

# DRAFT RECOMMENDATIONS

<b>RECOMMENDATIONS .....</b>	<b>1</b>
1. Establish a board of directors to provide VHA overall governance, set long-term strategy, and direct and oversee the transformation process. [SENT 4/29] .....	1
2. Develop a focused, clear, benchmarked plan to transform VHA culture with full leadership engagement. [DRAFT] .....	4
3. Develop a leadership-succession system based on a benchmarked health care competency model for recruitment, development, and advancement within the leadership pipeline. [DRAFT] .....	7
4. Transform organizational structures and management processes to maintain consistency with national policy and standards, promote decision-making at the lowest level of the organization, eliminate waste and redundancy, promote innovation, and foster the spread of best practices. [DRAFT] .....	11
5. Streamline and focus performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a workforce performance management system for health care leaders in VHA that is distinct from an operational performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies. [DRAFT] .....	15
6. Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve a high performing health care system. [DRAFT] .....	18
7. Create a simple-to-administer alternative personnel system, in law and regulation, that 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. [DRAFT] .....	21
8. Develop fully integrated care networks of VHA and community care providers through which veterans receive coordinated medical care. [DRAFT] .....	25
9. Identify emerging problems with access and continue to develop clinically meaningful benchmarks and standards that reflect the many dimensions of access. [DRAFT] .....	28
10. Identify and address health inequities in subpopulations treated by VHA. [DRAFT] .....	30
11. Establish health-equity as a VHA priority. [DRAFT] .....	32
12. Modernize VA's IT infrastructure to improve veterans' health and well-being, and provide the foundation needed to support VHA's key business processes. [DRAFT] .....	33
13. Enhance health care value and staff productivity by ensuring staff has adequate resources and training, utilizing staff to their fullest potential, and expanding use of patient-centered care practices to improve access and quality. [DRAFT] .....	44
14. Improve clinical workflow by implementing appropriate staffing practices, creating a culture of continuous improvement, ensuring bed levels correspond with demand, and tracking resource distribution in real time. [DRAFT] .....	46
15. Transform the management of the medical and surgical supply chain in VHA. [DRAFT] .....	49
16. Provide VHA the tools required to meet and manage its capital needs. [DRAFT] .....	51

17. *Establish an expert body to develop recommendations for VA care eligibility and benefit design.* [SENT 4/29] .....54

18. *Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.* [SENT 4/29].....55

19. *Develop pilot programs to test the feasibility of enabling veterans' spouses and higher-income veterans to obtain VA care through their health plans.* [DRAFT].....56

20. *Develop a program to ensure veterans know how to access VHA health care.* [DRAFT].....58

21. *Transform contracting support and culture to create a more flexible and responsive approach to business functions across VHA.* [DRAFT].....58

---

# RECOMMENDATIONS

---

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

[SENT 4/29]

### Conclusions

Given VHA's scope and magnitude, transforming the organization will take years and will require new governance that can provide strategic focus and direct change. Such a governance model must enable VHA to undertake, successfully complete, and sustain transformation. That entity must provide governance, strategic direction, decision-making, and oversight of VHA's operations and transformation. It also must be independent of department leadership.

A governance board, more specifically, a board of directors, would facilitate the goal of transforming VHA. A board structure, with appropriate reporting systems and capabilities in place, could carry out the governance functions identified as critical (see p. #). Although some might consider Congress to be VA or VHA's board of directors and question the appropriateness of establishing a VHA board of directors, this governance model does not change or diminish Congress' role. Instead, a board, which would report periodically to congressional committees, would provide a level of close oversight and health care expertise that would complement the work of the Congress and relieve the need for extensive oversight hearings..

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A board structured to provide continuity of membership is vital. A step toward assuring such continuity would be to provide that the SECVA's term on the board overlap with that of the SECVA's successor. It is also important to re-examine the tenure of the USH and the process for selecting candidates for that position.

In recent years, USHs have served for relatively short periods, leaving office with a change in administration or sooner. This pattern has deprived VHA of sustained leadership and has likely contributed to a focus on the short term. VHA history shows a connection between longer tenure and transformative accomplishment. As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders' strategic horizon and create a pattern of leadership discontinuity. VHA, Congress, and the president would be better served by an USH who holds a 5-year term of office for the position with an opportunity for a 5-year reappointment with the approval of the board of directors. Given the expertise and level of experience members of a board of directors would have, when the office of the USH is vacant, the board should have the authority to recommend to the president an individual for appointment. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the president.

A VHA board of directors must be tailored to the unique needs of VHA. It should have appropriate expertise and experience to provide strategic guidance and continuity of leadership and possess authority to exercise the powers needed to realize and sustain a VHA transformation.

One suggestion for the composition of the board would be to use a political paradigm not unlike the composition of the Commission. Under that paradigm, the voting members would be two members each, to be appointed by the president, the majority leader of the senate, speaker of the house, and the minority leaders of the senate and house. The SECVA will serve on the board as a voting member. Other paradigms would have a “blue ribbon” board appointed by either the president of SECVA.

A change in governance alone will not bring about successful transformation; thus, this recommendation is interdependent with other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities. Establishing appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

### **Enabling Requirements**

- Congress should provide for the establishment of an 11-member board of directors that is accountable to the president, responsible for overall VHA governance, and has decision-making authority to direct the transformation process and set long-term strategy. The board should be structured based on the following key elements:
- **Qualifications:** Members should be selected to achieve collectively broad experience, expertise, and leadership, including experience in senior management of a large, private, integrated health care system; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans’ representation.
- **Terms:** Board members should serve staggered terms of up to 7 years, with the board members electing a chair and vice-chair from among the membership for 3-year terms and with the term of the Secretary to overlap with the term of the Secretary’s successor.
- **Personnel Matters:** Compensation should be sufficient to attract senior, recognized leaders and experts; members might serve full- or part-time, and the time commitment of the chairperson, at least, would be substantial.
- **Funding:** Congress would provide a specific budget for the operation of the board as a separate account within the VA’s appropriations.
- **Relationship to USH:** The board would provide the president its recommendation for an USH; the president would appoint an USH to a 5-year term; the board would be empowered to reappoint the USH to a second 5-year term.

- Staff: The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the USH.
- Powers: The board would have the power to do the following:
  - Direct and exercise decision-making authority regarding the transformation process
  - Establish priorities, milestones, and timelines for the transition process

[NOTE: If the concept of a board is not implemented, is the Commission providing fall back milestones, particularly for the items capable of immediate fixes?]

  - Review and approve major new initiatives; major operational and organizational plans (including plans regarding real property management and disposal); strategic and business plans; and goals and metrics relative to established priorities
  - Review, approve, and/or amend VHA's budget request, and independently to assess and comment on pertinent elements of the president's budget, as deemed appropriate
- Reporting: The board would report annually to the president and Congress on VHA's progress toward transformation, and after year-5, would report biannually.

## Implementation

### *Legislative Changes*

- Amend 38 U.S.C., Chapter 3 to establish a VHA board of directors.
- Amend 38 U.S.C. § 305— which currently provides in subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred— as follows:
  - Repeal subsection (c) of that section.
  - Provide instead for the board to recommend an USH candidate.
  - Provide for the president to appoint the USH to a 5-year term of office.
  - Authorize the board to reappoint the USH to a second 5-year term.

### *VA Administrative Changes*

- None required.

### *Other Departments and Agencies*

- None required.

## 2. Develop a focused, clear, benchmarked plan to transform VHA culture with full leadership engagement. [DRAFT]

### Conclusions

VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission at all levels of the organization (VA, VHACO, VISN, VAMC, and CBOC). Through guiding messages, support from leaders, coaching, training, and tools, leaders and supervisors must model desired behaviors and discourage unhelpful ones. Simultaneously, identifying and sharing best practices, demanding improvement, and encouraging innovation must be modeled.

VHA needs to create and publicize standards to establish uniform expectations across the organization and create a single organizational culture. To embed expectations, the USH and other senior leaders need to model and reinforce behaviors to be integrated into leadership assessment tools (e.g., a 360 evaluation), performance evaluation frameworks, and coaching guides. Thus, the plan should also include the development of tools, guidelines, and operating procedures to support leaders in developing and deploying this new skill set.

Top executives and leaders must use their authority to affect the climate and culture in their organization and commit to a change process plan. Leaders must understand the role they play in the change process to inspire their teams to make change. VA and VHA top executives, national program offices, and fellow leaders, with outside experts as appropriate, must provide training, incentives, support, feedback, coaching, and, when needed, admonishment to support cultural transformation. Rewards and recognition (nonmonetary) should liberally acknowledge leaders and staff who embody the best actions that support positive organizational culture. At the same time, leaders and staff at all levels must be held accountable with recognition of when an employee needs coaching or retraining, or progressive levels of disciplinary action if they fail to meet expectations.

To create a clear focus and accountability for transformation, VHA must establish a cross functional executive team to oversee the selection of one leadership competency model and develop an implementation plan. VHA should collectively be charged with examining the current models, past resource investments and resulting tools and material, and evidence for success of the models. The executive team must include the leaders from existing teams such as leaders developing leaders, patient safety/just culture, National Center for Organizational Development, ethics, patient-centered care and cultural transformation, health care talent management). Field experts should lead the new team but engage and include relevant stakeholders to ensure broader acceptance and support for the final model. The team should create an initial design and be responsible for executing it and tracking progress. The executive team responsible for this reprogramming would report directly to the USH on this effort.

The executive team should choose a single, coherent benchmark concept for cultural transformation and staff engagement that is consistent with the new leadership competency model for VHA. It should then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution to put forward a single strategic plan. Localized efforts would then be abandoned. The USH and the executive team

should present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed, with the result that separate local models will be terminated.

The plan also will establish and clearly articulate job performance actions, incorporated into the hiring process to enable appropriate hires and into performance evaluations and individual development plans, reinforced through rewards and sanctions.

### **Enabling Requirements**

VHA must create integrated and sustainable cultural transformation by aligning programs and activities around a single, benchmarked concept.

- VHA should establish a cross-functional senior executive team reporting directly to the USH with long-term responsibility for creating, executing, and tracking the cultural transformation.
- VHA should align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA should align front-line staff in support of the cultural transformation strategy. Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.
- VHA should require standards and a strategy for execution of the cultural transformation of every program office and facility and these efforts must be fully funded.
- VHA should develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve.
- VHA should establish a transformation office which (among other responsibilities) tracks progress of this transformation and reports on it to VHA new governance board and the USH. (See Recommendation #X, page X. governance)

### **Implementation**

#### **Legislative Change**

- None required.

#### **VA Administrative Changes**

- Assess cultural transformation models and decide on a single model, create an execution strategy for cultural transformation, and develop a communication strategy and materials and release.
- Establish a subcommittee under the executive team to drive leadership transformation; establish leadership standards for behaviors and actions; publicize the standard; develop

assessment tools; provide coaching to the standards; and collect standards, training, support materials into a living curriculum for leaders.

- Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.
- Establish a subcommittee to transform staff; establish behavioral expectations for staff; develop hiring tools against the staff standard; and establish expectations (in policy) for use of standard for IDP, performance reviews, advancement in grade/promotions.
- Establish execution policy, assign responsibility for metric development, develop and test metrics, deploy metrics, and identify outliers and provide them intervention.

***Other Department and Agency Administrative Changes***

- None Required.

### **3. Develop a leadership-succession system based on a benchmarked health care competency model for recruitment, development, and advancement within the leadership pipeline. [DRAFT]**

#### **Conclusions**

VHA leaders should give sustained attention to recruitment, retention, development, and advancement. Without substantial changes, high-potential staff will continue to have difficulty understanding their career trajectory. Absent a single competency model, executive positions will continue to be filled without a uniform standard against which applicants are measured. Coordinated training is critical to developing tomorrow's leaders.

#### **Executive Commitment**

The USH and other top VHA executives should prioritize leadership management, development, recruitment, and diversity. VA should establish operational plans and accountability mechanisms to achieve critical leadership management goals. VHA leaders should themselves model leadership competencies and develop subordinate leaders.

#### **Leadership Model**

VHA needs to adopt a single health care competency model that mirrors private-sector standards. The model should embrace leading through ethics and creating a strong organizational culture. Key career tracks, such as VISN director, facility director, and VHACO program executive should be clearly delineated in the competency model, with a career path that identifies the requisite competencies for moving to a higher position.

#### **Training and Assessment**

VHA should develop assessment tools based on the competency model, including 360, 180, self-assessment, and a supervisory review process. Leaders and developing leaders should be required to use at least one of the assessments each year to identify their training and development needs. Assessment findings should form the basis for an individual development plan (IDP) for each leader or developing leader.

Training should be mapped to the competency model career track, with gaps identified and filled with commercially available or, where needed, internally developed training. VHA should look for opportunities to partner with DoD and the private sector to provide joint training and development opportunities for military and veteran health care issues.

VHA should give consideration to establishing a master's degree-level training program, based on the benchmarked competency model, to develop the health care management skills that physician-executives require to lead a medical facility. Graduates of this program would be candidates for recruitment into the VHA leadership pipeline, with a pay-back commitment to VHA for participating.

Since experiential learning opportunities and formal coaching are critical to executive learning, it would be valuable to establish individual and group coaching standards and programs for developing and new leaders. One idea would be to establish a program to pair senior leaders with national health care leaders, as well as provide opportunities for developing leaders to

rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. Similar rotations from the private sector into VHA could be developed with partner-institutions to develop private-sector competencies to care for veterans.

### *Apply the Leadership Model*

With the leadership development program activated, VHA should apply the adopted competency model in hiring decisions for executive career field positions. Internal candidates should demonstrate mastery of the competencies before qualifying to apply for a position; VHA should identify and recruit external experts with the competencies VHA needs.

VHA should require competency assessments and IDPs for all leaders to identify gaps in any competency. Completion of IDP development opportunities should be available and then required for advancement in grade or promotion to higher position.

VHA should manage a leadership-candidate pool, derived from annual ratings and leadership development program graduates, by identifying and tracking all high-potential individuals. Supervisors and executive leaders should provide ongoing coaching to this pool of developing leaders. VHA should identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Candidates who agree to be in this pool could enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level field positions (VISN director, facility director, VHACO chief officer), it would be helpful to have a pool of approved or precertified candidates in addition to other candidates who may apply.

To expand the perspectives and management experience in its leadership pipeline, VHA should develop strategies to recruit diverse candidates at critical midcareer transition points. VHA could develop midcareer entry points for military and private-sector candidates, using temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competency standards have been met. Such opportunities can, wherever practicable, be developed collaboratively with DoD to establish legal and policy requirements.

### *Stabilize Leadership*

VHA should immediately stabilize its leadership ranks by authorizing VAMC and VISN director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA can also add flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN CMO, assistant nurse executive, deputy chief officer). These individuals, a pool of potential leaders, also could cross fill positions.

### **Enabling Requirements**

- VHA should make the leadership system a top priority for funding, strategic planning, and investment of time and attention.
- VHA should adopt and implement a comprehensive system for leadership development and management.

- VHA should fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- VHA should aggressively manage leadership recruitment, retention, development, and advancement using its new leadership competency model, which should be used to qualify all hires and promotions.
- VHA should establish a formal on-boarding process and curriculum for leaders at all levels that reinforces the leadership competency model.
- VHA should take immediate steps to stabilize the continuity of leadership.

## Implementation

### *Legislative Changes*

- Establish VA-specific veterans' preference for recruitment and retention.
- Establish an authority based on the model of the Intergovernment Personnel Act for providing individuals from the private-sector who have needed expertise with time-limited positions in VHA. (This could be done as a pilot program with a report back to Congress before making the authority permanent.)

### *VA Administrative Changes*

- Establish a competency model in regulation to include a requirement for use of the competency model in hiring, promotion, development opportunities, discipline, and veterans' preference.
- Establish how VHA will apply veterans' preference to executive hiring.
- Extend the length of the period of an authorized detail for VMAC and VISN director positions and allow the detailee to compete for the position.
- Adopt the VHA leadership management goal and establish an operational plan and accountability mechanisms for meeting these goals.
- Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets. Submit the leadership management goal to VA for inclusion in the budget submission for 2018.
- Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior. Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values, and expectations for ethical behavior.
- Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.
- Create functional statements for all key positions based on the competency model. Establish a process for certifying internal candidates for advancement to the next

position. Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.

- Create career tracks for key positions based on this new competency model.
- Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.
- Establish an indefinite delivery/indefinite quantity (IDIQ), PBA, or similar contracts for executive recruitment. Establish IDP requirements in policy for all ECF, SES, and SES-equivalent employees and a plan for developing and managing the candidate pool.
- Convene a group to review ACHE and the National Center for Health Care Executives to develop a benchmarked model that meets the needs of health care executives in VHA.
- Assess existing training against the model and identify and remove gaps. Assess opportunities to share leadership training with DoD. Develop and fund face-to-face training to fulfill competencies for critical career positions. Develop a master's degree-level training program for clinical leaders in partnership with academic medicine.
- Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations. Create an experiential learning program to parallel the competency model, to include a coaching program.
- Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).
- Extend authority for length of details and ability to compete for detail position.  
(Regulation or policy? Look up)
- Establish and fund assistant-level positions in all key career development tracks.

***Other Department and Agency Administrative Changes***

- None required.

**4. Transform organizational structures and management processes to maintain consistency with national policy and standards, promote decision-making at the lowest level of the organization, eliminate waste and redundancy, promote innovation, and foster the spread of best practices.**

**[DRAFT]**

**Conclusions**

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign [its] operating model to create clarity for decision-making authority, prioritization, and long-term support.” Additionally, VHA should take a systems approach to reorient its leadership operations.

Transformation of VHA will require recruiting new expertise, making advancement decisions based on new competencies, reinforcing competencies through recognition and performance assessment, and developing a new skill set in current staff through training and coaching. This skill set includes having a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders, demonstrated skills in coaching, staff development and training, certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined, and where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can align functions to achieve patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important patient outcomes rather than aligned in professional silos.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to make decisions rather than relying on bureaucratic paper-based processes as a means of negotiation. VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition, recruitment, and account reconciliation to prevent staff at each program office from needing to perform these complex activities. The net savings resulting from this reorganization should be reinvested in the transformation process.

VISNs must also examine the skills needed to improve services and share best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify problems and emerging issues that need to be raised to VHACO for help in clearing barriers to effective operations. VISNs should define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation. They should train and coach staff to develop these competencies. The USH should establish a required staffing ratio for VISN offices and eliminate excess staff.

Under a transformed operating model, medical center directors should control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. Specific-purpose funds must no longer be used to direct obligations at facilities. To support these changes and create transparency, medical centers should be accountable for their expenditures by ensuring accurate, complete, and timely cost accounting, which should be supported by an effective financial management data systems and fully trained staff and leadership who understand how to use such a system.

The USH should establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. This office should oversee transformation and incubate new initiatives with the goal of incorporating these programs into regular work of other program offices. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

Finally, as part of cultural change within the leadership system, the USH, VISN directors, and program office leaders should promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The USH should model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

To create an effective leadership system, VHACO should restructure and reorient its program as described below:

- Use fact-based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements.
- Establish feedback mechanisms to incorporate system learning into policy development and operational guidance.
- Establish communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals.
- Support effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices.
- Create analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities.

#### **Enabling Requirements**

- The USH must redesign VHACO to create high performing support functions that serve VISNs and facilities in their delivery of patient driven care. This redesign includes the following:
- The USH must clarify and specifically define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, pushing decision making down to the lowest executive level and ensuring policies, budget, and tools support this change.
- The USH must establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- To accomplish this transition and manage the large-scale changes outlined throughout this report, VHACO should establish a transition office, reporting to the USH with broad authority and a supporting budget to accomplish the change.
  - The office has responsibility for new initiatives and crisis response efforts with a long term goal of establishing long term approaches that become the responsibility of permanent program offices.
  - Establish an initial appointment term of seven years with the option for two additional re-appointments of four years each. This tenure must be paired with a longer initial probationary period of two years to ensure high quality, effective leadership in this position over the long term.
  - The transition office must acquire expertise in business process engineering.
  - The transition office must develop and publish an operational plan to accomplish transformation.

## Implementation

### Legislative Changes

- None required.

### VA Administrative Changes

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. (see org chart, figure xx) Eliminate the duplication of functions between VHA and VA by closing VHA offices. Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.
- Undertake a reduction-in-force (RIF) in VHACO that promotes organizational flattening and efficiency in communication and decision-making. Prepare an initial RIF for offices eliminated.
- Engage the VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.

## STAFF PREDECISIONAL WORKING DRAFT

- Each program office in collaboration with the VERC or other transformation resources identifies areas of “stop work” with staffing and budget savings.
- Publish clear roles, responsibilities and expectations that apply to all VHACO offices.
- Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.
- Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.
- Modify in-service training and implement in on-boarding process for new VHACO employees.
- Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.
- Draft basic competencies for VHACO program staff (e.g. customer service, quality improvement, coaching, effective communication, change leadership, data analytics).
- Require the basic competencies in functional statements as a basis for hiring and promotion.
- Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.

### ***Other Department and Agency Administrative Changes***

- None required.

**5. Streamline and focus performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a workforce performance management system for health care leaders in VHA that is distinct from an operational performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies. [DRAFT]**

**Conclusions**

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.

The Commission generally agrees with this approach to performance measurement. VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement outside VHA.

VHA requires a cohesive, integrated performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes accountability to key organizational outcomes but also assesses organizational and professional objectives. A new performance management system must be free of OPM standards and instead be benchmarked to the private sector and consistent with the new leadership competency model (see [Recommendation #3, page X](#)). Congress provided DoD with the flexibility to establish such independent standards for the Commanders of Military Treatment Facilities and should consider doing the same for VHA. This new performance assessment model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with past practice and current perceptions of rating scales, it would be helpful to establish a new rating scale for the performance management system, then conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must include establishing clear and meaningful written performance requirements for subordinates under a beneficial system. Raters provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The USH must

clearly communicate what is required of raters and model this behavior. Ratings should distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings where the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching, or if justified, sanctioned. To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the continuous performance assessments they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to supervisors. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers for further development.

## Enabling Requirements

### *Performance Measurement*

- VHA must continue to streamline organizational performance metrics, emphasize strategic alignment, meaningful impact, and the use of benchmarked metrics that facilitate direct comparison to the private sector.
- The new office for organizational excellence must work with experts to re-organize their internal structure to align business with field needs and consolidate and eliminate redundant activities.

### *Performance Management System*

- Create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The USH and all secondary raters must hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- Meaningful distinctions in performance are recognized with meaningful awards.

## Implementation

### *Legislative Change*

- Obtain legislative relief from the requirement to use the OPM ECQ system of competencies and ratings (similar to the authority granted by Congress to the MTF commander rating system) and tied to new Title 38 pay authority for health care leaders. [\(See Recommendation #7, page X.\)](#)

### *VA Administrative Changes*

- VHA should create a new performance management system for VHA leaders appropriate for health care executives through all of the following actions: the

transformation office with support from Workforce Management and Consulting should establish a workgroup and engage outside experts to create a new performance management system that is benchmarked to private sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. It should include a new rating scale to be completed in six months.

- Workforce Management and Consulting within a year should develop and conduct training on the new performance management system for all participants to describe the system, rating, process and expectations. Workforce Management and Consulting should establish within the next three months a mechanism to capture performance assessment outcomes and track and manage high potential staff. Workforce Management and Consulting should establish a project plan to deliver annual guidance to field and VHACO leaders at least a month in advance of the start of each new fiscal year.
- Workforce Management and Consulting should provide training to raters on the application of the new performance management systems and expectations for the ratings process within a year. Workforce Management and Consulting within three months thereafter should require raters to establish plans for subordinates that are timely and meaningful, and track and provide feedback on meeting these expectations.
- Workforce Management and Consulting should establish an oversight and feedback process in the next year to examine raters performance on these expectations and incorporate this into the raters performance evaluation; and supervisors within the next year should provide coaching to rates and focused reviews of their rating profiles to ensure meaningful distinctions in ratings.

***Other Department and Agency Administrative Changes***

- None.

## **6. Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve a high performing health care system.**

**[DRAFT]**

### **Conclusions**

Significant deficiencies in human capital management still remain. The funding mechanism to support human capital management functions at the department level does not support long range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted. The reporting structure does not allow HRA to hold human capital management staff accountable for effective service delivery. Investment in human capital management information technology systems has been inadequate for decades.

Top leadership, including the secretary, deputy secretary and USH should make the transformation of human resources a top priority by investing their personal time in human capital management transformation, reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem solving sessions with human capital management leaders to refine and advance transformation efforts. They should demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The USH should hire an executive to lead the human capital management function who has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and should make this individual part of the executive leadership team on par with other key functions like finance and clinical operations.

The secretary, deputy secretary, and USH should engage subordinate leaders in the transformation process by ensuring the needs of these leaders have been elicited to inform the transformation solutions, that subordinate leaders are assigned specific responsibilities under the transformation plan, and that they are held accountable by the USH for outcomes. The secretary, deputy secretary, and USH should also ensure that the human capital management transformation and ongoing human capital management function is adequately resourced to be successful.

VA HRA should engage change management experts to undertake a review of its business processes, management structures, funding, and technology needs in human capital management to create a transformation agenda and human capital management plan. The plan should address all of the following issues:

- Consistency with benchmark standards of private sector health care systems
- Key organizational structures and roles and responsibilities of VA and VHA in human capital management are clearly defined and consistent with benchmark organizations

- Effective support by human capital management to fully meets the needs of managers and staff for the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline)
- Federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability exist to provide meaningful, timely data to manage staffing, performance tracking, and accountability
- Meaningful performance metrics and risk management indicators are established for human capital management
- Funding and staffing human capital functions meet private sector benchmark standards for health care
- The knowledge, skills, and ability required of human capital management professionals at each grade and within each series is defined and a requirement to assess current staff, new hires, and promotions against this standard is instituted, including procedures for dismissal.

Once completed this analysis and draft plan must be shared widely within the department to gain feedback and it must be shared with OPM, OMB and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the secretary must mandate.

HRA should develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the progressive discipline process. All managers, supervisors, frontline leaders, and human capital management professionals should complete the training; and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA should develop HR staff members to be effective coaches, so they can provide the coaching and support managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VA supervisors and managers should be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VA should have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016. The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VA.

**Enabling Requirements**

- VA and VHA leaders must make transformation of Human Capital management a priority with adequate attention, funding and continuity of vision.
- VA must realign HR functions and processes to be consistent with best practice standards of high performing health care systems.
- VA should develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 hybrid, Title 38 7306, and SES).

**Legislative Changes**

- None required.

**VA Administrative Changes**

- HRA, with OIT's assistance, should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability. This plan should be shared with OMB and Congress for funding consideration.
- Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.
- Establish meaningful measures and risk indicators for VA human capital management
- Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan

**Other Departments and Agencies**

- None required.

**7. Create a simple-to-administer alternative personnel system, in law and regulation, that 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. [DRAFT]**

**Conclusions**

A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organizations.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job.
- Allow flexibility in the processes used to hire staff including direct hiring when needed, e.g., CV-only applications without screening by delegated examining units, multiple hiring from open certificates, etc.
- Support career planning and professional development through the application competency models and training specific for health care as part of position management.
- Support flow of staff between VHA Central Office (VHACO) and the field. (If VHACO and the field have different authorities this flow would be impeded; also, currently most VHACO offices have field-based staff who are managed by field-based HR offices.)
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals.
- Allow development and training of the HR workforce in VHA to focus on Title 38.
- Reduce competition within government where shortages of HR professionals across the board create competition for Title 5 HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff. Sick leave, vacation pay, pay equity, awards and bonuses, and compensatory time off would be made equitable. Currently, staff in the same position under different authorities have different time and leave policies and benefits applied to them.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and

ensure that the new system is built to be compatible with the private-sector and support a high performance health care system.

### **Enabling Requirements**

Create a modern human capital management system that serves the needs of employees, managers, leaders, and veterans and promotes VHA integration with private-sector health care. To accomplish this, the following requirements must be implemented:

- Congress should create a new alternative personnel system under Title 38 authority to simplify human capital management in VHA, create more fairness for employees, and improve flexibility to respond to market conditions.
- VHA should work with union partners, employees, and management to write and implement regulations for the new alternative personnel system that do all of the following:
  - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
  - Continues to promote veteran preferences and hiring.
  - Embodies merit system principles (merit based, nonpartisan, non-discrimination, due process) through simplified, sensible processes that work for managers and employees.
  - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards and processes.
  - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
  - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
  - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
  - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
  - Grandfathers current employees with respect to pay and benefits.
- VHA should ensure that retention and advancement programs meet the needs of employees and the enterprise.
- VHA should ensure that all positions, to include human resource management staff, are adequately trained (including on-the-job training if necessary) to fulfill duties.

## Implementation

### *Legislative Changes*

- Create an alternative personnel system for all VHA employees under Title 38 that promotes a single human capital management approach in VHA, creates fairness for employees, is simple to administer, and is consistent with best practices of private-sector health care organizations. (See Appendix E, Summary of Legislative Actions.)
- Update veterans' preferences to ensure that training and experience are a component of the selection process and that former employees fired from any federal position are not eligible for preference status.
- Update student loan reimbursement limits to be competitive with state programs and establish a median to use in states with no loan repayment program. These amounts should be considered a maximum, but local recruitment conditions should determine if a lower amount can be used to meet recruitment and retention goals.
- Allow dual compensation for health care professionals, health care administrators, and other experts in the management and operations of a health care system, allowing reemployment without salary offset.

### *VA Administrative Changes*

- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and outsource the process as much as practicable through a national indefinite delivery/indefinite quantity (IDIQ) contract or similar vehicle that all facilities can draw upon.
- Biannually release market pay information to the field for all job categories using commercially available data and information.

### *Other Department and Agency Administrative Changes*

- OPM should continue to oversee and administer benefits for VHA but must not impose any other conditions or requirements on the management of the new alternative personnel system. This includes no limitations on pay, performance awards, or performance and disciplinary processes other than those imposed by the new Title 38 legislation.
- VHA employees should still have access to the merit system protection board appeal process for terminations, but the rules used to adjudicate each case must be based on

VHA's new employment rules promulgated under regulations for the new alternative personnel system.

## 8. Develop fully integrated care networks of VHA and community care providers through which veterans receive coordinated medical care. [DRAFT]

### Conclusions

#### *Consolidation of Authorities to Support Development of Provider Networks*

Establishing a single statutory authority to replace conflicting care-contracting requirements is a necessary precondition to VHA's establishment of integrated care networks. Congress should establish a single statutory framework that enables VHA to create provider networks and replace current contract-care authorities. Consolidation should bring the salient features of VHA's existing purchased-care programs – the traditional program, the PC3 program, the Access Received Closer To Home (Project ARCH) pilot, and the Veterans Choice Program – into a single system-wide program. That authority must, in turn, support the requirements inherent in establishing effective provider networks, and the goals of doing so – enhancing access, choice, quality, and veterans' well-being.

#### *Budget Management by Local Authority*

VHA facility directors, responsible for all aspects of veterans' care delivery and medical center operation and maintenance, must also manage separate budgets in carrying out those responsibilities. Funds are not fungible across VHA's different budget accounts under which monies are available only for specified purposes – medical care, medical support and compliance, and some nonrecurring maintenance. Meetings with facility directors have underscored the importance of providing them the basic tools to meet veterans' health care needs.

Establishing integrated care networks should foster provision of relatively seamless care. In hindsight, the establishment of a separate budget account for the Choice Program may have frustrated that objective. Because VACAA allocated funds to a special, restricted-use choice account, relatively low utilization under the Choice Program resulted in a surplus in FY 2015 that could not be used to provide community-based care under other authorities. In response to continuing access challenges, Congress enacted legislation that authorizes VA to use \$3.348 billion from its Veterans Choice Program to pay for non-VA care for the remainder of this fiscal year.

#### *Provide VHA with Budget Flexibility*

To facilitate establishing seamless networks of care that integrate VA-furnished services with those provided in the community, Congress should eliminate the use of a separate appropriation account available only for funding services provided in the community. Facilities and VISNs need flexibility to manage local funds to meet their multiple operational requirements. Maintaining separate accounts – one solely for contract care and another for general care-delivery – would compound the challenges of establishing and operating provider networks.

Should Congress provide VHA such budgetary flexibility, VHA would need to develop capacity to provide detailed cost accounting and reporting of its expenditures on an ongoing basis. Developing that capacity will require a major IT investment to modernize and integrate VHA's financial accounting systems, including VHA's financial management system (FMS), integrated funds distribution, control point activity, accounting, and procurement (IFCAP)

system, and fee basis claims system (FBCS). VA has started this process, and must successfully complete it.

### **Mitigating Risk**

A clear and comprehensive strategy for providing integrated care networks must take account of and mitigate the limitations, unavoidable barriers, and potential risks in this approach. It must account for variability among markets and regions with respect to availability of needed services and circumstances in which contracting is not a feasible option. Currently, contract care will only overcome geographic access barriers for certain types of services. Veterans who live far from a VA medical facility may have good geographic access to non-VA community hospitals, emergency care, and primary care physicians, but poor access to hospitals and physicians that provide specialized services. Expanding access to non-VA providers in these regions can help most veterans seeking routine and emergency care, but may have limited benefit for veterans who need access to advanced and specialized care. Markedly more convenient access to care over the long term might encourage more veterans to seek VA care, potentially straining the capacity of provider networks. Planning must account for variability and limitations. VHA reliance on contracting could, in some instances, have unintended consequences for already underserved communities and veterans who rely on Medicare and may not be eligible for VA care. In such instances, VHA reliance on contracting could induce providers to forego participation in Medicare or simply close their practice to new Medicare patients, veterans among them, and elect to join a VHA network instead. Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

### **Enabling Requirements:**

- Congress should provide VHA clear authority to develop fully-integrated provider networks to foster and guide a fundamental transformation of care-delivery for veterans and to better align the demand for VHA care with the system's capacity to deliver care.
- Congress should eliminate the use of a separate appropriation account available only for funding services provided in the community and should instead permit VHA to use medical care funding to cover the costs of direct provision of services as well as purchased care in order to facilitate establishing seamless networks of care that integrate VA-furnished services with those provided in the community.
- VHA should follow sound program management when planning and implementing integrated care networks. Purchased care activities require improved program management, with responsibilities assigned to the appropriate level of VHA's administrative hierarchy. VHA leadership should issue clear policy and procedural requirements while facilitating appropriate flexibility in the field at the local level. VHA must ensure that data are collected and managed at the appropriate level on such items as cost-per-patient and episode-of-care, market supply and demand, quality, outcomes, and other aspects of purchased care performance and processes. A stronger base of data and analysis could not only help improve the monitoring of purchased-care processes, but veterans' outcomes.
- VHA should provide adequate incentives for providers. To help ensure sufficient provider participation, careful attention should be given to streamlining business

processes and contractual requirements such as credentialing or medical record documentation. An automated payment system must be employed to provide timely and accurate payment.

- VHA should standardize requirements for community providers. To provide oversight and ensure veterans receive quality health care in the community, contracts with non-VA providers should include requirements for data-sharing benchmarked to private-sector or CMS requirements, routine quality-of-care reporting, and collaborative coordination of care. Contracts should set expectations regarding cultural competency (to include military cultural competency) as an element of quality. Contracts should also make explicit how non-VA providers will communicate and coordinate with VHA, particularly for patients with complex medical and behavioral health conditions.

## Implementation

### *Legislative Changes*

- Congress should work with VA to develop legislation that would provide the needed framework to establish integrated care networks (including repeal of inconsistent provisions of law), and should enact such legislation.
- Congress should ensure that the VA/HUD appropriations act provides that VA medical care funds are available to cover both direct provision of services as well as purchased care in order to permit the administration of seamless networks of care that integrate VA-furnished services with those provided in the community

### *VA Administrative Changes*

- VHA should establish the administrative, contracting, managerial, IT, and cost-accounting infrastructure needed to support all aspects of the development and operation of integrated networks of care.

## 9. Identify emerging problems with access and continue to develop clinically meaningful benchmarks and standards that reflect the many dimensions of access. [DRAFT]

### Conclusions

Despite improvement efforts, problems with access continue. National Public Radio reported on VHA clinics that have stopped accepting new patients and resorted to referring new patients' care elsewhere. VHA is not turning these veterans away, but refers them to other more distant VHA care sites or to the Choice Program. This sort of action demonstrates that the system is still struggling to meet demand.

Mental health is also an ongoing challenge. Despite continuing to increase staffing, VA states the demand for mental health care is growing exponentially and admits that more staffing is needed to keep pace with the increase in encounters. Mental health providers' productivity is higher for VHA providers than for those in other systems, yet the need is still outpacing VHA's ability to meet it.

Even with improvement efforts underway, growing demand for services will continue to make access a challenge for the foreseeable future. VHA must continue to develop clinically meaningful access benchmarks and standards that incorporate measures of timeliness, patient satisfaction, and geographic proximity. VHA must be transparent in sharing its challenges with meeting veterans' needs to ensure that Congress provides adequate funding for meeting these needs.

VHA's access standards and measures, though lacking in many regards, are not the root cause of its access shortcomings; it is the system in which they exist that is flawed. VHA measures and standards must be strengthened to accurately measure performance and enhance data management tools that support sound operational decision making.

VHA should develop dynamic, multidimensional access standards. Access standards should be dynamic so that VHA can be responsive to the needs of the changing veteran population and changing models of health care delivery, including telehealth. Access standards should be multi-dimensional to better meet the needs of patients. The dimensions of the access standards should include both systems-level and patient-level outcomes. Access standards for other dimensions, such as cultural access, should also be developed and used in performance monitoring and improvement. Access performance metrics should be sensitive to patient needs and dynamic to evolving perspectives of access. Incorporation of patient perception of access should be considered as a potential measure.

To enable the development of dynamic, multidimensional access standards, VHA should prioritize and adequately invest in health services research to advance access standards and improvement interventions research. More evidence and research is needed on ways to improve access and access standards, with a focus on outcomes. Future research should focus on the quality and appropriateness of care and patient-level outcomes, as well as systems-level outcomes. Research should have national relevance and applicability. Additionally, the Rural Policy Research Institute report indicates that health services researchers should refocus on

understanding health care access and designing access measures that help key stakeholders evaluate rural health care policies. VHA should use a systems approach to ensure that its research priorities align with the priorities of the agency.

Understanding that access standards should be dynamic and multidimensional, the eligibility criteria in the Veterans Choice Program adequately addresses the need for access measures sensitive to patient needs because it includes other criteria for qualifying for care in the community and exceptions for the 40-mile rule. A tension exists between access framework complexity and practical application of a standard.

Literature indicates that most distance or time measures are arbitrary and it may be that the 40-mile rule is no different; however, VHA may still be successful in using this access standard for the present time because of its feasibility to implement it along with other qualifying eligibility factors. VHA should continually evaluate the adequacy of its geographic access standards.

### **Enabling Requirements**

- Ensure that VHA has performance measurement and data management systems for sound operational decision making. This should include developing meaningful, multi-dimensional measures, reporting and tracking of data in real time (or as timely as possible), standardization of reporting requirements (including clinical and military cultural competencies), and use of benchmarks.
- VHA should continue to streamline organizational performance metrics emphasizing strategic alignments and meaningful impact. Core performance metrics should be benchmarked against the private sector. Data must be tracked in real time, or as timely a manner as possible. The performance management system for health care leaders in VHA must be distinct from performance measurement.
- VHA should advance the efficacy of access standards and measures through the prioritization and adequate investment in health services research to advance access standards and improve interventions research. This includes a focus on patient-level and system-level outcomes and alignment with national VHA priorities.

### **Legislative Changes**

- None required.

### **VA Administrative Changes**

- None required.

### **Other Department and Agency Administrative Changes**

- None required.

## 10. Identify and address health inequities in subpopulations treated by VHA. [DRAFT]

### Conclusions

#### Cultural Competency

To realize the goal of ensuring access to equitable care for veterans irrespective of geography, gender, race, age, culture or sexual orientation, VHA must require that those caring for veterans have clinical cultural competency – cultural competence is defined as:

*an acknowledgement and incorporation of, on the part of clinicians and healthcare systems, the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.*

Cultural competency includes ensuring cultural access for veterans through the standardization of data collection and reporting for all vulnerable populations (race/ethnicity, sexual orientation, etc.) to understand disparities and encouraging clinical and military cultural competency training. It is especially important as care in the community expands. For veterans receiving care in the community, ensuring cultural competency includes monitoring quality, satisfaction, and health equity implications as well as tracking the state of care and disparities in the vulnerable groups. Additionally, ensuring cultural access to care includes offering military cultural competency training. Training and data accountability are important components of implementing clinical cultural competencies.

#### Telemedicine

As an important component of expanding access and overcoming geographical access barriers, VHA must continue to invest in telemedicine and other innovative care models. In addition to geographical access barriers, improvements in digital access could greatly diminish the temporal and cultural access problems faced by many patients. Telemedicine is vital to expanding access to certain specialty care services. VHA should use an integrated systems approach to ensure operational efficiencies and ensure that the services meet veterans' needs and that veteran and provider acceptability and capabilities exist. This includes adequate training for veterans, providers, and staff. Because VHA must use state-of-the-art technology when providing telehealth, IT management structures that ensure sufficient resources are essential for the success of innovative models of care (see Recommendation #X, page X for discussion on IT management).

#### Enabling Requirements

- VHA should standardize data collection and reporting for including veterans in racial and ethnic populations as well as other minority groups.
- VHA should encourage clinical and military cultural competency training to ensure providers can identify aware of clinically meaningful events in veterans' medical histories and differences in various populations' risk for disease and response to treatments.

- As part of its access strategy, VHA should continue to serve as the vanguard in telehealth initiatives.
- VHA should use an integrated systems approach to manage its connected health portfolio.
- VHA should establish IT management structures to align and support its connected health portfolio.
- VHA should address geographic inequities by continuing to advance telehealth and other technologically enabled initiatives.

## **Implementation**

### ***Legislative Changes***

- None required.

### ***VA Administrative Changes***

- None required.

### ***Other Department and Agency Administrative Changes***

- None required.

## 11. Establish health-equity as a VHA priority. [DRAFT]

### Conclusions

VHA leadership should make health care equity a priority by providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successively achieve its mission and goals, to include providing additional needed funding to support implementation of the Health Equity Action Plan. Additionally VHA leadership should ensure OHE reports to senior VHA leadership.

### Enabling Requirements

- Restore OHE's budget to provide the level of (8 FTE) staffing under which the office operated in March 2013.
- Reinstate OHE within the office of the USH, to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.
- Monitor and evaluate the department's success in implementing the VHA Health Equity Action Plan.
- Appoint clinical health-equity champions at all medical centers and VISNs to support operationalizing health-equity efforts.
- Measure and provide incentives for better health care quality for minority veterans and other vulnerable populations.
- Increase the availability, quality, and use of data to improve the health of minority veteran populations with strong surveillance systems that monitor trends in health and quality of care measures (as well as patient-centered research activities).

### Implementation

#### *Legislative Change*

- None required.

#### *VA Administrative Changes*

- None required.

#### *Other Department and Agency Administrative Changes*

- None Required.

## 12. Modernize VA's IT infrastructure to improve veterans' health and well-being, and provide the foundation needed to support VHA's key business processes. [DRAFT]

### Conclusions

#### *IT Management and Processes*

Health information technology is integral both to modern health care delivery and to successful transformation of the VA health care system. As such, the budget process should bring VA health care IT funding into alignment with medical care funding. That can be accomplished by establishing a line item for health item IT within the Department's IT appropriation, and providing for advanced appropriations for that account. In addition to these vital changes in funding VHA IT needs, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act in April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems. VA's IT budget also needs to align with private sector spending rates in order to protect veteran and VHA data. For example, private sector spending on cyber security has doubled in the past few years, to about \$120 billion annually, and estimates suggest a 24% increase in spending this year. In contrast, the federal government, excluding DoD, is spending between \$6 billion and \$7 billion with an 11% annual increase in spending.

Collaboration between OIT and VHA is paramount to ensuring that health IT needs are met. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on making sure needed collaboration occurs and that the IT needs of VA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments. But VHA's extensive IT needs require a VHA CIO with authority over the health IT budget. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the VA CIO and USH to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT strategy. Most systems implementations that place over multiple years and VA must commit to funding system deployments through to their completion.

VA OIT is in the process of replacing PMAS with the veteran-focused integration process (VIP) which focuses on value over documentation, reducing number of required artifacts by 88 percent, and establishes a new way of accounting for project milestones and cost. VIP centralizes project development and modernization under the EPO and is focused on security, delivery and, most importantly, the veteran. As VIP is adopted into VA's system development process, VA should measure the effectiveness of this process and ensure that it results in better outcomes for system users and veterans.

#### *Interoperability*

Interoperability across VA's entire IT enterprise and interoperability of health information among VA, DoD, and community health partners is a prerequisite for veterans and their VA and non-VA providers to be able to access their health care information from any location. The

establishment and expansion of integrated, locally-determined health care delivery networks to provide veterans care where and when they need it requires a unified, modernized health information technology infrastructure, necessitating VA health care data, systems, and services are standardized and integrated.

Implementation of a Digital Health Platform (DHP) will enable VHA's transformation toward more integrated care. It will allow for more effective integration with community partners and the outside health care community by connecting members of a veteran's care team from within and outside VHA. The DHP will create an open, intelligent, accessible platform that benefits national understanding of health, enables veteran care, and informs advanced precision and personalized medicine.

### ***Electronic Health Record***

Given the current complications with the VistA, VA OIT and VHA leadership are in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open source EHR, should be purchased and deployed. The Commission recommends that VA purchase a COTS product for the following reasons:

- Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs. This trend away from home-grown systems to more agile COTS products is also being experienced in the federal IT sector. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.
- VA must consider whether software development and maintenance is one of VA's core competencies. If not, VA should implement a COTS EHR where system development and maintenance is the responsibility of the vendor.
- Given the high costs of developing and maintaining VistA, there is now parity between the cost of upgrading VistA and buying a COTS EHR. If the cost of upgrading VistA is similar to implementing a COTS EHR, then VA should purchase a COTS product.

If VA moves forward with the purchase of a COTS EHR, the agency should consider the following items:

- The COTS EHR needs to be a product that can be optimized for VHA's clinical workflows and clinician usability.
- COTS EHRs can come with high upgrade costs. Epic users spent an additional sum between 40 and 49 percent of the system's initial costs in major and minor upgrades, yet Cerner users spent between 30 and 35 percent and Allscripts users spent between 20 and 22 percent. VHA must factor these costs into its analysis of the overall cost of a COTS implementation.

- VA should require whichever EHR provider it selects to publish its API to create a self-service integration option, rather than forcing VA's community partners to hire the EHR company to do integrations, which creates a bottleneck to move data around.

### ***Enabling Systems and Tools***

VHA has developed and is in the process of a national roll out of VistA Scheduling Enhancements, which provides a vastly improved user interface (i.e., GUI) in addition to the old scheduling tool. The VSE deployment involves a 2-week standard face-to-face training for medical support assistants (MSAs) who will be using the new tool. This rollout is a first step in improving VA's scheduling system. Although the solution of a GUI interface will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic utilization. For instance, VHA's new Healthcare Operations Dashboard shows that more than 55 percent of clinic slots in VHA go unused each day. However when questioned about this data, VHA notes that it is not accurate. The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately to reflect clinician time allocation, then VHA will not have the data it needs to effectively manage the supply of clinic slots.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new medical appointment scheduling system (MASS) in August of 2015. This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders. VA is waiting to move forward with the MASS implementation until a decision is made regarding whether to continue to modernize VistA or purchase a COTS EHR. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities. Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.

VA's financial system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting. VA must align and modernize its financial management system in order to streamline and automate VA's revenue cycle.

### **Enabling Requirements**

#### ***IT Management and Processes***

- With regard to IT funding, Congress should:
  - Fully fund the IT changes needed to support VHA's transformation, including funds that ensure VA infrastructure receives proper maintenance and upgrades in preparation for new and successor technologies.

- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account.
- Fund government-wide IT legislation, such as H.R. 4897: The Information Technology Modernization Act, which provides multiyear funds to modernize outdated federal IT systems.
- The VA CIO should establish an SES-level position of CIO for VHA to manage the health IT budget; be responsible for the planning, prioritization, and implementation of health IT projects; and define and oversee the budget for all new and existing IT systems involving VHA-related business processes.
- VA should complete the national rollout of the veterans-focused integration process (VIP) and measure the effectiveness of VIP by conducting an analysis of the outcomes of system implementations conducted under this new process.
- VA should increase resident health IT expertise within VHA. The majority of VHA's health IT knowledge is currently provided by contractors. As a result, contractors often drive system requirements, development, and outcomes. VA needs to hire more employees with health IT knowledge and experience or train existing IT employees with this knowledge so that they can effectively drive the intended outcomes of system implementations.
- VA should update its current IT procurement processes. Instead making substantial investments of money and time getting procurements through the acquisition process every few years, lengthier contract vehicles allow efficiencies that otherwise go by the wayside. As long as procurements ensure an avenue to onboard emerging technologies in a competitive fashion, such as by awarding contracts to multiple vendors and issuing task orders for vendors to compete on, lengthy contracts have a high-value proposition. As VA moves toward a true Agile approach to system development, these types of contracts will be necessary.

### *Interoperability*

- VA should implement a digital health platform (DHP) that will enable VHA's transformation towards more integrated care.
- Patient consent should be *opt out* instead of *opt in*. Congress should pass a bill that allows veteran records to be shared with trusted partners in an opt-out model that allows the veteran to choose to not allow record sharing by exception.
- Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VA/purchased care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged because only 3 percent of veterans have opted in to allow VA to share their health information. The standard industry policy is to have patients opt out of having their health data shared with their other health care providers.

- In response to this issue, VA approved and submitted Legislative Proposal VHA-10 (10P- 07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with non-VA providers instead of having to opt in. The proposal was approved by the OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee (SVAC) staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the Choice Program. VA's Office of Congressional and Legislative Affairs (OCLA) responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.
- Congress should pass a bill that allows veteran records be shared with trusted partners in an opt-out model that allows veterans to choose to not allow record sharing by exception.
- The Office of the National Coordinator for Health IT should establish and implement a national unique patient identifier and the president should mandate that all U.S. health providers implement this identifier within an established deadline. To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient identifier. This practice is currently not used. VA currently uses a patient's social security number as a unique identifier whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to accurately identify patients. Studies suggest that patient identification error rates range from 7-20 percent. In order for VA to accurately identify patients and their records, a unique identifier is essential. The ONC should establish and implement a national unique patient identifier and the president should mandate that all U.S. health providers implement this identifier within an established deadline.
- VHA should establish clear data sharing standards by accelerating efforts to establish semantic definitions for data elements through the use of standard nomenclatures, terminologies and code sets.
  - Executive Order 13410, signed by President George W. Bush in August of 2006, established a mandate for federal interoperability in stating that as each federal agency "implements, acquires, or upgrades health information technology systems used for the direct exchange of health information between agencies and with non-Federal entities, it shall utilize, where available, health information technology systems and products that meet recognized interoperability standards." Despite this mandate, there are currently no clear, mandatory and enforced standards for health care information in the United States.
  - Lack of clear standards is one of the biggest barriers to interoperability and improved information exchange. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical

record can contain as many as 100,000 different data fields. VHA should accelerate efforts to establish semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. By doing so, VA can ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.

- VA should follow the cybersecurity guidelines and best practices that will be developed by the Department of Health and Human Services, as mandated in the recently enacted Cybersecurity Information Sharing Act.
  - One in three Americans had health care records breached in 2015. Recent hacks of U.S. hospital health care systems through the use of ransomware, a virus that holds systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity as well as needed funding. For data sharing to be secure, only the designated correct parties can have access to patients' data. VA should follow the cybersecurity guidelines and best practices that will be developed by the Department of Health and Human Services, as mandated in the recently enacted Cybersecurity Information Sharing Act.
  - VA should ensure that appropriate, strong, and effective safeguards for electronic health information are in place as interoperability increases and should support greater transparency for veterans regarding the business practices of VA partners that use their data. VA has network security obstacles that impede health information exchange with non-VA providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which are currently handled solely within VHA, so that they can assist in removing the existing impediments to health information exchange.
- VA should follow the National Interoperability Roadmap:
  - The Office of the National Coordinator for Health IT, under the Health and Human Services agency, is responsible for advancing national connectivity and interoperability of health information technology. The ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange so that information can follow a patient where and when it is needed, across organizational, health IT developer and geographic boundaries. The Roadmap, shaped by stakeholder input, lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.
  - The collaborative efforts of stakeholders are crucial to achieving the vision of a learning health system in which individuals are at the center of their care; providers have a seamless ability to securely access and use health information from different sources; an individual's health information is not limited to what is stored in electronic health records (EHRs), but includes information from many different sources and portrays a longitudinal picture of their health, not just episodes of care; and where public health agencies and researchers can rapidly learn, develop, and deliver cutting-edge treatments. VA's plan to expand veteran care to more community providers through the creation of locally-integrated health care networks

requires that VA follow the Roadmap and standards, including the Continuity of Care document to exchange data, which are established by the ONC and followed by the community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and the Digital Health Platform, and has committed VA to following the roadmap.

- VA should implement an application program interface (API) framework that allows secure access to data from core systems and advances interoperability with DoD and community partners.

### **Electronic Health Record**

- VA should purchase and deploy a commercial off-the-shelf (COTS) EHR. In the interim, VA should continue along with planned upgrades to VistA (i.e., VistA 4), including the development of the enterprise health management platform (eHMP).
- VA should establish an electronic health record platform with one logical instance.

### **Enabling Systems and Tools**

- VA should develop a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, and other core VHA business processes. VA should integrate supply chain and financial systems with the electronic health records to provide accurate operational data.
- VA should modernize the VA appointment scheduling system so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans.
  - VA should complete the national rollouts of the VistA Scheduling Enhancements (VSE) and Veteran Appointment Request (VAR) systems and measure the effect of these tools on veteran access and satisfaction.
  - VA should refresh the technology of its telephony system to support scheduling process changes. Some pilot projects that have developed call centers have succeeded, but resources (funding, human capital) and the lack of consistent guidance and prioritization have limited progress across the system.
- VA should focus on automation, integration, and interoperability for billing and claims. VHA initiated its Health Care Payment System (HCPS) as a replacement for its Fee Based Claims System (FBCS) to serve as VHA's centralized claims processing system and to address many existing issues. The system is approximately two-thirds complete; however, further development has been stalled by funding issues. VHA should resolve the HCPS funding issue to ensure that this needed functionality is delivered. An effort similar to HCPS is also necessary for VHA's billing process. There are a number of specific capabilities required for VHA's billing system, such as integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction.

Automation of claims payment is essential to expanding veteran care with community providers.

- VA/VHA should assess the effectiveness of analytical products in driving health and business outcomes and implement an analytics platform that transcends traditional data management. They should identify and recommend improvements needed in the information systems that serve as the sources of the data to improve the reporting capabilities. VA/VHA should track actions taken as a result of the analytical products and quantify how effective those actions were in improving health and business outcomes.
- VA should build the IT infrastructure required to support the community care processes and the creation of high-performing, integrated community health care networks.
  - Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service. VA should automate community care-related workflows as much as possible. Barriers to automation are multifactorial, including confusing eligibility rules governing which veterans may receive care outside VHA, for what conditions in what circumstances and which services may be billed to third party insurers; multiple authorities for purchasing community care – all with different business rules and reimbursement rates; and antiquated financial management information systems that are not standardized to private sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated, poorly trained, experience high turnover and a continuous 20 percent vacancy rate; thus they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation. Standardizing and requiring a 2-week comprehensive training for staff involved in these processes, including didactic and on-the-job elements, will increase employee performance and morale and result in better outcomes for veterans.
  - One result of these issues is that VHA is unable to auto-adjudicate claims via its Fee Basis Claims System (FBCS) and must instead manually review each claim. In comparison, the private sector claim auto-adjudication benchmark is 79 percent. Similarly, in FY15 VHA electronically received only 36 percent of claims for the payment of non-VA/community care, compared to 94 percent in the commercial health care sector in FY14. A paper based claims process such as this increases manual processing and workload and also increases the likelihood for payment errors. A factor contributing to VHA's inability to reduce the error rate is its lack of standardized performance metrics and reporting. Each VA Medical Center has its own version of productivity reports which extrapolate similar data fields (number of pre-authorizations, number of claims paid within 30 days, etc.). Standardization of these reports would allow for comparison across VAMCs and allow leadership to identify low performing facilities that may require additional training. This lack of standardization can also be seen with the 130+ instances of VistA cited for medical supplies. Similar to the Supply Chain Modernization Transformation initiated by the Veterans Engineering Resource Center (VERC), data

sets should be standardized, a data analytics system developed, data should be integrated among various databases, and best practices should be consistently shared among Medical Facilities.

- In order to fully integrate community care, ongoing training must be provided to community care providers. Many of the small providers are not well versed with the various VA business rules; therefore, abiding to them can be quite difficult. This has an adverse effect as an improperly billed claim can result in delay or denial of payment, which can be detrimental to small clinical practices and individual providers. Timely claims payment ensures our community providers are able to continuously provide the services needed by veteran patients that the VHA does not have the capacity to offer. A second element of complete integration is ensuring that all community services are paid within the FBCS system. Expansion of electronic payment should include Community Adult Day Health Care, Community Nursing Home, and Veterans Directed Home Based Care. Attempting to manage various payment mechanisms can be confusing for both VHA revenue cycle staff and for the community providers themselves.

## Implementation

### Legislative Changes

*With respect to funding, Congress should:*

- Fully fund the IT changes needed to support VHA's transformation, including funds that ensure VA infrastructure receives proper maintenance and upgrades in preparation for new and successor technologies;
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account.
- Provide a specific appropriation to fully fund the complete development and deployment of a digital health platform (DHP).
- Fund the implementation of a COTS EHR for VHA.
- Fund government-wide IT legislation, such as H.R. 4897: The Information Technology Modernization Act, which provides multiyear funds to modernize outdated federal IT systems.

*Other Requests:*

- Congress should amend section 7332 of title 38, U.S. Code, to authorize VA to share patient medical records for treatment purposes with trusted partners unless the veteran affirmatively disallows such disclosure.
- Congress should amend the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d, if applicable, to ensure that non-VA providers can share patient medical records with VA unless the veteran affirmatively disallows such disclosure.

## VA Administrative Changes

### *IT Managements and Processes*

- In addition to establishing a VHA CIO, VA should assign a Chief Medical Information Officer (CMIO), Chief Nursing Informatics Officer (CNIO), and Chief Medical Officer (CMO) to assist in making health IT decisions. The VHA CIO should report to the VA CIO and the USH.
- VA should also consider establishing an IT investment review board (ITIRB) composed of VHA stakeholders, including veterans, which has a long-term strategy (e.g. a 5- to 8-year plan) that is focused on assessing the strategic needs and alternatives of VHA's IT investments. The ITIRB could collaborate with the new Enterprise Program Management Office (EPMO) and the VHA CIO to ensure that VHA's IT needs are prioritized in VHA's project portfolio and resources are aligned appropriately to each project.
- The Commissioners support VA OIT's plan to assign a Customer Relationship Managers (CRMs) to each of VA's five regions that will establish a clear and consistent process for collaborating and communicating with field staff and key IT stakeholders. VA should continue to pursue this plan.
- VA should measure the effectiveness of the veteran-focused integration process (VIP) by conducting an analysis of the outcomes of system implementations conducted as part of this new process.
- VA should increase resident health IT expertise within VHA.
- VA should update its current IT procurement processes.

### *Interoperability*

- VHA should accelerate efforts to establish semantic definitions for data elements through the use of standard nomenclatures, terminologies and code sets.
- VA should follow the cybersecurity guidelines and best practices that will be developed by the Department of Health and Human Services, as mandated in the recently enacted Cybersecurity Information Sharing Act.
- VA should follow the ONC's National Interoperability Roadmap.
- VA should implement an application program interface (API) framework that allows secure access to data from core systems and advances interoperability with DoD and community partners.

### *Electronic Health Record*

- VA should purchase and deploy a commercial off-the-shelf (COTS) EHR.
- In the interim, VA should continue along with planned upgrades to VistA (i.e., VistA 4), including the development of the Enterprise Health Management Platform (eHMP).

- VA should establish an electronic health record platform with one logical instance.

*Enabling Systems and Tools*

- VA should develop a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment and other core VHA business processes.
- VA should modernize the VA appointment scheduling system so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans.
  - VA should complete the national rollouts of the VistA Scheduling Enhancements (VSE) and Veteran Appointment Request (VAR) systems and measure the effect of these tools on veteran access and satisfaction.
  - VA should refresh the technology of its telephony system to support scheduling process changes.
- VHA should focus on automation, integration, and interoperability for billing and claims.
- VHA should resolve the HCPS funding issue.
- VA/VHA should assess the effectiveness of analytical products in driving health and business outcomes and implement an analytics platform that transcends traditional data management.
- VA should build the IT infrastructure required to support the community care processes and the creation of high-performing integrated community health care networks.

*Other Departments and Agencies*

*Interoperability*

- The Office of the National Coordinator for Health IT should establish and implement a national unique patient identifier and the president should mandate that all U.S. health providers implement this identifier within an established deadline.

**13. Enhance health care value and staff productivity by ensuring staff has adequate resources and training, utilizing staff to their fullest potential, and expanding use of patient-centered care practices to improve access and quality. [DRAFT]**

**Conclusions**

VHA can improve productivity by hiring additional administrative and medical support team members, so all team members can work at the top of their licenses; by ensuring sufficient space for clinic operations; by speeding its CPRS-driven activities; and by emphasizing the need for complete documentation of care episodes.

As health care industry payment structures evolve to reward value rather than volume, IPUs offer VHA a direction for transformation. Many features of IPUs exist in VHA's long-term rehabilitation programs, including multidisciplinary care, case management, a focus on a particular disease or condition, and use of the hub-and-spoke model.

VHA can enhance health care value and staff productivity by building on the IPU model -- employing it to reorganize care-delivery for health conditions that are systemwide priorities.

VHA has already developed many innovative health care delivery models to ensure the consistency of quality and outcomes throughout its system, including IPUs centered on its expensive and comprehensive, long-term rehabilitation programs and extensive use of case management for patients with complex care needs. VHA should also consider doing the following:

- Expand the use of some specialized PACTs for care in areas such as geriatrics, post-deployment health, and serious mentally illness, for which there may be high demand.
- Identify additional chronic conditions prevalent within an aging veteran population that could serve as the focus of new IPUs, such as diabetes, arthritis, or hypertension.
- Use best practices to expand access and enhance value through disease management, patient education, use of telehealth, phone care and other technologically enabled care, home monitoring and messaging with providers.
- Introduce nurse navigators to assist patient care coordination and facilitate communication among all members of each patient care teams.
- Use additional peer support or community-based health workers to eliminate patients' barriers to care better ensuring health equity and timely access to needed care.
  - VHA should develop policy to ensure these individuals receive training and are adequately supervised. Guidance should also delineate clear responsibilities critical to making peers and community health workers effective in assisting patients.
  - Training should assure that peers or community workers understand and appreciate military service and the difficulties of reintegrating in communities. Recruitment

should be aimed at other veterans and represent the racial, ethnic, or cultural composition of the population served. Peers or workers should be able to communicate effectively in patients' native languages to increase effectiveness.

### **Enabling Requirements**

- Improve health care value by redesigning health care delivery around diseases or conditions that are systemwide priorities.

Understand value by creating informatics systems to identify true costs of care for each patient and identifying desired outcomes for a range of treatment options.

- Use nurse navigators focused on patients with complex conditions to help coordinate care, provide education and to provide counseling and emotional support.
- For the most vulnerable veterans who require the most care resources, extend use of case management and more community peers (already used with behavioral health programs and certain OEF/OIF/OND veterans) focused on to address health inequities in accessing care.
- Extend use of case management within the most vulnerable populations requiring the most resources.
- Enable staff to be more productive by ensuring that they have adequate support and space and training, and are utilized to their fullest potential.

### **Implementation**

#### ***Legislative Changes***

- None required.

#### ***Administrative Changes***

- Manuals, handbooks, and directives regarding clinical program management, human resource management, information resource management, and community care policy and regulation must be amended as appropriate to adapt programs' focus on diseases or conditions.

#### ***Other Departments and Agencies***

- None required.

## **14. Improve clinical workflow by implementing appropriate staffing practices, creating a culture of continuous improvement, ensuring bed levels correspond with demand, and tracking resource distribution in real time. [DRAFT]**

### **Conclusions**

Adopting patient safety as the foundation for change will best support transformation. By centering its efforts on patient safety and quality outcomes, VHA might identify high-level effects of manipulating standards of timeliness, efficiency, effectiveness, equity and patient-centeredness.

VA employees need to be assured that if they follow established protocols they will not be blamed or punished if they report problems, including their patient care mistakes or near misses. Without transparency and rigorous root-cause analysis when adverse events occur, VHA will not be able to improve systems that may lead to additional problems. Patient safety was a priority for the VHA system in from the late 1990s to early in the 21st century, but fear of media scrutiny and Congressional reprisals derided the culture of trust and transparency necessary for employees to come forward with mistakes. VHA leaders responded by moving the organization's patient safety activities lower in the organizational chart, and they continue to be buried beneath organizational layers today.

The Affordable Care Act (ACA) requires nonprofit hospitals to develop triennial Community Health Needs Assessments (CHNAs) to maintain their tax-exempt status. Hospitals identify needs based on the populations they serve with input from many stakeholders. The law requires involvement from public health experts; patients; representatives of low-income, minority, and medically underserved people; and individuals with chronic disabilities. The law further requires an implementation plan for measuring improvement in certain areas of need in a community in which the provider has substantial influence. As a federal health care provider, VHA is not required to develop a CHNA, but not participating puts VHA at risk of being irrelevant to the rest of the local health care community.

The opportunity for VHA to build from successful models is encumbered by limited sharing of best practices despite the numerous repositories and collection sites available. Nationally, challenges exist due to unclear guidance on implementation, occasional flaws in the design of programs, and a lack of VAMC adoption. Locally, scaling seems to be inhibited by limited infrastructure for information-sharing and lack of resources. To address these issues and afford VHA the opportunity to fully leverage institutional strengths, there needs to be a mechanism for improving practices through a combination of targeted national guidance (e.g., streamline veteran-centered care initiatives and mandates) and nationally-supported, local best practice sharing and innovation (e.g., build infrastructure to promote cross-facility sharing of best practices). To progress, the mechanism needs to be widely implemented and sustained.

A successful long-term plan should also include adoption of best practices from the private sector and other government sectors (e.g., the Medicare program, related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels, to reflect regional and local differences in provider supply, veteran needs, and marketplace characteristics, among other factors. VHA needs to

employ better template management, conduct more electronic health record reviews, and encourage provider query responsiveness—i.e., providers' responsiveness to requests for consultation or referrals—through individual performance metrics. Formalizing the process for change in these areas by implementing LEAN practices will provide a vehicle for quality management through continuous process improvement.

To have usable management tools, managers need access to data closer to real time that easily integrates staffing and other resources with patient care activities. In the short term, some kind of interface between databases might make these resources more comprehensible to program managers.

Patient safety and quality should be systemwide priorities for VHA. To address these priorities, VHA needs to improve all information systems to allow integration of personnel resources with patient care activities. VHA also need to assure that data is easily accessible and available in user-friendly formats for management purposes.

VHA needs to address a number of related issues before it can evolve into a modern, efficient health care delivery system, including addressing the following specific problems:

- Ineffective data collection and management drive a lack of transparency in many key aspects of clinical operations, hindering VHA's ability to effectively manage inpatient care.
- VHA resources do not always match veterans' care needs.
- Although best practices are implemented in some contexts, communication and support for implementation at scale appear to be a challenge.

These are substantial barriers to implementation of key reforms VHA supports, including LEAN principles, VHA's transformation into a learning organization, and its closer alliance with local health care delivery networks in initiatives such as MyVA Communities.

### **Enabling Requirements**

- Congress should relieve VA of the de facto moratorium on bed closures imposed by the Millennium Bill. VHA must then have a "stand down" during which medical centers inventory beds and adjust official bed counts to reflect actual capacity.
- VHA should develop a culture to inspire continuous improvement of workflow processes by embracing LEAN Six Sigma.
- VHA's reengineering systems and repositories for best practices should enjoy more visibility within the system. VHA should task the VERCs to assist transformation efforts. Leadership should refer senior managers whose facilities have substantial deficiencies in areas of performance to these resources.
- VHA should develop CHNAs and corresponding improvement plans. As an important part of the public health infrastructure in the communities it serves, it is appropriate for VA medical systems to enhance local efforts to improve population health. Working

with VHA's Office of Policy and Planning in using its Enrollment Health Care Projection Models to determine expected workloads in their markets and submarkets will also enhance VHA facilities' understanding of demand for care and their ability to respond to this demand.

- VHA should use a dashboard with real-time data to improve distribution of resources.
- Facilities should ensure operating bed levels are accurately reported and beds are staffed to meet patients' needs.
- VHA should staff to allow clinicians to perform work appropriate to their level of education and training and endorse full practice authority for advance practice nurses and physicians assistants.
- VHA should use clinic managers to improve resource allocation and ensure appropriate staff training.

## **Implementation**

### ***Legislative Changes***

- Eliminate bed reporting requirements under the Millennium Bill.

### ***VA Administrative Changes***

- Require, as a part of the MyVA Communities process, that VHA participate in its own Community Health Needs Assessment and Implementation Improvement Plan involving various stakeholders and community health care leaders.

### ***Other Department and Agency Administrative Changes***

- None required.

## 15. Transform the management of the medical and surgical supply chain in VHA. [DRAFT]

### Conclusions

In an environment with limited sharing of best practices and transparent, open communications the complicated VHA reporting structures can cause great decline in customer-service quality and effectiveness. In many instances, separate supply chain offices within VA and VHA perform the same functions. The original intent when these organizations were set up was to consolidate and strengthen purchasing power through the establishment of national contracts; however, this growth has created a complicated, bureaucratic system filled with redundancies. These broken processes serve as a precursor for an organization at risk for catastrophic systems failures.

Further support is required to sustain VHA's supply chain growth into a complete clinician-driven sourcing program such as clinician collaboration and input for purchasing of medical supplies. This would further drive the development of procurement standards and life cycle management. Standardizing supply chain processes requires strong physician engagement and education, supported by robust data collection and analysis on case-based usage patterns. VA's fragmented and complex organizational structure, its history of poor collaboration as with physician engagement, and its data systems, are inevitably inadequate to support standardization.

True sustainment cannot be achieved with fragmented information systems that do not communicate. VHA has a long history of either developing or purchasing computer information systems that do not interface with each other. Some examples include the credentialing package VetPro and the Human Resources information systems. Currently, fiscal, supply chain, and clinical informatics systems do not interface, which has previously resulted in some facilities paying as much as 1.3 times the price for the same medical supply and the creation of 130 instances within the VISTA system. Therefore, complete, consistent, and timely support should be provided to the VERC so it does not experience delays in implementing the supply chain modernization initiative.

### Enabling Requirements

- Establish an executive position for medical and surgical supply chain management, a VHA Supply Chain Chief Operating Officer (COO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Create a vertically integrated business unit in VHA reporting to the Supply Chain COO by consolidating and streamlining organizational structures and functions for medical and surgical supply chain management in. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management, which includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.

- Support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative. VERC will require consistent support, especially in the form of funding. Its data standardization project was delayed due to a lack of IT funding for the graphic user interface (GUI) overlay. Due to the five month waiting process, the supply chain modernization initiative had to be extended by six months. It is now scheduled for completion in FY 2017. Other funding delays include the following initiatives: Clinician Driven Sourcing initiative, Workforce Management, and Point of Use.

## Implementation

### *Legislative Changes*

- As recommended elsewhere, VA should request and Congress should consider establishing a new excepted service under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

### *VA Administrative Changes*

- VHA should reconcile the VAARs with the FAR. VA should consolidate the VAARs into one version to align with recent updates to the FAR.
- VHA should provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR regulations as well as a thorough understanding of how they need to be administered.

### *Other Department and Agency Administrative Changes*

- None required.

## **16. Provide VHA the tools required to meet and manage its capital needs.** **[DRAFT]**

### **Conclusions**

#### ***Realignment***

Establishing in law a process for capital asset realignment is vital to transforming and modernizing the VA health care system, and realizing a new vision of health care delivery for veterans. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for both a sound planning process and a reliable mechanism for implementation. Congress should establish that framework because VHA's current authority does not lend itself to effective execution of a capital asset realignment plan.

#### ***Property Repurposing and Divestiture***

VHA needs flexible enhanced-use-leasing authority to enter into long-term arrangements that provide for improving unneeded VHA property for any use that is not incompatible with VA's mission. In situations for which long-term leasing would not be practicable, VHA needs a flexible, streamlined mechanism for divestiture of unneeded property.

#### ***Meeting Need for Clinic Capacity and Other Infrastructure***

Despite the importance of developing a new delivery model under which VA service-delivery is centered on providing core services and unique service capabilities—changes that will have implications for system-rightsizing—VHA will continue to need new and replacement medical facilities.

Congress and VA should work together to find the means to meet VA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic-leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. It should consider an approach in which, for example, it does not design such clinics and its lease payments do not cover all or most of the builder's debt over the life of the lease. In essence, VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, where VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner.

Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

### **Enabling Requirements**

- VA leaders should strengthen the capital asset programs' operation and management, through steps such as better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool.

- VHA should establish a locally-based planning process to provide the foundation for recommendations regarding realignment and capital asset needs. Among the elements to be considered, the process must determine veterans' future need for services, VA and community capabilities for meeting those needs, and which services should be VA-delivered and which should be community-delivered. The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law and opportunities to engage community providers in collaborative partnerships. VHA should analyze its physical infrastructure and its capacity, or alternatives, for providing those services that it would provide directly.
- A VHA board of directors should set criteria for that planning process, ensure the soundness of the decisions that result, and ensure those decisions are implemented.

### **Legislative Changes**

#### *Realignment*

- Congress should enact legislation that establishes a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care. Such legislation would call for the following:
  - VHA would systematically develop a national capital asset realignment plan (under the direction, and subject to the approval, of a VHA board of directors) that would include recommendations for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
  - The plan would identify (a) the criteria used in developing realignment recommendations, (b) the plans for reinvesting (in the pertinent VISN) savings/cost-avoidance resulting from the realignment, (c) the projected care-improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA would retrain and reemploy such displaced employees.
  - In developing the plan, VHA would employ a planning process that is based on criteria approved by the VHA board of directors and that incorporates field-based findings and analyses.
  - An independent commission would be established and charged with reviewing the board's recommendations, and where indicated, proposing changes through a process that would include holding public hearings and making site visits.
  - VHA would implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.

*Property Divestiture*

- Congress should amend pertinent provisions of 38 U.S.C. §§ 8161 et seq. to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Congress should provide a VHA board of directors (*proposed on pages \_\_\_\_*) authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements; (b) allowing VHA to retain the proceeds of any property sale; and (c) a streamlined process to address historic preservation considerations.

## **17. Establish an expert body to develop recommendations for VA care eligibility and benefit design. [SENT 4/29]**

### **Conclusions**

Substantial changes have occurred since Congress last comprehensively examined eligibility for VA care. Those changes merit a reexamination of VA health care eligibility. The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead as calling for it to make recommendations on this fundamental issue of congressional policy. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected-disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

### **Enabling Requirements**

- The president or Congress should consider tasking another body to examine the need, if any, for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria.
- The SECVA should revise VA regulations to provide that service-connected-disabled veterans be afforded priority in access to care, subject only to the priority dictated by clinical care needs.

### **Implementation**

#### ***Legislative Changes***

- None required.

#### ***VA Administrative Changes***

- The SECVA should amend chapter 17 of title 38, Code of Federal Regulations to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

#### ***Other Departments and Agencies***

- None required.

**18. Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.**

**[SENT 4/29]**

**Conclusion**

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination of those. This approach would allow VA to provide meaningful access to treatment without delay to those likely to be granted eligibility. VA should also revise its regulations, at least for health care purposes, by recognizing that the severe punishment of characterizing a person's service as "dishonorable" is not justified where extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct.

**Enabling Requirements**

- VA should revise its regulations to provide tentative eligibility for health care to former service members with an OTH discharge, who, because of the circumstances of their service, are likely to be deemed eligible, and recognize substantial favorable service, or extenuating circumstances that mitigate a finding of disqualifying conduct, for purposes of health care eligibility.

**Implementation**

**Legislative Changes**

- None required.

**VA Administrative Changes**

- VA should amend section 17.34 of title 38, Code of Federal Regulations to provide for tentative eligibility determinations applicable to certain individuals with OTH discharges.
- VA should amend section 3.12(d) of title 38, Code of Federal Regulations to provide for recognition of circumstances that show, for purposes of health care eligibility, that service was not dishonorable.

**Other Departments and Agencies**

- None required.

## 19. Develop pilot programs to test the feasibility of enabling veterans' spouses and higher-income veterans to obtain VA care through their health plans. [DRAFT]

**Conclusion 1:** VHA maintains a robust non-veteran workload under existing authorities.

### *Expanding Access to VHA Services for Certain Nonveterans*

Increasing access to VHA services to nonveterans is an intuitively attractive means of:

- Bringing in new sources of revenue to contribute to funding for veterans health care
- Raising patient volume to acceptable thresholds in “mission critical” veterans programs or diversifying case mix (note: these are currently acceptable reasons for expanding sharing agreements).
- Maximizing the return on investment of federal tax payers’ funds by improved coordinated federal resources to optimize access to health care for veterans and other federal program beneficiaries
- Optimizing productivity and cost-effectiveness by ensuring that sufficient patient volumes make use of staffed beds, clinics, equipment and clinical provider availability (bringing down per patient costs so long as there is not a need to add capacity).
- Enhancing participation in the local health care community.

Appendix \_\_\_ details a proposal to allow nonveteran spouses and higher-income veterans who are currently ineligible for health care (because of income and lack of service connection) access to VHA care under fee for service models or within accountable healthcare organizations at selected sites across the system. All participants would have to bring health insurance coverage to VHA. Participating sites must certify that they are in compliance with VHA access guidelines for enrolled veterans.

In sites selected to serve as accountable healthcare organization pilots, VA-delivered care would be provided whenever possible, but VHA would be authorized to subcontract with its private sector partners (those included in its integrated care networks) to provide care that is unavailable or inaccessible at VHA in the same manner as it provides care to enrolled veterans. VHA would determine the appropriate benefits package and plan design to correspond with participants’ health care coverage.

### **Enabling Requirements:**

- Congress must authorize VHA establish pilot programs to provide care to spouses and higher income veterans.
- Congress must waive prohibitions on use of Medicare funds in federal agencies; in the absence of such a waiver, VHA could still engage in pilots with individuals with other forms of third-party health coverage.

- VHA billing and collections activities must improve and correspond with those of private sector delivery systems.
- Collections under the demonstrations would be retained at the VHA delivery sites and not subject to offset.

**Conclusion 2:** As a participant in an integrated healthcare network, VHA could potentially benefit from treatment of certain insured populations who are currently ineligible for VHA provided or funded care.

**Legislation:**

- Authorization for Medicare (Parts A, B, C, and D) to reimburse VHA.
- Authorization to treat non-veteran spouses not eligible for CHAMPVA in VHA Pilot sites.
- Authorization for VHA to collect and retain payment from third-party payers for the care of ineligible veterans and non-veteran spouses.

**Administrative:**

- Secretary must authorize care of higher income veterans in pilot sites.

**20. Develop a program to ensure veterans know how to access VHA health care. [DRAFT]**

**21. Transform contracting support and culture to create a more flexible and responsive approach to business functions across VHA. [DRAFT]**