternatively, provide better care than s/he can receive at a VA medical center or community-based outpatient clinic? On the other hand, save the system money?

In addition, consider the potential for this: if a patient who is covered by private health insurance chooses to be treated by a physician not in the network assembled by her health insurer, she has to pay that doctor out of pocket and fill out a claim form to receive some reimbursement from her insurer. Yet what if that veteran wants to go to a clinician whom the VA has not credentialed? Will he have to shell out his own money, even if he has a disability rated at, say, 70 percent? Will that veteran complain to his Member of Congress, who will then demand from the local VHA Care System why Dr. X has not been "credentialed?" It is not difficult to foresee a bureaucratic headache of major proportions.

Clinical Operations/Recommendation #2

This recommendation negates the acknowledged quality of VA health care. To "enhance clinical operations through more effective use of providers and other health professionals" in effect charges the VA with clinical mismanagement. The core of the problem, which the commission acknowledges, "starts with inadequate numbers of providers." This, however, is a problem not limited to VA health care. There is

something like a 90,000-clinician shortage across the country, a situation that is particularly acute in rural and remote areas as well as inner cities.

The report nitpicks, e.g., "[f]or example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff." Just who do the commissioners foresee writing prescriptions? Alternatively, ordering consultations? While it is true that if you have seen one VA medical center, you have seen one VA medical center, but . . . doctors escorting patients? Alternatively, cleaning exam rooms? (Attempts to locate these allegations through the report's footnotes proved well nigh impossible, e.g., there is no page 95 in the cited document.)

The commission does, however, offer some sensible, and well-considered concepts, e.g., that VHA adopt policies to allow health professionals "to make full use of their skills;" and that "VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants."

Recommendation #3

Citing uncertainties among VA patients and clinicians alike as to just what VHA's policy for resolving clinical disputes is—there appears to be not one but 18 different policies, one in each Veterans Integrated Service Network, or VISN—it is hard to disagree with the commission that VHA ought to "convene an interdisciplinary panel to assist in developing a revised clinical-appeals process." Achieving this, however, requires neither a whole new system of governance nor a revamped "care system."

Recommendation #4

Here is another sensible and potentially viable recommendation: consolidating idea and innovation portals, and best practices and continuous improvement efforts, in the currently underutilized Veterans Engineering Resource Center. The commission imagines the VERC as having considerable input in properly aligning "system wide activities [that] require substantial change"—human resource management, contracting, purchasing, information technology.

Recommendation #5

Ever since President Harry Truman issued the Executive Order in 1948 that integrated the military services, the Armed Forces have been, for the most part, a meritocracy that has gradually decreased if not fully eliminated racial, ethnic, and religious disparities in assignments and promotions. As a result, veterans today are perhaps the single most diverse assemblage of Americans in the Nation.

There is certain hollowness to this recommendation in that it assumes, with little empirical evidence, that significant healthcare disparities based on race and ethnicity exist in the VA healthcare system. No one will disagree that such disparities are unacceptable and must be eliminated where it might exist. The commissioners' assumptions appear to be based, for the most part, on a 2007 document, *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review.* This work, prepared by investigators with the Portland VA Medical Center for the VHA's "Health Services Research & Development Service," is useful, and mirrors other studies that have similar results showing disparities. This recommendation warrants universal endorsement, and points up the need for VHA to regularly monitor clinician behavior to ensure that such systematic bias is eliminated.

The VHA must make health care equity "a strategic priority," and should "increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures." A new system of governance need not be put in place to achieve this.

However, there is need to eliminate the foolish bifurcation of the chains of command between operations and policy. This has led to too many people at the VA at the VAMC, VISN, and national level who do not deliver care directly. Those who do not engage directly in patient care need to be re-educated, and out to work directly providing medical care to veterans.

Facility and Capital Assets/Recommendation #6

The commission rightfully cites the need for "transformative changes to the VHA's capital structure." It notes that in many areas VA healthcare facilities are housed in aging edifices with outdated or outmoded physical plants. "VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. . . . It is critical that an objective process be estab-

lished to streamline and modernize VHA facilities . . . to ensure the ideal balance of facilities" within each of the localized networks conceptualized by the commission.

The commission envisions its new governing board as the overseer that will make critical decisions "in alignment with system needs." Moreover, here the paper tiger effect of the "Board of Directors" comes into sharp focus. Because all of this is dependent on funding, and it is the President who submits a budget based on the recommendations of the Secretary of Veterans Affairs, and it is you in Congress who add funding or cut dollars from the department's capital budget. It is the local VA medical centers that note their construction needs. Placing a new governing board between local entities and the overall "VHA Care System" will likely have the effect of adding yet another layer of bureaucracy, with Congress remaining as arbiter of how much funding goes into what capital projects. (Think back, if you will, to the VA's CARES program, which attempted to address this issue. To achieve its goals, $1 billion was supposed to be requested and allocated each year over an initial period of five years. Alas, this was not to be, as fiscal restraints imposed by both the Executive branch as well as the Congress, even as we spent hundreds upon hundreds of billions on the wars in SE Asia, scuttled CARES.)

The commission also offers that the "facility and capital asset realignment process" be modeled after the wildly unpopular but perhaps necessary DOD Base Realignment and Closure Commission (BRAC) process "as soon as practicable." With Congress not particularly enthusiastic about the BRAC process for eliminating outmoded or unneeded DOD facilities in CONUS and perhaps across the globe, it seems to be unlikely that legislators will embrace this concept to shutter VA facilities.

Information Technology/Recommendation #7

Here is another recommendation the basis of which cannot be challenged: ". . . VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health." VA senior management have been grappling with IT issues for years, nudged by Congress to devise a system that allows for a "seamless transition" of medical records and information between DOD and VA, and among the trio of administrations within the VA. Achieving this interoperability, as with many other initiatives, demands mutual commitment and adequate funding, and here again this boils down to a matter of funding. Can anyone, including the legislators from both parties in this room today; forecast a scenario in which Congress abrogates its constitutional authority by ceding the power of the purse to a "board of directors?"

Supply Chain/Recommendation #8

The commission savages the ability of VHA to "modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management." The problems in this realm, the commission has concluded, are "systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization." Because of the inadequacy of VA IT systems, the commission charges, "VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide."

The commission's solution to this morass? Establish the position of VHA chief supply chain officer, to be compensated "relative to market factors," the first step in achieving "a vertically integrated business unit extending from the front line to central office." Again, if this recommendation is embraced by Congress and VA/VHA leadership, there is no reason why it cannot be implemented under VHA's current configuration. However, VVA is extremely skeptical of the current occupants of key positions in the VA doing anything to really "fix" problems with procurement. Their idea is to push more and more procurement onto the delegated (by the General Services Administration (GSA) authority VA Federal supply schedules, claiming that this saves money. However, there is absolutely no empirical evidence for this claim. The fact that VA continues push "strategic sourcing" as an answer to most of their problems is akin to putting lipstick on the ugliest pig in the pig pen and proclaiming this "marvelous" pig is answer to all of VA's procurement woes. In fact, the pig is still a pig, and procurement decisions at VA are still messed up.

GOVERNANCE, LEADERSHIP, AND WORKFORCE

Board of Directors/Recommendation #9

Here is the crux of the commission's report. It is based on nuggets of reality, e.g., the "short tenure of senior political appointees [and] each administration's expectations for short-term results." The solution proffered by the commission: "Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process."

It is not that the VA currently is so consumed by short-term considerations that it cannot look past the next election. Every few years, the VA puts out another five-year strategic plan, although these plans are little more than a waste of paper as well as hundreds of staff hours engaged in meetings and thinking through and writing up real issues and perceived goals.

The commission cites a 2015 Booz Allen Hamilton report that indicted weak governance as one of the "indirect causes" of the Phoenix VAMC wait-time "scandal." The "gap in leadership continuity and strategic oversight from one executive leadership team to another" contributed significantly to wait-time problems. The recommendation of the commission: the creation of an 11-member board of directors accountable to the President, "with decisionmaking authority to . . . set long-term strategy." Among its responsibilities, and its powers, the board would "recommend a [C]hief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment . . . [and] be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions." The recommendation goes on to note: "If necessary, the CVCS can be removed by mutual agreement of the President and the governing board."

Yet it is the role of the President to nominate, and the authority of the Senate to approve, the appointment of the Under Secretary for Health, the current iteration of the Commission on Care's "chief of VHA Care System." Would you seriously consider abrogating your responsibilities and hand over this authority to a board of directors?

Nowhere does the commission come to grips with the costs of operating such a board. Will the directors be full-time, quasi-governmental employees? On the other hand, would they have other jobs and meet on a monthly, bi-monthly, or even quarterly basis? What staff, with what capabilities, will be required to do the work of the board? What might be the costs of operating the board? Just what authority, and how much power, would the board have in hiring and firing, in disciplining workers, in setting policies and allocating funds?

In essence, Congress, and specifically the Veterans' Affairs Committees in the House and Senate, is the de facto directors of the Department of Veterans Affairs. Creating a board of directors, even one with a limited power of the purse, is not something that the Congress or the veterans organizations or military organizations are likely to embrace. VVA, for one, rejects this idea.

Leadership/Recommendation #10

Here, the commission sees VHA healthcare leaders being "aligned at all levels of the organization in support of the cultural transformation strategy and [held] accountable for this change." It asserts that "VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems." (There is no footnote citation for the source of this allegation. Nor is there an explanation of just what "cultural health" is supposed to be.) Next to the creation of a board of directors, the need for strong, sustained leadership is integral not only to the rest of the commission's 20-year plan, but is a necessity in the current construct of the VHA as well.

Recommendation #11

No argument with the premise here, that "VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders." The commission asserts that "VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion."

Among its recommendations is that Congress must authorize "new and expanded authority for temporary rotations and direct hiring of health care management

training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts."

Another is the establishment of "two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs."

What the commission advocates here, and what was a key discussion point during its public meetings, is the need to attract, and to train, the best and the brightest, who would serve for a set term or the long term, and who would be recompensed according to the market in a particular catchment area. To achieve this, Congress must empower the VHA to offer competitive salaries and benefits to attract the most qualified candidates, both from within and from out of the VHA hierarchy.

Again, Congress needs to rethink compensation for medical professionals so that the VA can be competitive in hiring in specific regions of the country. Yet this can be done without introducing a whole new governance structure to VA health care, and it might actually have a salutary effect on attracting, and retaining, the clinicians needed to enable the VA to handle a growing, aging, and medically complex cohort of veterans.

Recommendation #12

Here, the commission targets the confusing model of organization that afflicts the smooth functioning of the VHA. "VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization." The commission charges that the "responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined."

This situation, to the extent that it is an impediment to the effective functioning of the VHA on a national level as well as the operation of individual VA medical facilities, can be corrected by competent, creative, inspired leadership. It does not require the institution of a whole new system of governance, although the operations/policy split must be eliminated in order to be able to hold those in leadership positions accountable. It needs to attract, and retain, more leaders in the mold of Dr. David Shulkin, the current Under Secretary for Health; in fact, it needs to retain Dr. Shulkin himself, no matter who is elected less than 50 days from now.

The commission, however, does not recommend the scuttling of the VISNs, or the establishment of regional cohorts of VA medical centers, which the current VHA leadership appears to be contemplating. However, the commission does, to its credit, call for the establishment of "leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialog, and collaboration." This should address a persistent problem that plagues the VHA: too often, a directive flows from the Undersecretary to VISN and VAMC leadership, but does not filter down to the clinicians and support personnel who need to be informed. A case in point: the excellent "Military Health History Pocket Card for Clinicians" rarely gets circulated to the clinicians for whom it was created and updated. Nor does it get disseminated outside the VA, to clinicians who treat the majority of veterans, yet who get some of their training in VA medical centers. Better internal communications can remedy this situation, and can be instituted if the top management at the VHA prioritizes the need for vastly improved lines of communication.

Recommendation #13

This is essentially an extension of the previous recommendation. It assumes, however, that "core metrics" for "organizational performance measurement" in the private sector are superior to any metrics and measures used by the VA. It is rife with linguistic pabulum. Still, its objective must be acknowledged: "VHA must effectively measure outcomes and hold leaders accountable for improvement." Too often, an ineffective or venal medical center director is transferred, or even promoted, rather than be offered the opportunity to resign, or be fired.

Diversity and Cultural Competence/Recommendation #14

The commission deserves kudos for its acknowledgment of the need for "developing the cultural and military competence of [VHA] leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans." Practitioners in VA healthcare facilities cannot help but gain an understanding of the unique healthcare needs of their veteran patients. The commission is on target in asserting that "cultural and military competency" must be among the criteria for "credentialing" external clinicians to treat veterans.

Workforce/Recommendation #15

The commission calls for the creation of "a simple-to-administer personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector." There can be little argument that "VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century." Hence, the recommendation that "Congress create a new alternative personnel system . . . in collaboration with union partners, employees, and managers . . . that applies to all VHA employees and falls under Title 38 authority . . . and improves flexibility to respond to market conditions relating to compensation, benefits, and recruitment."

On one hand, this makes eminent good sense: to obtain and retain top professionals in both medical treatment and hospital administration, the VA healthcare system needs to be competitive with the incentives in the private sector. In addition, certainly, VHA's ability to hire qualified staff cannot continue to be hamstrung by bureaucratic constraints and ineptitude. While many clinicians choose to work at the VA because of job security and protected pensions, others also feel a calling to use their skills to care for the men and women who have served the Nation in uniform, many of whom have special needs derived from their wartime experiences.

On the other hand, however, Congress quite likely will be skeptical at best about setting precedent by creating an alternative personnel system. Convincing you in Congress to in effect turn the VHA into a quasi-governmental entity while continuing to fund its operations will be the ultimate hard sell. It was the wait-time access issue, a long-time reality in many VA medical centers, which raised the ire of Congress, not the quality of health care delivered by VAMC personnel. Integrating additional healthcare providers into the VA system, where appropriate and when needed, is part of the rejuvenation of the VHA under the current undersecretary. This makes sense.

The conceptualization of the commission to create a new entity, one in which VA and private-sector clinicians, many with similar skill sets, in essence "compete" to treat veterans will not materially improve health care for those veterans who obtain their care at a VA facility. It is likely to dramatically increase the costs of providing care; and it is likely to lead to the underutilization of certain VA medical centers and community-based outpatient clinics and the subsequent shuttering of several of them, with the consequent turmoil in staff morale and, eventually, the loss of tens of thousands of jobs. Still, the VA must resolve a situation that continues to plague it: "Hiring timelines [for medical professionals] can span 4–8 months compared to private-sector hiring that takes between 0.5 and 2 months."

Recommendation #16

This, too, is more or less an extension of the previous recommendation. However, it is difficult to quibble with aligning "HR functions and processes to be consistent with best practice standards of high-performing health care systems." You should, however, reject the underlying assumption of the commission that VA clinical staff provides less efficient, poorer quality health care than private "high-performing health care systems."

Eligibility/Recommendation #17

Finally, a relatively radical recommendation that warrants congressional consideration: "Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service." The commission recognizes, rightfully, that some former servicemembers in fact "have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as Traumatic Brain Injury [TBI], Post Traumatic Stress Disorder [PTSD], or substance use) caused by, or exacerbated by, their service," thus rendering them ineligible for VA health care and other benefits. "This situation leaves a group of former servicemembers who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides"—care that they vitally need.

The commission recommends that "VA revise its regulations to provide tentative eligibility to receive health care to former servicemembers with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct." This may not be simply a matter of the VA revising regulations—Congress will need to enact legislation to enable the VA to treat these veterans—but it is an idea worthy of merit, one that the VSO and MSO communities should grab the baton and run with.

Recommendation #18

Prefacing this recommendation, the commission acknowledges that the capacity of the VA to provide care "is constrained by appropriated funding." In its recommendation that Congress or the President charge some entity with examining the "need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria," the commission opens the door to initiating pilot projects "for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance."

The 1996 eligibility reform act created eight "priority" groups of veterans eligible for VA health care. Priority 7 and Priority 8 veterans, who are not afflicted with service-connected conditions, must agree to a co-pay for the care and prescription drugs they receive from the VA. They account for around 40 percent of third-party collections by the VA. In addition, the Vet Centers do, as a matter of course, treat the family members of veterans, a necessity to successfully treat many of the mental health maladies suffered by the veterans they love.

To open a beleaguered health care system to non-vets seems counter-productive. In addition, it also would dilute the very essence of what should be a veteran-centric system. Because there is a certain specialness inherent in receiving care in a place where your service is acknowledged, where an array of conditions—traumatic amputations, spinal cord injuries, mental health afflictions—are understood, where you are among your peers. On this, a monetary value cannot be placed.

CONCLUSION

The commission acknowledges the raison d'etre for its own creation by the same act of Congress that initiated the so-called Choice Program: the issue of access. Yet it also acknowledges, "Access is not a problem for VHA alone: delivering timely care is challenging for many civilian providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals."

The commission notes the key question with which Congress must grapple: Does the VA healthcare delivery system, despite the wait-time scandal, require "fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering?" This is a question VVA and other VSOs and MSOs and veterans across the country need to consider: can the VA, given the impetus generated by the issue of access, fix itself, or does it require a radical reformation, one that can conceivably result in its demise?

We believe that the VA, specifically the Veterans Health Administration, can fix itself and in fact is fixing itself, in great measure because of the impetus generated by passage of VACAA. We would hope that you in Congress would monitor what VA leadership is accomplishing; and that members of the media who cover veterans issues would focus less on dramatically highlighting the problems and more on what is being done to correct them. When the VA messes up, by all means report it and let Congress call VA leadership on the carpet. However, report, and so acknowledge, some of the good things that the VA has been doing, e.g., making what is now a cure for hepatitis C available to all veterans enrolled in the VA healthcare system. Thousands of lives are being saved, and this, too, ought to be reported.

Senators, Vietnam Veterans of America thanks you for your attention to our position and our conclusions *vis a vis* the recommendations of the Commission on Care. In addition, we thank you for all that you have done, and are doing, for veterans and our families. I would be pleased to respond to any questions you might care to put to me.

Chairman ISAKSON. Thank you very much, Mr. Weidman. We appreciate your input and your time.

Mr. Steele, with emphasis added at the end of your testimony, you said, what do we do, addressing the appeals process and appeals reform in terms of the Veterans Administration. I will answer that question for you.

My good friend, Senator Blumenthal, as I understand it, has introduced a version of his veterans appeal bill sometime today. Chairman Miller from the House has introduced one. We passed a demonstration project in the Committee, a proposal by Senator Sullivan. Also, the Obama Administration, Denis McDonough and his

people at the Administration, have been working for about 3 months on an appeals reform bill.

Am I correct, Mr. Secretary?

Secretary MCDONALD. Yes, sir.

Chairman ISAKSON. The question then is, what do we do? Well, what we do is: we have got to get everybody that has got an interest in getting this done getting their heads together, including getting out of pride of authorship and getting it done. That is how it is going to get done.

I am going to make a suggestion here. The 445,000 pending appeals that we have right now in backlog, we should not do anything to reform the appeals process in the future until we tell these people how in the world we are going to give them an answer from the past. I am serious as a heart attack about that.

I think one of the things we need to do is to make sure we are reforming it so it does not happen again, but we do not need them being in a black hole and never getting an answer for the appeals that have long since gone past the time they should have gotten it.

I hope that I can help be a—I do not have a dog in this fight. My desire is to fix it, but I do not have a—I am not squiring a bill around and saying it is my way or the highway. I will be glad to work with the Ranking Member, with the Secretary, with Denis McDonough, with all our veteran service organizations, Chairman Miller in the House. Let us find a way to find the 80 percent we agree on and make a deal rather than always worrying about the 20 percent we do not find agreement on.

When we do it, we have to make sure the people who have already been left behind in the appeals process get an answer to the question they ask, which is the same one you do: when? So, I think that is the answer to your question.

Mr. STEELE. Thank you.

Chairman ISAKSON. Ms. Augustine, did I correctly hear you say that you all were opposed to Recommendations 1, 9, and 17?

Ms. AUGUSTINE. Sir, we are opposed to the external primary care provider recommended in Recommendation 1. We are opposed to Recommendation 9. We support Recommendation 17, which offers a streamlined path to eligibility for other-than-honorable discharges.

Chairman ISAKSON. OK. I got two out of three right. That is pretty good. [Laughter.]

What is your organization's position on the Veterans First bill?

Ms. AUGUSTINE. Sir, we support many of the provisions within the Veterans First bill, but we strongly oppose the pay for that has been offered for the bill, as we publicly stated and the 30,000 messages from our members to Congress have also echoed.

Chairman ISAKSON. Well, let me offer—see, I heard that in the testimony, the reference to the "do not take away any benefits," and I would like to make a suggestion to all of you. When we are trying to address the concerns that all of you bring to us to improve the benefits to our veterans and make the VA work better, we have to find ways to pay for improvements in the future.

That does not mean we want to take money out of Richard Blumenthal's pocket as a veteran, or out of my pocket as a veteran,

or anybody. But it may mean from time to time, just as we are going to have to do with Social Security and other things in terms of entitlements, we have to reform eligibility in the future to pay for eligibility in the present.

It is very difficult for us to move forward if, out of right field, we get an objection that does not give us fair warning and a chance to explain ourselves, which is what happened on Veterans First in that particular situation.

I just want to memorialize for the public and the record, I sit here as Chairman—and think Richard is the same, as Ranking Member—we are ready anytime, any place, anywhere, if somebody thinks we are taking away something to hurt a veteran—because we are never going to intentionally do that, but we also want to take a holistic approach and look at where we are putting together the money for the future to deal with the challenges of the future. Is that fair enough to say?

Senator BLUMENTHAL. Well, Mr. Chairman, I think as long as we are memorializing, I should state for the record my own view that there really should be no requirement as to a pay for when we are taking about benefits for veterans. That is simply a matter of principal with me. I recognize that the majority has a somewhat different position, but there is no requirement in law or policy, so far as I know, that we could not go to the floor and ask for a budget point of order. I think it would pass and I am prepared to support that effort.

I will continue looking for other pay fors, if that is a requirement, outside of veterans programs, because I believe that the Veterans First bill is a dramatic and historic step forward, and any additional funds required to support it should come from non-veterans programs. You and I have worked together very collegially in formulating this bill, and I hope we can continue to so that before it passes we will find alternatives.

I really do appreciate your leadership, Mr. Chairman. You and I have spent many, many hours in seeking to address this dilemma, and I know you have done it in good faith. This bill, hopefully, will pass in an even better form than what we have right now.

Chairman ISAKSON. I appreciate those comments and subscribe to them, but my point I am trying to take to the VSOs is this: if you see us doing something that you have an objection to or perceive there might be a benefit challenge to, come to us first—I am talking about "us" being Senator Blumenthal and myself—and let's see if we, first of all, can make sure we understand what change we are making and work together to get it changed, because a lot of times one little cog in the machine can stop everything else from happening because we just did not address it and talk about it. That is the main point.

I agree with everything he said, but who is in charge right now requires us to put a pay-for on the floor. We can go to the floor for UCs, but since we have the requirement we ought to try to first see if we cannot find a way to meet the requirement before we decide we have got a battle going on. That was my main point.

Senator BLUMENTHAL. And hopefully meet that requirement outside the——

Chairman ISAKSON. And that is where we are working——

Senator BLUMENTHAL [continuing]. Outside the VA——

Chairman ISAKSON. Right.

Senator BLUMENTHAL [continuing]. Programs, the VA mission, and the VA budget.

Chairman ISAKSON. Precisely.

I am sorry to have taken so much time but I wanted to—I think both those points need to be addressed both in terms of let's get this appeals done, let's get it worked out, and let's make sure we do not leave behind the 445,000 that are waiting. And let's make sure that in the future, when we have differences on benefits, we talk about them first before we declare war on each other and end up slowing us down from making progress.

With that said, I am going to go to my distinguished Ranking Member, Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

I want to ask about the board of directors. I apologize; I was not in the room for some of your testimony, but I have read it. I have taken from that testimony that there seem to be very broad reservations—perhaps I should say opposition—to the idea of a board of directors, for very understandable and well-merited reasons.

Ms. Augustine, you have made the point that it is an additional bureaucracy and that, in fact, it diminishes, potentially, accountability. I think, Mr. Fuentes, you made some—this point has been made by many of you. Have I correctly interpreted your views?

Ms. AUGUSTINE. Yes, sir.

Senator BLUMENTHAL. In terms of the other recommendations, if each of you could just give me what you regard as the most important recommendations that you have supported—in other words, not that—I understand that you have opposed some, but in terms of your finding merit in these recommendations.

I do not want to put you on the spot here, but just to kind of cut through the really excellent testimony that you have offered—it is very complete, excellent, but just in terms of what you regard as the most important of the recommendations you have supported.

Ms. ILEM. I will go ahead and take a—go first on that one.

I think the modernization—Recommendation Number 7 of VA's IT system is so inclusive of everything that—you know, regarding the disparities that exist and have been well-documented with the scheduling system and so many other parts of what today is really modernized health care. Without that there cannot be, within the integrated networks, that clear, seamless access between the community provider and VA.

I think that one is probably the largest one that impacts on so many other things. If that were resolved and really try to tackle that one first and foremost, many of the other issues would be automatically resolved within that one.

Senator BLUMENTHAL. Thank you.

Commander CAMPOS. I would like to add that in terms of—I think this report—it has been clear to us that the report has been provided in whole, and if you start piecemealing it, you are not going to get the results of the recommendations going forward.

For the sake of answering the question, I think, from our perspective, that nothing can really happen—real cultural change,

transformation will not occur without an investment in leadership and the human capital management system.

Mr. FUENTES. Senator, I would like to echo the importance of some of these recommendations that have already been mentioned, but I do want to add that Recommendation Number 1, although we do not support exactly how it is written, the need to reform the way that VA purchases care and how you integrate the private sector into the delivery-of-care model is vitally important.

As was discussed when the Secretary was testifying the Choice program is due to expire. There is an urgent need in reforming how VA reimburses emergency room care.

That is certainly vitally important, but also how VA expands and develops its capital infrastructure is also vitally important—Number 6—because no matter how many VA providers you are able to hire, you really need somewhere to put them. The way it is done now really needs to be reformed.

Ms. AUGUSTINE. I would echo the comments from my partner from DAV that Recommendation 7 is vitally important to every other recommendation.

Modernization's impact on the VA, as we look at integrating a network of care that expands beyond the VA, as we look at integrating better human capital management programs, that all ties back to IT. Ensuring that the IT infrastructure can handle those changes and can meet the needs of the VA is vitally important to the success of transforming the VA.

Senator BLUMENTHAL. Thank you.

Mr. STEELE. I will conclude by just saying stable leadership. The VA needs to find a way and Congress needs to find—we need to find a way to incentivize top performers like Dr. Shulkin and Mr. McDonald to serve our veterans—stable leadership.

Senator BLUMENTHAL. Did you have anything, Mr. Weidman?

Mr. WEIDMAN. The continuity of leadership is a problem. Whether through statute or through practice, which, in fact, it could be done, particularly at the Under Secretary level on up, is something that is really very difficult, because when people come in for a relatively short period of time—and I believe political appointees across the board serve on an average of 1 year and 9 months, historically, whether it is the Democratic or Republican Administration—that lack of continuity hurts all of the agencies' effectiveness. Frankly, we can not afford to have those kinds of lapses at the VA, particularly in the health care delivery system.

Senator BLUMENTHAL. Well, I appreciate your comments. I know that this session is not the last we will have on these issues. I would note that the recommendations that I believe you have identified are all either underway or seen as feasible by the VA, so I think we have a lot of consensus here.

One of the criticisms made of the Commission's report—I am not sure who made it; I think it may have been the IAVA—is that it fails to take account of the actions already underway in the VA, reforms already ongoing. I think that the support that you have indicated, and the Commission's support for the work that is underway really indicates that we are all putting our shoulder to the same wheel here.

Again, my thanks for your leadership. I want to just finish by saying thank you for your support for the appeals process reform bill that I introduced earlier today. We can disagree on the details, but there is absolutely no question that the present system is broken. The President thinks so. The VSOs think so. Our veterans think so. The Congress should think so and should act.

I very much respect that the Chairman is looking at all of the options available. I am not wedded to any single solution. I am certainly more than happy to be persuaded that there are better paths to the same goal. I think, there again, we should be able to reach a consensus on appeals reform sooner rather than later because time is not on our side, time is not on the veterans' side, when there is delay on appeals of these claims.

Just to say what you all know: these claims do not seek handouts or hand-ups. They seek benefits that were earned through service and sacrifice to our Nation and injuries or wounds that caused these claims to be made. So, this Nation has to do the job. Thank you.

Chairman ISAKSON. I want to thank Secretary McDonald and Dr. Shulkin—who must have paid off most of our witnesses, with all the comments he got today. Dr. Shulkin, they were bragging about you pretty good. You deserve it well. I appreciate Bob McDonald and his effort. I was with Secretary McDonald last night. He is a 24/7 guy working for our veterans and appreciated very much.

To all our VSOs, we are going to count on you helping put your oars in the water and help us move forward these last 2 months. We have got a lot of things that are this close and it is just a matter of us making up our mind we are going to get it done. If we can find 80 percent agreement, let's make a deal. Do not lose it over the 20 percent where we do not.

I appreciate very much your taking the long time that we had to wait, but it was great testimony, great input, and it is going to end up benefiting the people we are all here to serve, and that is the veterans of the United States of America.

With that said, this hearing will stand adjourned.

[Whereupon, at 5 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO AND THE AFGE NATIONAL VA COUNCIL

Chairman Isakson and Ranking Member Blumenthal: The American Federation of Government Employees, AFL–CIO and its National VA Council (AFGE) thank the Committee for the opportunity to share our views regarding the final recommendations of the Commission on Care. AFGE represents nearly 700,000 Federal employees including more than 230,000 employees of the Department of Veterans Affairs (VA). Within the Veterans Health Administration (VHA), AFGE represents employees at nearly every medical center and is by far the largest representative of medical and mental health professionals and support personnel.

OVERVIEW

Although the Commission did not formally adopt the controversial "strawman" proposal, the impact would be very similar. Both would dismantle our veterans' only specialized integrated health care system and incur unsustainable costs that will inevitably lead to lower quality care and fewer health care services for fewer veterans.

Both would also destroy veterans' true source of "community care": care provided within the Veterans Health Administration (VHA) that is closely coordinated with VA Vet Centers and Veterans Benefits Administration (VBA) benefits and employment services. The Commission's description of non-VA care as "community care" is a misnomer. Veterans strongly prefer to receive their care from the VA over the private sector according the Vet Voice Foundation poll and other recent polls.

The Commission recommendation (#15) to eliminate all civil service protections under Title 5 would increase retaliation against employees who report mismanagement and take veterans' preference rights away from thousands of veterans who choose VHA careers. The loss of seniority-based pay under the Commission's proposed new Title 38 personnel system would severely weaken the VA's ability to retain experienced providers. The proposed elimination of Title 5 due process protections and Merit Systems Protection Board appeal rights would allow managers to hire and promote based on favoritism and political affiliation instead of merit.

As the Committee contemplates the future of the VA health care system, AFGE also strongly urges the Committee to save our treasured health care system from "death by a thousand cuts." VA health care is already being dismantled "brick by brick" through the closures of many emergency rooms, intensive care units and other essential medical units. AFGE is also very concerned about the impact of VHA's overreliance on contractor-run outpatient clinics on quality of care, care coordination and costs and the secretive process for issuing and renewing these contracts. The most recent stealth attack on VHA is the imminent replacement of nearly all VHA compensation and pension (C&P) disability exams with contractor exams without any apparent analysis of the impact on veterans' disability ratings, access to integrated VHA care or costs.

Recommendations #1 and #9: AFGE vehemently opposes Commission recommendations that would result in a massive shift of VA care to the private sector through unrestricted access to non-VA primary and specialty care and the transfer of primary control over veterans' care from the Secretary to an unelected corporate-style board running a new VHA Care System. AFGE concurs with Commissioner Michael Blecker that these drastic changes would result in "the degradation or atrophy" of critical veterans' health services. VA would also lose the critical core capacity that has enabled it to be the Nation's leading source of medical training and cutting edge research. Our nation would also lose the critical assistance that the VA provides through its "fourth mission" during national emergencies and natural disasters, from Hurricane Katrina to the Orlando mass shooting.

VHA must remain the primary source of veterans' care, the exclusive provider of primary care and the exclusive care coordinator. VHA must retain control over the design and oversight of local, integrated care networks. AFGE fully supports the proposal for local integrated care networks developed by the *Independent Budget* veterans' service organizations and the similar proposal included in the VA's Plan to Consolidate Community Care.

Putting a private governance board at the helm would also vastly reduce the ability of Congress and veterans to hold wrongdoers accountable for mismanagement, corruption and patient harm. The Commission acknowledged that the board would not have to comply with the open government requirements of the Federal Advisory Committee Act and most likely would not be subject to the Freedom of Information Act.

Recommendation #2: The Commission's proposal to relieve the Secretary of the requirement under the Millennium Act to report annually to Congress on the number of beds closed the previous year constitutes another unjustified assault on accountability. AFGE agrees that current bed count data is inadequate but the solution is not less data. We have repeatedly sought Congressional oversight of "bed count gaming" where managers manipulate bed count data to hide the number of actual beds available to veterans. When beds are closed (primarily due to management's unwillingness to hire sufficient nurses), veterans are sent to non-VA hospitals that are less equipped to treat their unique conditions, often imposing greater costs on veterans and taxpayers.

If the bed count reporting requirement is eliminated, thousands of veterans' beds will be lost forever, staff will be laid off, and smaller facilities may not survive. VA beds have also played a critical role in our national disaster response plan; during Hurricane Katrina, patients were moved to VA medical centers in Houston and other locations. Therefore, we urge the Committee to reject this recommendation and instead, conduct oversight of ways to improve bed count data collection with the input of veterans' groups and representatives of front line employees.

Recommendation #6: AFGE strongly opposes the use of a BRAC-like process to address VHA's facility and capital asset needs. We are equally opposed to giving a governance board any role in determining VHA's infrastructure needs. It is likely that any board-run process would be plagued by the same self-interest that impaired the decisionmaking process of a Commission filled with health care executives.

AFGE concurs with the *Independent Budget* veterans service organizations that a far more urgent need is to address current infrastructure gaps that threaten safety and interfere with care delivery. Clearly, a BRAC is not the answer. The RAND Corporation recently reported that through at least 2019, demand for veterans 'health care services is likely to exceed supply.

Recommendation #15: In its report, the Commission portrays civil service protections afforded to Title 5 employees as the enemy of innovation and quality improvement ("a relic of a bygone era," "an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission-critical"). The Commission then reveals its true agenda for eliminating Title 5 rights: it wants to make it easier to fire employees it doesn't like and hire through cronyism.

What the report does not tell us is that the Department of Defense Federal agencies operate health care systems effectively with Title 5 workforces that have full due process and collective bargaining rights that they use to speak up against mismanagement and negotiate with management over working conditions to the benefit of their patients.

This recommendation would eliminate all Title 5 rights currently afforded to the majority of VHA employees. These include full Title 5 employees, most of whom are service-connected disabled veterans (e.g. police, housekeepers, food service workers) and Hybrid Title 38 employee (e.g. Medical Support Assistants, nursing assistants, pharmacists, psychologists and social workers). Both groups would lose their right to third party review of removals and demotions by the Merit System Protection Board.

Both groups would also lose most of their collective bargaining rights that allow them to negotiate over working conditions such as scheduling, assignments and training.

Veterans who choose to work in VA health care after saving lives on the battlefield would also be greatly harmed by this Commission recommendation. Federal case law has made it clear that employees appointed under Title 38 (Hybrids and full Title 38 employees) are not covered by the Veterans Employment Opportunities Act (VEOA) and therefore lack veterans' preference protections against being passed over for a non-veteran in hiring. AFGE concurs with the *Independent Budget* that Congress should enact legislation to extend the VEOA to all VHA employees.

The proposed new Title 38 personnel system would ignore seniority when setting pay, at a time when VHA is facing low morale and increased attrition among providers with valuable experience because many new hires are being paid more than their senior counterparts.

OTHER RECOMMENDATIONS

AFGE generally supports recommendations #3 (appealing clinical decisions), #5 (health care disparities), #14 (diversity and cultural competence), #16 (human capital management) and #17 (eligibility for those with other-than-honorable discharges).

AFGE supports modernized information technology (IT) (#7) but urges Congress to mandate greater involvement of front-line employees using new IT systems to ensure successful implementation.

AFGE does not take a position on recommendation #4 (VHA transformation) because further investigation of the cost-effectiveness and lack of transparency of the Veterans Engineering Resource Centers is needed. We also take no position on #8 (supply chain) or #12 (VISNs) at this time.

We object to #10 (leadership) if it involves a governance board. AFGE also opposes # 11 (leadership succession) because direct hire authority will increase cronyism and discrimination against veterans. AFGE also opposes #13 (performance standards) because of its overreliance on private sector standards that are not applicable to VHA's mission or its unique patient population. AFGE is opposed to recommendation #18 (expert body to address eligibility) as unnecessary.

In closing, AFGE urges the Committee to reject all proposals to dismantle the VA health care system and shut the doors of its medical centers, either through unrestricted access to non-VA care under a governance board-run system or legislation to extend the broken temporary Choice program. Lawmakers should also investigate the growing number of incremental attacks on VA health care including outsourcing of C&P exams, contractor-run outpatient clinics and elimination of VA-provided emergency care and ICU services. AFGE urges the Committee to serve the best interests of veterans and the Nation by investing in VA's own high performing integrated, veteran-centric health care system. We welcome the opportunity to work with the Committee and VSOs s to ensure continuous improvement in our Nation's treasured health care system for veterans.

POSITION PAPER FROM THE ASSOCIATION OF VA PSYCHOLOGIST LEADERS, ASSOCIATION OF VA SOCIAL WORKERS, NURSES ORGANIZATION OF VETERANS AFFAIRS, VETERANS AFFAIRS PHYSICIAN ASSISTANT ASSOCIATION, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, NATIONAL FEDERATION OF FEDERAL EMPLOYEES, NATIONAL NURSES UNITED, AMERICAN PSYCHOLOGICAL ASSOCIATION, AND NATIONAL ASSOCIATION OF SOCIAL WORKERS

On June 30, 2016, the Commission on Care submitted its Final Report required by the Veterans Access, Choice, and Accountability Act of 2014.

As organizations comprised of and representing health care practitioners, researchers, educators, administrators and personnel devoted to serving Veterans, we have serious reservations about the report's major recommendation to replace the current VHA with a new entity, to be known as the VHA Care System. In the proposed VHA Care System, Veterans would be permitted to receive care from any local facility or provider who has been credentialed by VHA. Oversight for Veterans' health care would be handed over to a newly created, external governance board.

According to the Commissions' charter, "final recommendations will be data driven." As we demonstrate below, the recommendation to establish a new VHA Care System is at odds with compelling evidence of the VHA's current effectiveness.

As affirmed in the Final Report's introduction, RAND's 2015 evaluation (http://www.rand.org/pubs/research_reports/RR1165z2.html), RAND's 2016 summary (http://www.rand.org/pubs/research_reports/RR1165z4.html) and a 2016 literature review of 60 scientific publications (http://bit.ly/1UOlEmF), the current VHA system provides healthcare that is as good as, and more often superior to, non-VA care. It outperforms non-VA care on adherence to recommended preventative care guidelines, adherence to recommended treatment guidelines, outpatient processes and outpatient outcomes. Nevertheless, the Commission's Final Report ignores the implication that vastly expanding reliance on local non-VA providers and facilities could worsen, not improve, Veterans' health care.

The proposed VHA Care System disassembles one of the most effective, innovative features of current VHA care—the Primary Care/Mental Health Integration approach. The Final Report concedes that such integration is largely missing in the

community (p.22). Also absent in private sector healthcare are the integrated, wrap around services the VA offers though financial, educational, housing, caregiver and employment support.

The Final Report recognizes that VHA provides better coordinated care. "Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers" (p.28). It is the VHA, not the disjointed, larger non-VA system, which is the true provider of Veteran-centric community care.

The Final Report anticipates that 60 percent of eligible care will shift from VHA facilities to outside networks (p.31). The net result will reduce, not expand, Veterans' choices, since to pay for this shift, a VHA Care System will incrementally downsize the number of VHA providers and programs. The VHA system would be weakened.

The Final Report estimates the cost of creating and implementing a new VHA Care System to range from $65 billion to $85 billion in 2019, with a middle estimate of $76 billion (p.32). That's $11 billion more than the FY 2017 VHA medical care budget. If Congress saw fit to fund billions more yearly, there are better ways to strengthen the VHA, starting with expanded hiring at VA facilities where demand for services exceeds available staffing. But if Congress did not, the Final Report suggests that the expensive VHA Care System could offset costs by decreasing the number of Veterans eligible for VA health care, cutting services, or increasing Veterans' out-of-pocket expenses. In any of those scenarios, Veterans are worse off.

In sum, given the evidence of overall quality, efficiency, integration and innovation within the VHA, we believe that efforts to reform the VHA can best serve Veterans by expanding access to services the VHA currently provides. Where geographic challenges exist and/or VHA does not offer specific services, the VHA should purchase services from non-VA partners.

Any proposed transformation of the VA healthcare system should be data driven. Don't risk our Veterans' healthcare on unproven ideas. We must preserve and strengthen the VHA integrated health care community that Veterans deserve and overwhelmingly prefer.

Contact Information:

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LETTER FROM SHARON JOHNSON, MSN, RN, PRESIDENT,
NURSES ORGANIZATION OF VETERANS AFFAIRS

DEAR CHAIRMAN ISAKSON: On behalf of the over 3,000 members of the Nurses Organization of Veterans Affairs (NOVA), we would like to offer our thoughts regarding the Commission on Care Final report being discussed before your Committee today.

NOVA thanks the Commissioners for their hard work and believes many of the recommendations offered will improve the care we provide veterans every day at VA facilities around the country. Recommendations to include providing additional resources to modernize IT, increase H.R. and other support staff, strengthen capital assets and recruit and retain a high quality professional workforce, all have our support.

The most glaring recommendation—and one that has received strong opposition from veterans' advocates and those in the community working to care for veterans—is a proposal that would create a VHA Independent Board which would govern the VA health care system.

NOVA strongly opposes giving an outside board—made up of civilian health care executives who may have never set foot into a VA facility—the authority to make decisions about the care and services provided America's veterans. Creating another layer of bureaucracy, which would take VA's ability to manage care away from those who are held accountable by this very body seems ill-advised. Oversight for veterans' health care handed over to a newly created external board would all but dismantle the most effective and innovative features of the current VA system—the Primary Care/Mental Health Integrated approach. It also fails to take into account the many wrap around services that VA offers veterans, while ironically recognizing that VA provides better coordinated care than any of its private sector partners.

NOVA agrees in order to reform VA so it can best serve our Nation's veterans, we must expand access to services that it currently provides by hiring at VA facilities where demand exceeds available staffing, where geographic challenges exist, and specific services are not offered, allowing veterans the option of using purchased care available through its community providers.

Community providers should be a crucial part of the integrated network of care, but VA must remain the first point of access and coordinator of all care. As nurses, managing workflow and coordinating care is key to providing the quality that serves as a model for VA's "whole health" approach to care.

NOVA asks that any discussion regarding the Commission's proposed recommendations to improve gaps in service be made in a thoughtful, transparent process and involve all stake holders. Preserving an integrated health care community designed to put veterans first must include VA. It is VA care that veterans overwhelming prefer and deserve.

Sincerely,

SHARON JOHNSON,
MSN, RN, President,
Nurses Organization of Veterans Affairs.

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to express our views on the Commission on Care's Final Report. We appreciate the Committee's continued commitment to thoroughly examining the best way forward for comprehensive reform in the delivery of veterans' health care.

Before addressing the 18 individual recommendations included in the Commission report, we would like to address two underlying fundamental flaws within the report. First, the Commission seemingly reviews the Veterans Health Administration (VHA) as though it exists within a vacuum. The many recommendations do not contemplate the relationship that VHA has with the Veterans Benefits Administration or the National Cemetery Administration. We believe that any reform of VHA must consider the direct interaction that occurs between the three Administrations of the Department of Veterans Affairs (VA). Unfortunately, the Commission report does not.

Second, the Commission knowingly set aside consideration of the three additional missions the VA has beyond being a provider of services for veterans. Those missions include education and training of a large segment of America's health care workforce, research (particularly into conditions unique to military service), and serving as the backup resource during a national emergency or natural disaster. The Commission's recommendations are presented as though these responsibilities within VA do not exist.

We believe that failure to contemplate these two important points undermines the Commission report. That being said, many of the 18 recommendations are worthy of consideration. We applaud the Commission for taking on and thoughtfully addressing this complex issue. We also appreciate the fact that the Commission and its staff regularly sought feedback from the veterans' service organization (VSO) community as it proceeded. With this in mind we offer our thoughts on this important work.

REDESIGNING THE VETERANS' HEALTH CARE DELIVERY SYSTEM

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

PVA supports the creation of fully integrated health care networks with the Department of Veterans Affairs (VA) maintaining responsibility for all care coordination. This part of the recommendation is consistent with the proposal that PVA along with our partners in *The Independent Budget* (*IB*)—DAV and VFW—put forward late last year. We also support eliminating the 30-day and 40-mile standards for access established as part of the Choice program. The *IB* offered a similar recommendation last year suggesting that access to care and when and where to seek service should be a clinically-based decision determined by the veteran and his or her provider, not an arbitrary access standard. Despite our support for the concept

of creating fully integrated health care networks, we have some significant concerns with other aspects of the Commission's recommendation.

We are first, and foremost, concerned with the Commission's recommendation for "choice." The report proposes that veterans should have unrestricted choice for any primary care provider within their newly-constructed network. In order to access specialty care (outside of VA's specialized services), veterans would be required to get a referral from their designated primary care provider.

The Commission does not, however, discuss what the boundaries should be in establishing the networks. The breadth of the networks is limited only by the Commission's assumption that the networks will be "tightly managed" by VA and that primary care providers wishing to participate will meet certain quality standards. Together these two parameters do not establish a clear picture as to what extent VA may efficiently dilute its capacity to deliver care in favor of outsourcing to the private sector.

These networks must be developed and structured in a way that preserves VA's capacity to deliver high-quality care while specifically preserving its core competencies and specialized services. Without a critical mass of patients, VA cannot sustain the very infrastructure that supports and makes VA specialized services world-class. Providing veterans unfettered choice as to their provider jeopardizes this baseline of patients. A better proposal is found in VA's Plan to Consolidate Community Care Programs, which rests on a principle of using community resources to supplement service gaps and better realign VA resources. This sets a natural boundary that would prevent the networks from expanding to a harmful and unmitigated degree. Ultimately, the Commission failed to articulate what constitutes a "tightly managed" network, and it admittedly did not contemplate "[r]eductions in the volume of care within VA facilities, and potentially adverse effects [on] quality . . . "[1] The result we are left with is lip service paid to preserving VA's specialized services.

In addition to VA specialized services, there is insufficient discussion regarding care coordination within these networks. The recommendation suggests that care coordination take place through all primary care providers, but VA would assume overall responsibility for care coordination of all enrolled veterans. There is no delineation, though, as to exactly where VA and community providers hold responsibility. The recommendation is conflicting and could ultimately lead to finger pointing instead of well-coordinated care for veterans being served in the community. We would again point to VA's Plan to Consolidate Community Care Programs.[2] VA's proposal would administer care-coordination based on the intensity of coordination needed. This method offers the functionality and flexibility needed to ensure that patients with complex cases receive adequate attention and resources. It also tailors the level of care coordination to each individual patient's complexity and needs, regardless of whether the patient receives care in VA facilities or in the community.

We are further concerned with the report's consideration of funding for the new health care delivery system. It does not clearly reconcile how VA currently determines its appropriations needs through the Enrollee Health Care Projection Model (EHCPM) with how it will have to determine its appropriations needs through the new system with local leadership input.

The report also considers cost-sharing, particularly for veterans with non-service-connected disabilities. The cost-sharing opportunity would be used to expand options for choice, but it would likely come with increased costs for Priority Group 4 (non-service-connected catastrophically disabled) who do not currently have a cost for their care. This proposal is contemplated within the larger context of determining priority of service. The report recommends priority be given to service-connected disabled veterans and those with low incomes, but it does not properly consider the relationship of Priority Group 4 veterans to the system.

Finally, as VA begins to involve community providers at a greater rate, it is essential to ensure that the process for adjudicating medical malpractice claims is the same whether that care was received in the community or within VA. In almost all cases, the current process under 38 U.S.C. § 1151 treats malpractice claims the same regardless of where they received care. However, certain unique situations still present inequitable results for veterans.

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[1] Commission on Care, *Final Report*, June 30, 2016, p. 32 (hereafter "Report").

[2] Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care,* October 30, 2015, pp. 21–25,http://www.va.gov/opa/publications/va_community_care_report_11_03_2015.pdf.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

PVA generally supports this recommendation as it would allow providers in the VA health care system to practice within the full scope of their licenses. The report also addresses bed capacity reporting as originally established by Public Law 106–117, the "Veterans Millennium Health Care and Benefits Act." It appears to endorse a requirement for VA to report beds as closed, authorized, operating, staffed, and temporarily inactive.

We reiterate our support for reinstating the capacity reporting requirement originally established by Public Law 104–262, the "Veterans' Health Care Eligibility Reform Act of 1996." VA has not maintained its capacity to provide for the unique health care needs of severely disabled veterans. Reductions in both inpatient beds and staff in VA's acute and extended care settings have been continuously reported throughout the system of care, particularly since the capacity reporting requirement expired in 2008.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-funded programs.

PVA supports this recommendation as it aligns VA with widely accepted medical practice. As it stands, each Veteran Integrated Service Network (VISN) has its own process for appealing clinical decisions. Failure to standardize the appeals process across VA naturally produces a disparity in outcomes among similarly situated veterans seeking to bring clinical disputes. Furthermore, external review of final VA decisions is subject to the discretion of the VISN director.

One aspect of current VA policy that is not addressed in the Commission's report is the latent conflict of interest in the patient advocate office that each VA facility employs to manage and resolve complaints. While patient advocates generally serve as the liaison between patients and clinicians, their ability to fully advocate on behalf of the veteran is hampered by the fact that they are forced to present criticism to those who hold the keys to their career. The "program operates under the philosophy of Service Recovery, whereby complaints are identified, resolved, classified, and utilized to improve overall service to veterans."[3] Capturing useful data by documenting complaints in order to facilitate positive changes at VA is productive, but the incentive to downplay patterns of conduct and other pervasive issues exists and limits potential progress. As a solution, PVA has suggested before that the patient advocates should be removed from their current personnel structure and report instead to the *MyVA* Veterans Experience Office in order to offer more robust, constructive criticism when patterns emerge among veteran complaints.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

PVA supports this recommendation. The principle of diffusing knowledge and best practices throughout VA is important and should be encouraged. As the report indicates, VA currently has resources, such as the Veterans Engineering Resource Center (VERC), that are underutilized. To truly capitalize on these available benefits, though, VA must thoroughly pursue personnel management reform. A large contributor to stagnant innovation and distribution of best practices is due to persistent, wide-spread vacancies in senior leadership positions. Acting directors or senior managers, as opposed to permanent leaders, have a limited ability to implement long-term changes because of the uncertainty of their tenure. Fixing the issues that pervade the personnel system will go hand-in-hand with success in adopting a continuous improvement methodology.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

PVA supports certain aspects of this recommendation, but we believe that this recommendation perpetuates a false narrative about VA health care prematurely and without a thorough understanding of the scope of the problem. Health care sys-

[3] VHA Patient Advocacy Program, VHA Handbook 1003.4 (2005).

tems across the United States are acknowledging and seeking to address health care equity, inequality and disparities. VA has conducted its own studies and found that disparities do exist. Dealing with these disparities when and where they exist requires affirmative steps to combat the problem. It is essential, however, to thoroughly understand the root causes and true scope of the problem before implementing an effective plan.

VA's unique history of providing care for historically underserved populations, particularly poor or near poor veterans with chronic medical conditions and behavioral health conditions, suggests that patterns within the private sector should not be arbitrarily appropriated to VA without thorough examination. Furthermore, because cost is often not a barrier to care within VA, a significant distinction between VA and private sector care must be made based on the absence of typical market influences affecting private sector outcomes.

Before mandating that VA make "implementation of the VHA Health Equity Action Plan (HEAP) nationwide"[4] a strategic priority in the face of all the other competing issues, more research and better information is needed to help inform VA's planning and allocation of resources. The 2015 Evidence Brief relied upon by the Commission's report specifically states that the sources of the disparities identified were not examined.[5] The Evidence Brief concludes that more research, specifically related to the sources or causes of the disparities is needed before an accurate assessment of the issue can be made.[6] To this end, we support the proposal to plus-up the staff dedicated to examining this issue within VA. It will not only encourage VA to determine how pervasive certain issues are and root out causes of the disparities that exist, but it will also permit VA to apply lessons learned from its own successes, such as its leadership on the issue of health care equity in the LGBT community acknowledged by the Commission in its discussion related to diversity and cultural competence.[7]

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Position: PVA strongly supports this recommendation. VA's capital asset management has been substandard, to say the least, in recent years. We support, in accordance with the recommendations of *The Independent Budget*, the expansion of ambulatory or urgent care. We also believe that VA must make a concerted effort to right size its infrastructure, in light of the amount of unused and underutilized capacity in the system. However, we are not absolutely convinced that a BRAC-modeled concept is the most effective way for VA to realign its capital footprint. Finally, we fully support the recommendation the report offers to free the VA of the strict fiscal constraints that have hampered its ability to manage its capital leasing program.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

PVA fully supports this proposed recommendation. We have repeatedly advocated for reform to VA's IT system management and enterprise through *The Independent Budget* (*IB*). The *IB* strongly opposed IT centralization in 2006 (a move forced by then Chairman of the House VA Committee, Steve Buyer). We believe many of the problems identified by the Commission originated with that centralization, and the report essentially affirms our belief. We believe that the Commission's recommendations could be taken even further to fully decentralize IT into VHA once again. This will provide more health care IT innovation, flexibility with the IT budget and better IT outcomes.

However, we recognize that cost for these reforms remains a significant hurdle to advancement. Indeed, VA's Plan to Consolidate Community Care Programs similarly called for significant IT upgrades in order to be successful. The plan was presented to this Committee in late 2015 and was well-received on both sides of the aisle, but several Members of Congress balked at the cost of paying for this necessary upgrade. Ultimately, we strongly believe that this is a cost that must be met for VA to have the opportunity to fully modernize its IT infrastructure. This is par-

[4] Report, p. 54.
[5] Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA,* http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf, pp. 1, 3, 33.
[6] *Id.*, p. 28, 31.
[7] Report, p. 137.

ticularly true in light of the discussion regarding use of commercial off-the-shelf (COTS) IT products.

PVA has no strong position on whether VA should choose a COTS solution for its IT systems or design its own systems. However, it would seem that leveraging COTS would make innovation and modernization more dynamic and possibly more cost efficient.

Supply Chain

Recommendation #8: Transform the management of supply chain in VHA.

The Commission accurately outlines the supply and contracting problems within VHA and VA. The corresponding recommendations are good business concepts if VA and VHA have the funding, ability and leadership to implement them. The recommendation to have VA and VHA re-organize all procurement and logistics operations for VHA under the VHA Chief Supply Chain Officer (CSCO) is the correct organizational solution. However, in order to implement the recommendations, there must be multiple changes in other departments throughout VA and VHA. Absent these changes, implementation of these recommendations will cause disruption, confusion and uncertainty at the Central Office level and will be even worse at the field level.

PVA has also identified some additional concerns with the recommendation. The attempt to standardize medical equipment and supplies, as offered in the report, would include prosthetic equipment. The danger is that there is no leadership or expertise in VHA to manage the standardization of prosthetics. There are certainly prosthetic items and supplies that can be standardized, but even those items must be carefully reviewed by an expert clinical team composed of clinicians, contracting, prosthetic and veteran representatives who use the particular items under consideration. Additionally, the report does not contemplate how far down the supply chain standardization of prosthetic equipment should go.

If VA was to pursue the reforms recommended in this section, PVA has a number of implementation level items that could be offered to improve the process and increase the likelihood of a successful transformation.

GOVERNANCE, LEADERSHIP AND WORKFORCE

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

While PVA understands the intent of this recommendation, we do not support it. We agree with the notion that too frequent turnover of VHA leadership has stymied innovative leadership and transformational change. However, replacing politically-appointed leadership with a Board comprised of leaders representing multiple political ideologies will likely lead to even greater gridlock. At the very least, it is simply trading one political entity for another; it does not get rid of the political interference. We can easily envision a scenario where this new appointed Board becomes a reflection of the political leadership of Congress that has demonstrated no ability whatsoever to govern or compromise. While the current leadership of VA is based on nomination by the President and approval by the Senate, this proposal takes political influence too far. One only need to look at the workings of the Commission itself and a number of its politically-motivated members to realize the potential negative consequences politically-driven decisions could have on the delivery of health care for veterans.

Additionally, while the recommendation places emphasis on ensuring veterans are included on the Board, it does not include any real consideration of veterans' service organization representation.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

PVA supports this recommendation. This recommendation cuts at the necessary leadership to effect the cultural changes required to make VHA a more responsive and dynamic organization.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

PVA supports this recommendation. Succession planning for leadership is a problem that exists across the Federal Government, not just at the VA. The process by which senior leaders are brought into the VA system, particularly VHA, is cumbersome and complicated. VA too often loses out on some of the best candidates because of the nature of the H.R. process that fills open leadership positions. The direct-hire authority proposed by the report could provide improved opportunities to bring on critically needed senior staff in the health care system. Additionally, a renewed focus on leadership development and management could ensure that the best candidates are retained in the VHA system.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decisionmaking at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

PVA generally supports this recommendation. We believe the vision that the Commission provides for how to change the organizational structure of VHA could prove beneficial to improving management of the system and implementation of policy. We are disappointed that the report does not provide more discussion about the inefficiency of the current VISN structure. Additionally, we remain skeptical about the efficacy of the proposed simplification of the VHA budget. While this sounds reasonable out of context, it does not reflect the complicated nature of budget development and appropriations distribution within VHA.

We do support the notion of more transparent and detailed accounting and disclosure of VHA's expenditures. This recommendation is consistent with recommendations made by the *IB* during debate and passage of legislation to establish advance appropriations for VA health care.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

PVA generally supports the creation of a workgroup to establish a new performance management system for VHA leadership. However, we are not certain that it is appropriate to establish performance metrics that are identical to those used in the private sector. The nature of VA health care delivery is appreciably different from the delivery of health care in the private sector. While there are some aspects that are similar, the VA health care system is not so much like the private sector that it should be evaluated in exactly the same manner. With this in mind, performance standards for employees and management should not be exactly the same either.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

PVA generally supports this recommendation; however, we take exception to the implication that VHA somehow lacks the cultural and military competence to provide veterans' health care. VA is the embodiment of veteran cultural competence, and it is, in fact, one of the notable reasons veterans who receive health care from VA prefer it over the private sector. We strongly support the recommendation that cultural and military competence be criteria for allowing community providers to participate in the VA's integrated health networks. In the past, private providers have openly testified before the House Committee on Veterans' Affairs that one of their primary concerns with treating veterans is not understanding veterans and their experiences as patients. This very circumstance is one of the primary reasons that the private sector is not the ultimate solution to VA's access problems.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

PVA supports many of the pragmatic ideas found in recommendations 15 and 16 related to VHA workforce issues. A modernized and effective human resources operation is vital to any organization, especially one as large as VA. We believe the Federal personnel system is one of the largest hindrances to effective management of the VHA system. Recommendations 15 and 16 deal with two aspects critical to successful reform: the authorities which govern the personnel system and the overall management of human resources (HR) within VHA.

The multiple authorities governing the VHA personnel system are incompatible with a dynamic high-performing health care system. Hiring managers and their employees must attempt to understand the end-to-end hiring process under four separate rules systems. This unnecessarily adds complexity to the hiring system which is difficult for both the potential employee and the human resources staff to navigate. The unnaturally slow hiring process also produces lost talent. Quality employees do not often have the luxury to wait around for a VA employment application to be processed. Similarly, when an employee announces his or her forthcoming retirement or departure from VA, H.R. is unable to begin the recruiting or hiring process for that position until it is actually vacated. It not only causes an unnecessary vacancy—exacerbated by the lengthy hiring time—but it also prevents a warm handoff between employees and any chance for training or shadowing.

PVA also believes that VA has suffered from its inability to be competitive with its private sector health care counterparts who do not face the same restrictions on pay and benefits for critical staff. We support the recommendations to align pay and benefits to make the VA more competitive for important staff with the private sector.

The broad recommendation to consolidate all personnel authorities into one alternative personnel system will bring wide benefits, but it must also include increased flexibility in the actual hiring process. It must also establish clear standards for disciplining or removing poor performing employees without diminishing current due process protections afforded by law.

In short, the VHA workforce arena is ripe for numerous practical changes that would provide realistic opportunities to reconcile personnel reform and preservation of the due process protections currently afforded to VHA employees.

ELIGIBILITY

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

PVA supports this recommendation. This recommendation mirrors legislation introduced earlier this year—S. 1567 and H.R. 4683, the "Fairness for Veterans Act"—which PVA publicly supported. There is overwhelming evidence that the effects of war can cause psychological harm, drastically changing the personality and behavior of servicemembers. Sometimes those effects manifest and adversely affect the terms of the veteran's discharge. It is a poor irony and ultimately unjust to withhold care for an injury incurred during service solely because that injury provoked or caused the actions which led to their discharge classification. While most commanders are dedicated and caring leaders, many do not have the intimate knowledge of a servicemember's behavior prior to the trauma they experienced during military service. Other leaders may even find it "expedient" to rapidly discharge an individual to rid themselves of a problem in the unit. Too often these discharges are determined without regard to the cause of the altered behavior. Having an effective mechanism to review the discharge in a deliberate manner can ensure that veterans deserving of care for injuries incurred as a result of their service are not denied.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

PVA is very cautious of this recommendation. The Commission generally supports with evidence its belief that the issue of eligibility needs to be reexamined or updated in order to better align capacity and demand. But it does not support or even

present a rationale for why this undertaking should be conducted by an entity outside VA or Congress. The recommendation to outsource this task treads into the territory of eligibility with a different, and potentially harmful, perspective—that of business efficiency.

The benefits currently afforded to, for example, Priority Group 4 veterans reflects years of hard work and advocacy that forced our country's representatives to make tough business decisions within the context of long-accepted philosophical principles. What this country owes its veterans and what it can afford to pay cannot always be reconciled. It does not absolve this Nation's responsibilities to its veterans. In such circumstances VA and Congress should act from the perspective that they must fight not just to better manage resources but to also find the necessary appropriations to cover the obligation. "Restructuring the debt" and trimming veterans from the rolls based on a cold and calculated business-driven decision is not an option. The budget must not be balanced on the backs of veterans.

CONCLUSION

Mr. Chairman, we would like to thank you once again for the opportunity to testify on this important issue. This concludes our statement for the record. We would be happy to answer any questions the Committee may have.