Commission on Care

Final Report

COMMISSION ON CARE

June 30, 2016

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Commission on Care
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We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report,* and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

Respectfully Submitted,

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EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program,* to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.[1] The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

[1] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; Governance, *Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model*, *Leadership Implementation, History as a Context for Systemic Transformation, Veteran Feedback*, and *Additional Resources.* These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

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

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

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

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.[2]

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.[3] For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified "not working to top of provider licensure" as a barrier in health care provision.[4]

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[2] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[3] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.
[4] Ibid., 95.

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

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

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.[5] Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).[6]

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.[7] The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.[8]

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

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[5] MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process,* accessed June 3, 2016, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf.
[6] VHA Clinical Appeals, VHA Directive 2006-057 (2006).
[7] "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx.
[8] MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process,* accessed June 3, 2016, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

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

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.[9]

VHA has a program of system engineering—Veterans Engineering Resource Center (VERC)—that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

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

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

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[9] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs , Assessment F (Workflow—Clinical),* 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.[10] VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.[11]

Facility and Capital Assets

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

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

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[10] Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review,* U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf.

[11] Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

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

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.[12] VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

[12] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.[13]

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.

- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that 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.

- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

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[13] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

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

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.[14] As the authors of a root-cause analysis of the Phoenix scandal highlighted, "a governance gap in leadership continuity and strategic oversight from one executive leadership team to another" contributed to the wait-time problems.[15] The report authors observed, "Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors."[16] The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration's expectations for short-term results,[17] and VHA's operating in a "dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands"[18] offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

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[14] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[15] Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report,* September 22, 2015, 3.
[16] Ibid.
[17] Ibid.
[18] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

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

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

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

- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.

- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

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

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

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

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.

- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.

- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.

- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.

- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.

- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

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

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.

- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does 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.

  - Promotes veteran preferences and hiring.

- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, 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/processes.
- Provides due process and appeals standards to adverse personnel actions.
- 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 ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

▪ VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.

▪ VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.

▪ VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

- VA Human Resources and Administration and the Office of Information and Technology 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.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-*honorable* discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

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

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

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.[19]

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

[19] The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient–provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

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INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program,* to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient–provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

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

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.[20] In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.[21] In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."[22] Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.[23]

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:[24]

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[20] Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).
[21] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities),* 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.
[22] Non-VA Medical Care Program, VHA Directive 1601, (2013).
[23] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).
[24] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.[25] For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.[26] Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers[27] have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.[28]

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.[29]

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.[30] VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."[31] As further articulated by Dr. David Shulkin, USH:

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assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

[25] Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

[26] Ibid.

[27] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities),* 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

[28] Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care,* 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

[29] "Despite $10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy.

[30] Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care,* 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

[31] Ibid., 18.

> *It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . .[A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.*[32]

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally[33] They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.[34] These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.[35] Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

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[32] David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine,* 374, (2016): 1003-1005, accessed June 15, 2016, http://doi.org/10.1056/NEJMp1600307.

[33] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

[34] Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

[35] David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdbe726bddcbceea81f27.html.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.[36] Such a system is expected to drive improved quality and lower costs.[37]

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

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[36] "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, http://www.nationalpartnership.org/issues/health/macra.html.
[37] Ibid.

care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.[38] Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.[39]

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[38] Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, http://doi.org/10.1001/jama.2012.196.

[39] "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, http://doi.org/10.1001/jama.2012.196. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, http://doi.org/10.1111/j.1475-6773.2010.01123.x.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.[40]

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.[41] Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.[42]

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

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[40] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[41] "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you.
[42] Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.[43]

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.

- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.

- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.

- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option,* but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.

- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.

- **Eligibility Expansion**: Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.

- **Other-Than-Honorable Discharges**: A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

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[43] Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, http://doi.org/10.1377/hlthaff.2012.1007. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).[44] In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.[45] A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

[44] Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

[45] Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

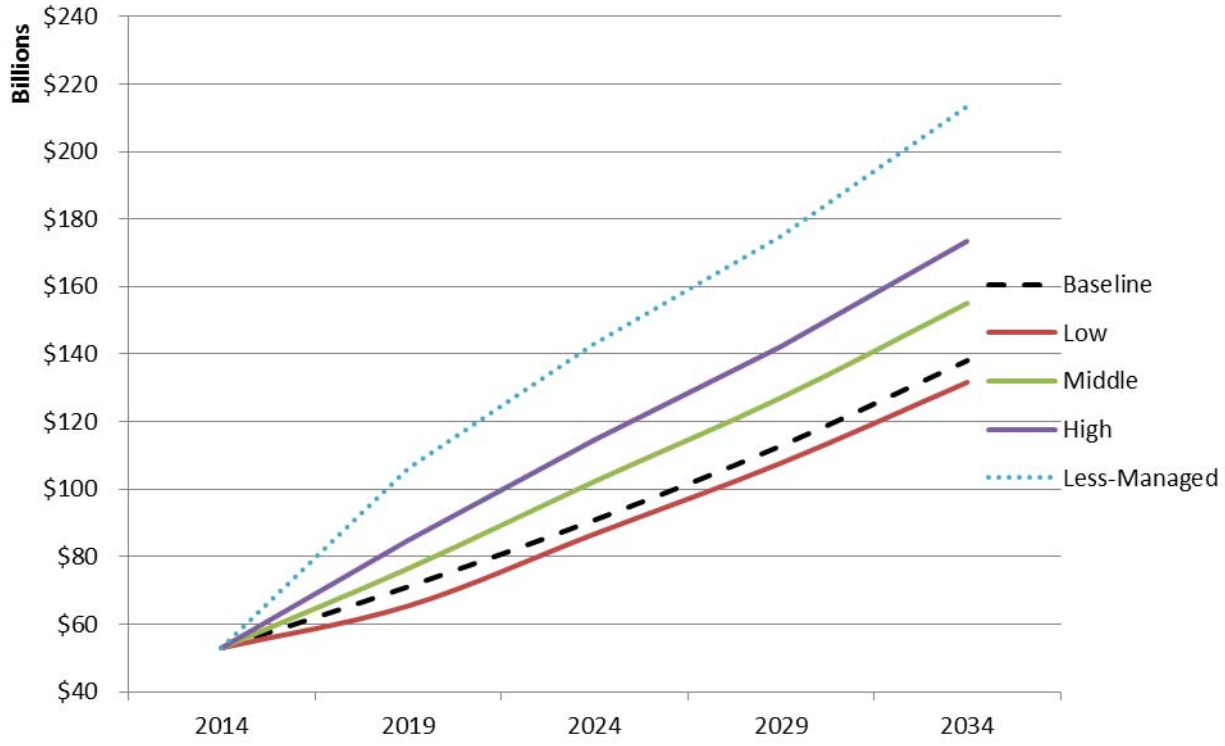
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from $65 billion to $85 billion in 2019, with a middle estimate of $76 billion. The middle estimate is moderately above the baseline projection of $71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is $106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.[46] VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.[47] Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned "choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans."[48] These organizations do not support providing unfettered choice, and the VSO leaders stated that "any health care reform proposal that elevates the principle of 'choice' above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

[46] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities),* 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[47] David M. Cutler and Fiona Scott Morton, "Hospitals, Market Share, and Consolidation," *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, http://doi.org/10.1001/jama.2013.281675.
[48] Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

in less 'choice' rather than the intended desire for more health care options for many disabled veterans."[49]

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

[49] Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.[50]

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.[51] VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.[52] Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.

- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

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[50] Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.
[51] It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.
[52] Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, http://www.ncbi.nlm.nih.gov/pubmed/21183845.

- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

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

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.[53]

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.[54] For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified "not working to top of provider licensure" as a barrier in health care provision.[55]

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA's problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

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[53] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[54] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.
[55] Ibid., 95.

Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.[56] VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.[57]

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.[58]

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.[59] To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act[60] and other requirements that essentially froze beds at FY 1998 levels.[61]

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.[62]

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

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[56] Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.
[57] 38 U.S.C. § 7401(3)(A)(iii).
[58] Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).
[59] Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).
[60] The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.
[61] Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.
[62] "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.[63]

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.[64]

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.[65] To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

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[63] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling),* 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.
[64] For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as $94,000.[64] The pay grade assigned for this position is GS-13, which pays about $73,800 in the first step and increases up to $96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf.
[65] Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

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

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.[66] Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).[67]

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.[68] The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.[69]

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.[70] In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.[71] In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.[72] That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

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[66] MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process,* accessed June 3, 2016, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf.
[67] VHA Clinical Appeals, VHA Directive 2006-057, (2006).
[68] "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx.
[69] MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process,* accessed June 3, 2016, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf. VHA Clinical Appeals, VHA Directive 2006-057 (2006).
[70] VHA Clinical Appeals, VHA Directive 2006-057 (2006).
[71] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).
[72] VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.[73] Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.[74] If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).[75] Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.[76]

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.[77] Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.[78] Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.[79] Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

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[73] Ibid.
[74] VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).
[75] VHA Clinical Appeals, VHA Directive 2006-057, (2006).
[76] Ibid.
[77] "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html.
[78] Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart-.pdf.
[79] MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process,* accessed June 3, 2016, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
  - Each level of review in the clinical-appeals process—from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
  - Whether VHA should establish a uniform national clinical appeals process.
  - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
  - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
  - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
  - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

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

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.[80]

VHA has a program of systems engineering—the Veterans Engineering Resource Center (VERC)—that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.[81] Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.[82] The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

[80] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs , Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.
[81] Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.
[82] MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

oriented practice.[83] So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.[84] VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA—health care capabilities, staffing, access, supplies, and facilities—and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.[85] VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.[86] Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint—Center for Improvement Education, VA Center for Innovation, MyVA—Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

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[83] MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

[84] The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs , Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

[85] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

[86] Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.[87]

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the 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 respective differences in provider supply, veteran needs, and marketplace characteristics.[88]

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.[89]

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.[90]

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care[91] and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.[92]

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

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[87] Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.
[88] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes),* 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf
[89] Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.
[90] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.
[91] "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, http://vaww.blog.va.gov/hsrd/category/queri-corner/.
[92] Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.[93]

A systems approach to health care is "one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost"[94] and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.[95] A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.[96]

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.[97]

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

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[93] RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities),* 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.
[94] Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.
[95] Ibid., 15.
[96] Ibid., 60.
[97] Ibid., 27-28.

Health Care Equity

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

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.[98]

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.[99] VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.[100]

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.[101] The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

[98] Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care,* accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.
[99] Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA,* accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf.
[100] Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care,* accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.
[101] Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, http://www.cdc.gov/mmwr/pdf/other/su6203.pdf.

providers and the health care system as a whole.[102] A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.[103]

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.[104] Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.[105]

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.[106] Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.[107]

Survey data show that minority veterans use VA health care more than White veterans, as shown below: [108]

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/Alaska Native: 38 percent
- White: 32 percent

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[102] G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHHSA* (2011), 146.
[103] "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, http://www.va.gov/HEALTHEQUITY/index.asp.
[104] "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, http://www.cdc.gov/minorityhealth/index.html.
[105] Ibid.
[106] National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report,* May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.
[107] U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS),* 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report,* accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf
[108] Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:[109]

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.[110]
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.[111]
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.[112]

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.[113] OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).[114] A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.[115]

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

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[109] Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.
[110] Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.
[111] Ibid.
[112] Ibid.
[113] Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments,* accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.
[114] "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, http://www.diversity.va.gov/.
[115] "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, http://www.diversity.va.gov/programs/default.aspx.

orientation."[116] HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities' National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.[117]

Despite OHE's best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.[118] The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.[119] OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA's organization structure. These include the following:[120]

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

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[116] Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018,* accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.
[117] "National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity, "U.S. Department of Health & Human Services, accessed May 16, 2016, http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286
[118] Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.
[119] "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., "Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review," *Journal of General Internal Medicine*, 23, no. 5, (2008): 654-671.
[120] Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.[121]

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research[122] and illustrated in the table below:[123]

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	**Hispanics**	**American Indian or Alaska Natives**
▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease	▪ Hepatitis C ▪ Cancer ▪ Heart disease	▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.[124]

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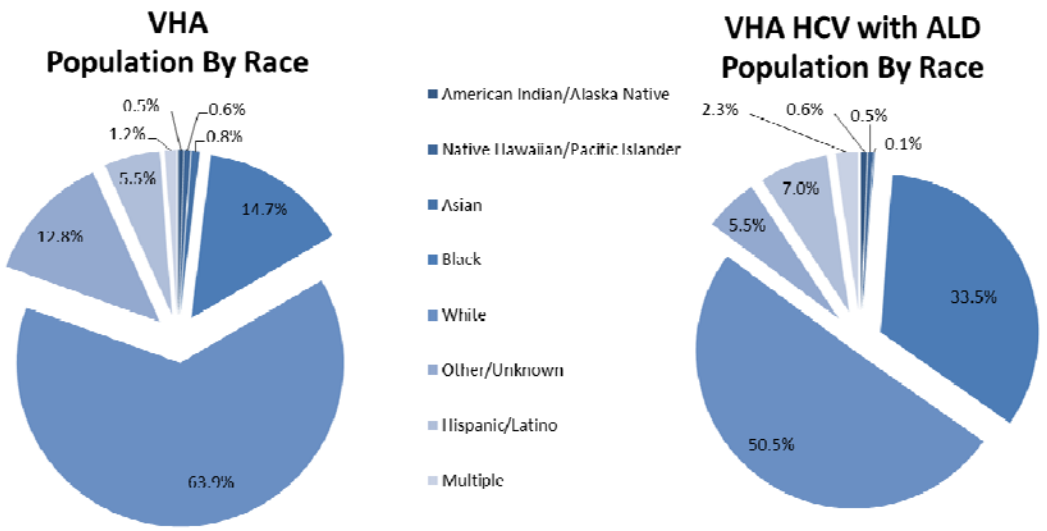
[121] Ibid.

[122] Andy I. Choi et al., "White/Black Racial Differences in Risk of End-Stage Renal Disease and Death," *The American Journal of Medicine,* 122, no. 7, (2009): 672-678. Andy I. Choi et al., "Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes," *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., "Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans," *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., "Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care," *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

[123] Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf.

[124] Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities,* accessed May 25, 2016, https://github.com/department-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf.

Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.[125]

Table 4. Comparison of Health Outcomes by Race

Comparison	Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence (based on VA data from the early 2000s)	
African American v. White	Increased end-stage renal disease among chronic kidney disease patients
	Increased end-stage renal disease among HIV patients (with or without diabetes)
	Decreased colon cancer survival 3 years after diagnosis
Hispanic v. White	Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients
Low-Strength Evidence (each finding supported by only a single retrospective study with important methodological limitations)	
African American v. White	Increased mortality among diabetes patients
	Increased risk of preterm birth among PTSD patients
	Increased mortality at 2 years post-hospitalization among stroke patients
	Decreased survival 3 years after diagnosis of rectal cancer
American Indian or Alaskan Native v. White	Increased risk of 30-day post-op mortality after major noncardiac surgery
	Increased risk of preterm birth among PTSD patients
Combined other racial/ethnic minority groups v. African American	Increased injury-related death among alcohol use disorder patients

[125] "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99.

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.[126] Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,[127] also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.[128] For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.[129] Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.[130] HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.[131] The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.[132] A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.[133] Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

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[126] Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf.
[127] James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in* Children and Adolescents, accessed April 1, 2016, http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf
[128] Ibid.
[129] "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, http://www.commissiononhealth.org/WhatDrivesHealth.aspx.
[130] Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf.
[131] Ibid.
[132] Ibid.
[133] Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018,* accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.

- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.

- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.[134]

- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

[134] Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

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

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in Recommendation #1 holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.[135] The average VHA building is 50 years old—five times older than the average building age of not-for-profit hospital systems in the United States.[136] Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

[135] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

[136] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K__Facilities.pdf.

sanatoriums, others for years primarily housed patients with mental health conditions.[137] Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,[138] meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.[139]

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.[140] Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than $51 billion in total capital needs during the next 10 years.[141] Capital funding during the past 4 years has averaged just $2 billion annually.[142] If funding levels remain consistent during the next 10 years, anticipated funding would be $25 billion to $35 billion less than the $51 billion capital requirement.[143] VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.[144]

Analysis

New Planning Paradigm

As the department acknowledged, "VA's health care delivery model must . . . change."[145] Importantly, it recognizes that "No organization can excel at every capability," and stated "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."[146] The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA's capital needs and capital asset management. Rather than assessing VHA's capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System's high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

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[137] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.
[138] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K__Facilities.pdf.
[139] Ibid.
[140] Ibid., 46.
[141] Ibid., 17.
[142] Ibid., 18.
[143] Ibid., 18.
[144] Ibid., 59-61.
[145] Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.
[146] Ibid.

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.[147] The SECVA recently testified that it costs VA an estimated $26 million annually to maintain and operate vacant and underutilized buildings.[148]

VA's authority to carry out property-management is circumscribed in law,[149] and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.[150] In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.[151] This authority allows VA to lease underutilized capital

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[147] Ibid., 92.

[148] "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2.

[149] Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain,* GAO-11-520T (Washington, DC, 2011), 5, http://www.gao.gov/products/GAO-11-520T).

[150] With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

[151] Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to*

assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.[152]

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.[153]

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than $1 million,[154] a Congressional Budget Office (CBO) ruling[155] has upended the approval process and halted the leasing program.[156] Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.[157] Currently, 24 major VA leases are in limbo.[158]

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), http://www.gao.gov/assets/130/122697.pdf). For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain,* GAO-11-520T (Washington, DC, 2011), 5, http://www.gao.gov/products/GAO-11-520T.

[152] Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012).)

[153] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K__Facilities.pdf.

[154] Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

[155] *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs,* 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm.

[156] Ibid. CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

[157] *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs,* 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm.

[158] "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2.

One of the primary benefits of leasing is that it can provide flexibility and speed.[159] But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,[160] in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.[161]

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public–private partnerships.[162]

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,[163] suggesting a need for transformative changes in operations.[164]

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.[165] Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

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[159] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K__Facilities.pdf.
[160] Ibid., 159-160.
[161] Ibid., 160.
[162] Ibid., vii-ix, 34.
[163] Ibid., vi, 20.
[164] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[165] Interviews of VA staff by Commission on Care staff, April 2016.

Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.[166] The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.[167] But that authority may generally not be unilaterally exercised.[168] In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,[169] reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model[170]—the military base realignment and closure (BRAC) process—to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.[171] This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

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[166] "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com,* accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578.

[167] Authority to Reorganize Offices, 38 U.S.C. § 510.

[168] Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

[169] Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm

[170] Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act),* accessed June 23, 2016, http://www.brac.gov/docs/BRAC05Legislation.pdf.

[171] "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com,* accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578.

legislation, in making recommendations regarding realignment and capital asset needs.[172] The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.[173] If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.[174]

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.[175] This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

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[172] 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, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat.119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

[173]The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

[174] Ibid., B-13.

[175] *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs,* 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm.

buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA'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. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which 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[176] 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.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.[177] Notably, minor construction funds, available for "constructing, altering, extending, and improving"[178] any VA facility, are limited to $10 million,[179] yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project—the amount above which a project requires specific authorization—more than a decade ago.[180] The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.[181]

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[176] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).
[177] VA Office of Inspector General, *Veterans Health Administration: Review of* Minor Construction Program, 8, accessed June 3, 2016, http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf.
[178] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).
[179] A major medical facility project is one involving a total expenditure of more than $10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).
[180] Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than $7 million to more than $10 million.
[181] One such public–private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include 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. These are all important elements of needed system transformation.

As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

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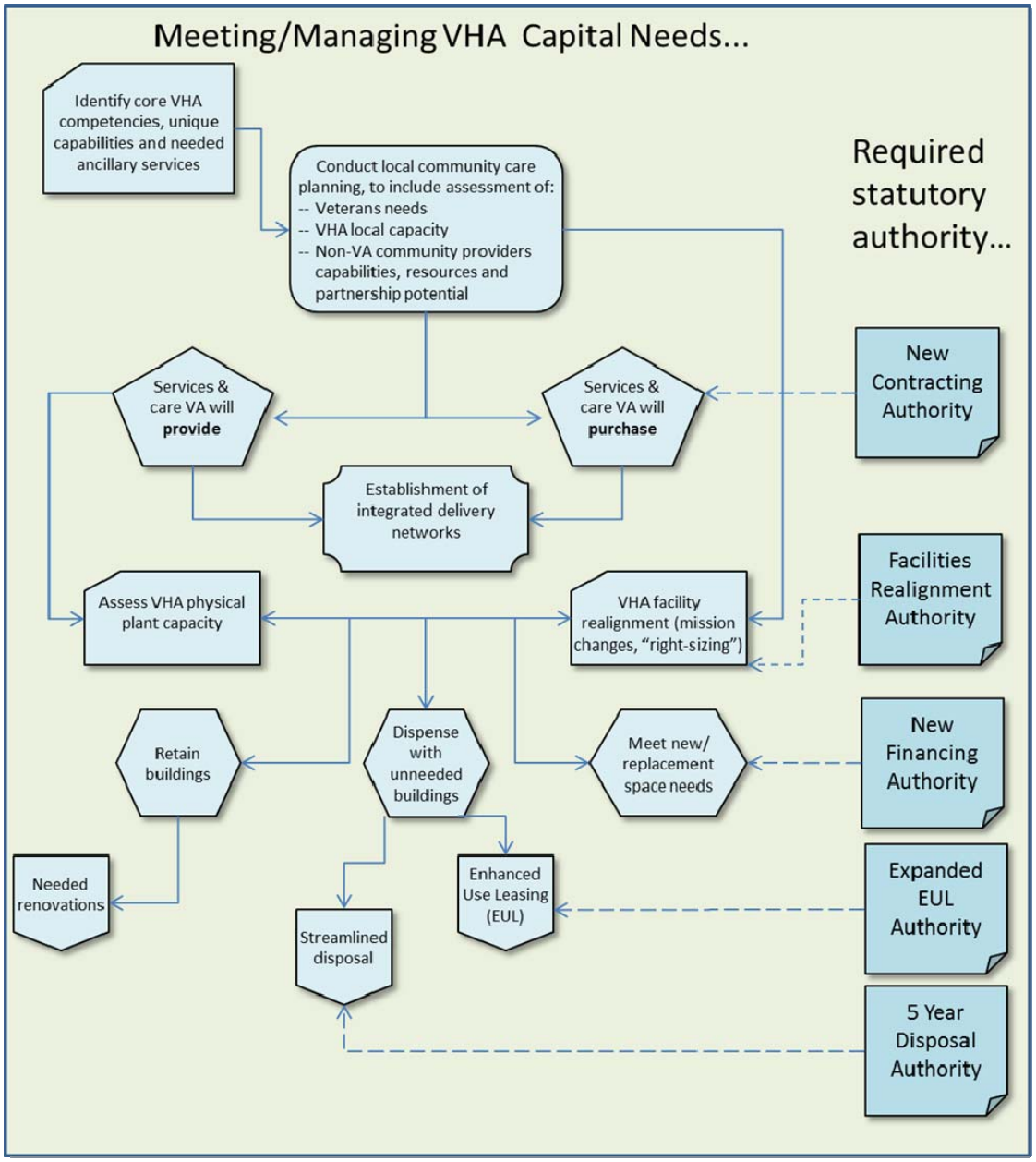
construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public–private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), https://www.congress.gov/bill/114th-congress/house-bill/5099.

Figure 3. The Complicated Process of Meeting and Managing VHA's Capital-Needs



Implementation

Legislative Changes

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.

- Establishing 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, and provides for:

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) 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 proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and 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 retrains and reemploys displaced employees.

- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.

- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.

- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from $10 million to $50 million.

- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, 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.

- Provide the VHA Care System governing board 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) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

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

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.[182] VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.[183] Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).[184] Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.[185] During the last decade, VHA has not been able to maintain an IT advantage.[186] Although in the past most VHA clinicians

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[182] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[183] "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.
[184] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[185] Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf.
[186] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.[187] Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.[188] DoD recently made the same choice.[189]

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.[190] Presently, VHA appears to lack a majority of these factors required for success.[191]

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.[192] VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

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[187] Ibid., 29-30.
[188] "$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.
[189] "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner.
[190] LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.
[191] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[192] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.[193]

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.[194]

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.[195]

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

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[193] Ibid., 10.
[194] "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, https://www.acep.org/content.aspx?id=79744.
[195] Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf.

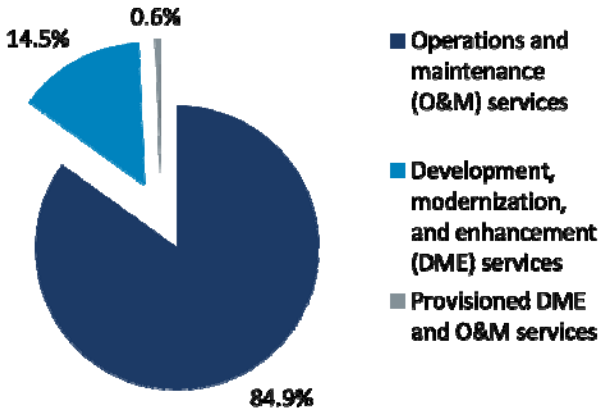
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.[196] The budget process is disconnected from total lifecycle IT costs.[197] That disconnect has grown wider with a change in law[198] under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.[199] As the Congressional Research Service (CRS) testified,

> *providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).*[200]

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),[201] meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.[202]

Figure 4. VA IT Spending



In July 2015, DoD awarded a $4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

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[196] "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx.
[197] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.
[198] Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).
[199] With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.
[200] U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives,* 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf.
[201] Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, https://itdashboard.gov/drupal/summary/029.
[202] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

during its potential 18-year life, the contract could be worth just less than $9 billion.[203] The recent Senate appropriations bill for VA OIT allots $63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).[204] Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short $3.67 billion in funding for a new COTS EHR, given the current funding amount of $63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.[205] Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.[206] VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. 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. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.[207] VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.[208]

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

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[203] "Cerner wins $4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post,* accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.
[204] S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1.
[205] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[206] Ibid., 41.
[207] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[208] Ibid., viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.[209] VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.[210]

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.[211] National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.[212] 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.[213] Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.[214] Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.[215]

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[209] "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, https://www.healthit.gov/policy-researchers-implementers/interoperability.
[210] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.
[211] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[212] "$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract.
[213] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[214] Ibid., vi.
[215] Ibid., vi.

VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.[216] To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI 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 use.[217] For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.[218] However when questioned about this data, VHA notes that it is not correct.[219] 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, then VHA will not have the information it needs to effectively manage the supply of clinic slots.[220]

VA's financial management information technology 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.[221] VA's current financial management system does not support streamlining and automation of VA's revenue cycle.[222]

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.[223] VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.[224] Barriers to automation are multifactorial,

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[216] Ibid., 39-40.
[217] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling),* 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.
[218] Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.
[219] Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.
[220] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling),* 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.
[221] Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015,* accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.
[222] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes),* 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.
[223] Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.
[224] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.[225] In addition, there are multiple authorities for purchasing community care—all with different business rules[226] and reimbursement rates, as well as 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 and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;[227] thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.[228]

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.[229] DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,[230] this was an important business consideration that is also consistent with VHA's long term direction. 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.[231]

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

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[225] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes),* 19-20, accessed April 26, 2015. http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[226] Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.
[227] Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans,* accessed April 25, 2016, http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf.
[228] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes.* I3-I4, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[229] "$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.
[230] "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner.
[231] "$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.[232]

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.[233] They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.[234] The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.[235]

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.[236]

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.[237]

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."[238] To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

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[232] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[233] "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, http://www.gao.gov/products/GAO-16-184T.
[234] Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.
[235] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[236] Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.
[237] LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.
[238] "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf.

identifier. This practice is currently not used.[239] Each health care system uses a unique patient identifier number, but it is specific to that system.[240] VA uses patients' social security numbers as unique identifiers; 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 match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.[241] For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.[242] Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.[243] VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.[244] Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.[245] For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.[246] Interoperability increases the risk to veterans' health records.[247] Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;[248] however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

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[239] "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0.
[240] "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf.
[241] "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability.
[242] "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records.
[243] "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm percent3Ahomepage percent2Fstory.
[244] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[245] Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf.
[246] "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0.
[247] Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.
[248] "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records.

are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.[249]

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community 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 in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.[250] The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.[251]

In response to this limitation, 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 VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee 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 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.[252]

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA 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, including VHA.[253] An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO 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

[249] Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.
[250] Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015
[251] 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.
[252] Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.
[253] "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a $3.1 billion revolving fund for upgrading outdated federal IT systems.[254]

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is 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 used.[255] The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.[256] It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

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[254] "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx.
[73] Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.
[256] "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner.

Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.[257]

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure 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, consistent with the overall VHA IT strategy.

- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.

- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):

  - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability[258]

  - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines

  - the requirements for new systems

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[257] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[258] Ibid., 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place

- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
  - establishes one logical version of an electronic health record platform in VHA[259]
  - standardizes evidenced-based, best practice clinical order sets across VHA
  - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation[260]
  - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans[261]
  - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: 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[262]
  - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
  - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
  - supports the development of full interoperability with integrated community care network facilities and providers

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[259] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.
[260] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.
[261] The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.
[262] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data[263]

- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

[263] LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that 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.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.[264]

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.[265] This effort includes examining the supply chain for ways to save money.[266]

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[264] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

[265] Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine,* 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

[266] "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health care-costs/.

Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.[267] Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.[268] VHA, which in FY 2014 spent approximately $3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.[269]

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.[270] To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.[271]

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

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[267] John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, http://content.healthaffairs.org/content/28/5/1336.
[268] "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, http://my.clevelandclinic.org/services/supply-chain-management. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering.
[269] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[270] "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway.
[271] "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends. "Strategic Supply Chain Management," Lee Ann Jarousse, accessed April 28, 2016, http://www.hhnmag.com/articles/4522-strategic-supply-chain-management. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering.

managing pharmaceutical supplies, logistics, and prescribing.[272] PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.[273] Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.[274] PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.[275] As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.[276]

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).[277] The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.[278] Eighty percent of prescriptions in VHA are filled through CMOP,[279] which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.[280] Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,[281] and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

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[272] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[273] Ibid., 20.
[274] VHA Formulary Management Process, VHA Handbook 1108.08 (2009).
[275] Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[276] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[277] Ibid.
[278] "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.
[279] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[280] "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG.
[281] "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/index.asp.

Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

> *Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*[282]

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.[283] In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.[284] Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).[285] Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.[286] To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)[287] (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.[288] This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

> *National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*[289]

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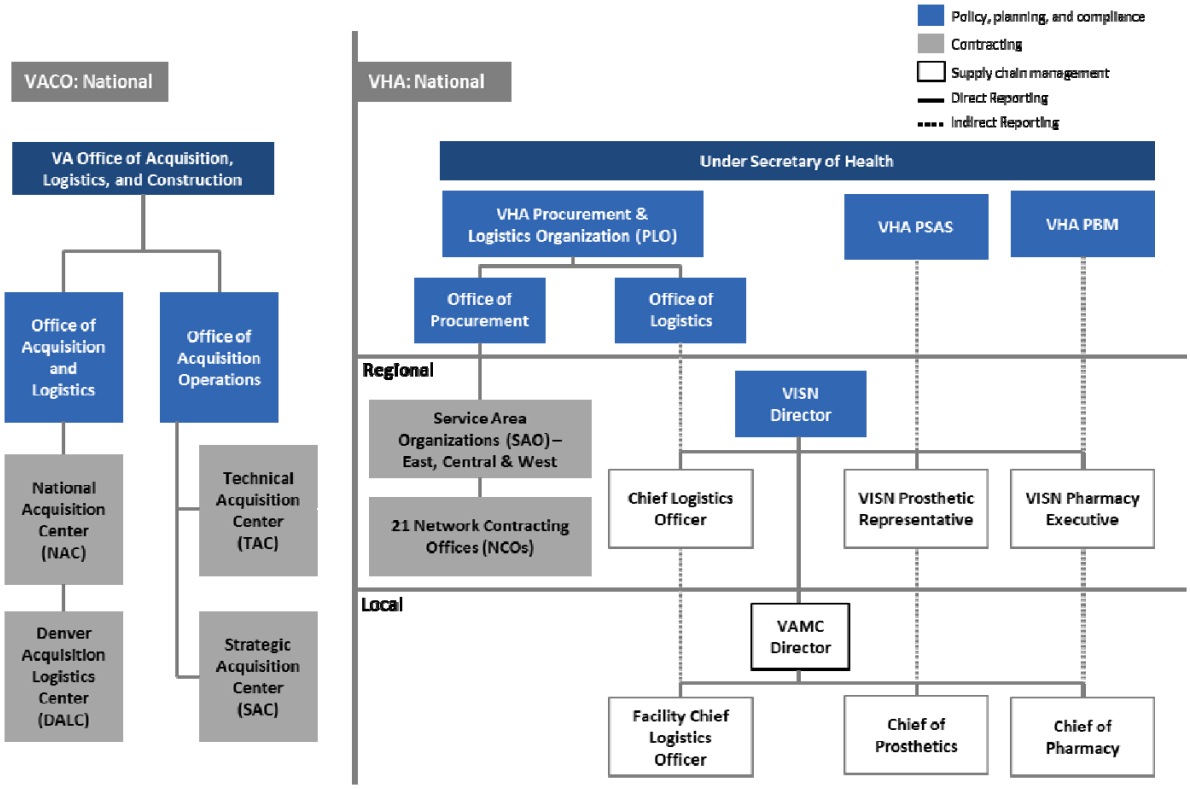
[282] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[283] Ibid., 57-58.
[284] Ibid., ix.
[285] Ibid., 96-97.
[286] Ibid., 47-50.
[287] Ibid., 58.
[288] Ibid.
[289] Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain[290]



Note: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold ($3,000), thus the purchase must be made through the contracting process.[291] Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,[292] findings borne out by low customer satisfaction scores given to these organizations.[293]

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

[290] Ibid., 49.
[291] Ibid., 67.
[292] Ibid., 68.
[293] Ibid., 69.

complicated, bureaucratic system filled with redundancies.[294] These broken processes serve as a precursor for catastrophic systems failures.[295]

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

> *In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.*[296]

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.[297] As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.[298] To date, national product standardization has been achieved in only a limited number of categories.[299] Since 2011,

> *VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.*[300]

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[294] Ibid., 47-50.
[295] Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.
[296] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[297] Ibid., xii.
[298] VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.
[299] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[300] Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.[301]

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.[302]

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.[303] VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.[304]

> *VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*[305]

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.[306] Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

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[301] Ibid., 54.
[302] Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.
[303] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[304] Ibid.
[305] Ibid., 60.
[306] Ibid.

and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.[307]

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards[308] and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.[309] This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,[310] yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.[311] It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the $3,000 purchase card limit.[312] An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.[313] Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in "group purchasing organizations" to achieve the scale that VHA naturally enjoys.[314] Weaknesses in logistic management have been recognized in VHA for some time and still remain.[315] For instance, a review of logistics business

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[307] Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.
[308] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[309] Ibid., xii.
[310] Ibid., x.
[311] U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, http://www.gao.gov/assets/650/648644.pdf.
[312] U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf.
[313] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[314] Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine,* 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.
[315] U.S. Government Accountability Office, *Veteran's Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, http://www.gao.gov/assets/660/653886.pdf.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.[316]

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.[317]

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.[318] VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.[319] As of April 2016, an estimated $24.4 million in supply chain costs had already been avoided since January.[320]

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

[316] U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.
[317] Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.
[318] Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.
[319] Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.
[320] Ibid.

receive the first response from contracting requesting, for example, additional information or paperwork.[321] This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than $3,000, for example, scalers for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.[322]

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.[323] Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.[324]

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.[325]

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.[326] Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.[327]

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

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[321] The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[322] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation),* 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.
[323] The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),*)69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[324] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[325] Ibid.
[326] Ibid., xii.
[327] Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.[328]

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.[329]

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.[330]

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.[331] The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.[332] Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.[333]

> *It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*[334]

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

[328] Ibid.
[329] Ibid.
[330] Ibid., xiii.
[331] Ibid.
[332] Ibid.
[333] Ibid., 87.
[334] Ibid., 88.

organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

> *The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.*[335]

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.[336]

Implementation

Legislative Changes

- Establish a new excepted personnel system 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

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.

- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.

- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.

- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.

- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

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[335] "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, http://www.acquisitionacademy.va.gov/schools/scm/message.asp.
[336] "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b.

regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

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

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.[337] As the authors of a root-cause analysis of the Phoenix scandal highlighted, "a governance gap in leadership continuity and strategic oversight from one executive leadership team to another" contributed to the wait-time problems.[338] The report authors observed, "Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors."[339] The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration's expectations for short-term results,[340] and VHA's operating in a "dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

[337] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[338] Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.
[339] Ibid.
[340] Ibid.

competing demands"[341] offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.[342] VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.[343] VAEB serves as the department's risk-governance board and determines VA's strategic direction. VAEB oversees the department's planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.[344]

Among its principal recommendations, the *Independent Assessment Report* calls for "establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures."[345]

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.[346] Additionally, the leadership vision has lacked continuity.[347] The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

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[341] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[342] "Legislation," U.S. House of Representatives, House Committee on Veterans' Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.
[343] Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).
[344] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[345] Ibid., 23.
[346] Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report,* September 22, 2015, 52-54.
[347] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.[348] The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.[349]

Previous studies, dating back 20 years,[350] have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.[351] The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,[352] and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.[353] Although the authors of the 1996 report presented a VHA government

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[348] Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed "solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope" there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH ("United States Secretary of Veterans Affairs," Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

[349] Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

[350] Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

[351] Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as "a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures." Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, https://fas.org/sgp/crs/misc/RL30365.pdf. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce,* accessed June 15, 2016, http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that "the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities." The study report states, "VHA provides excellence in care in spite of its operations/governance structure, not because of it."

[352] Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

[353] Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.[354]

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of "governance mechanisms to bridge 'Secretary suite' leadership transitions and provide more stable strategy, oversight, and stewardship."[355] Explaining that "the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,"[356] the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. "The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition."[357]

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.[358] 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. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

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multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

[354] Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

[355] Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report,* September 22, 2015, 59.

[356] Ibid.

[357] Ibid.

[358] See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,[359] referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; 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. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

[359] Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level.[360]
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	The board would have the power to do the following: ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently 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.

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 governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.[361] VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

[360] The rate of compensation provided for members of the Commission on Care.

[361] Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. 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.[362]

A governing board must be tailored to the unique needs of VHA.[363] It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.[364]

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
  - Amend 38 U.S.C. § 305—which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and 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:
    - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
    - Repeal subsection (c) of that section.
    - Provide instead for the governing board to recommend a CVSC candidate.
    - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

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[362] Under Secretary of Health, 38 U.S.C. § 305.
[363] Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report,* September 22, 2015, 60.
[364] The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership

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

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Problem

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.[365] For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.[366] They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.[367] An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.[368] Engaged

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[365] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[366] "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage.

[367] http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx

[368] "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/.

employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.[369]

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.[370] Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.[371] Companies with engaged employees outperform those without by more than 200 percent.[372] Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.[373]

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.[374] This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.[375] There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.[376] Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.[377] Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.[378] The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.[379] Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

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[369] U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf.

[370] "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage.

[371] U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement,* September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

[372] U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement,* September 2015, 4. Dee Ramsel, Improving VHA's Culture: A Presentation Before the National Leadership Council, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change,* 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

[373] Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

[374] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

[375] Ibid., 44.

[376] Ibid., 47.

[377] Ibid., 46.

[378] Ibid., 46.

[379] Ibid., 49-51.

reinforcement or clear feedback on performance.[380] As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive[381]) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.[382]

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.[383] The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.[384] At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.[385]

Table 6. Cultural Transformation Efforts in VA and VHA[386]

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

[380] Ibid., 53 and 60.
[381] U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change,* 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.
[382] Ibid.
[383] Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.
[384] See "Ethical Leadership, Fostering an Ethical Environment and Culture," National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, http://www.ethics.va.gov/integratedethics/elc.asp. "Stop the Line for Patient Safety Initiative," U.S. Department of Veterans Affairs, accessed June 22, 2016, http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp. "VHA Center for Organizational Development," U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement,* September 2015.
[385] Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.
[386] Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 29-31.

VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.[387] This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

[387] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director[388] and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

[388] This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. 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. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

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

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

> *Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*[389]

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.[390] The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.[391] This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.[392] Investing in new supervisors and emerging leaders is critically important because

[389] U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf.
[390] Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).
[391] Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.
[392] Ibid., 3.

employees report that when they quit a job they leave their supervisors and not their organization.[393] In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.[394]

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.[395] Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.[396] Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.[397] The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.[398] An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."[399]

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.[400] VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

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[393] "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, http://www.forbes.com/sites#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3.

[394] Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

[395] U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT.

[396] Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization,* accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

[397] Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization,* accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success.

[398] Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization,* accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

[399] Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization,* accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf.

[400] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.[401] Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.[402] As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.[403]

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.[404] Having a cogent competency model is a prerequisite to a coherent strategy.[405] Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.[406] Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.[407]

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.[408] HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

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[401] Ibid.
[402] Ibid., 38.
[403] Ibid., 37.
[404] The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.
[405] Ibid.
[406] Ibid.
[407] Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, http://www.nchl.org/static.asp?path=2852,3238.
[408] "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, http://www.nchl.org/static.asp?path=2852,3238.

position requirements, performance management, and training content.[409] The plan mentions coordination with VA Learning University but provides no detail.[410] The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.[411]

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.[412] As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.[413] Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.[414] For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.[415]

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).[416] VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).[417] Minority women shoulder the biggest burden of formal mentoring within the organization.[418] VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.[419] Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.[420]

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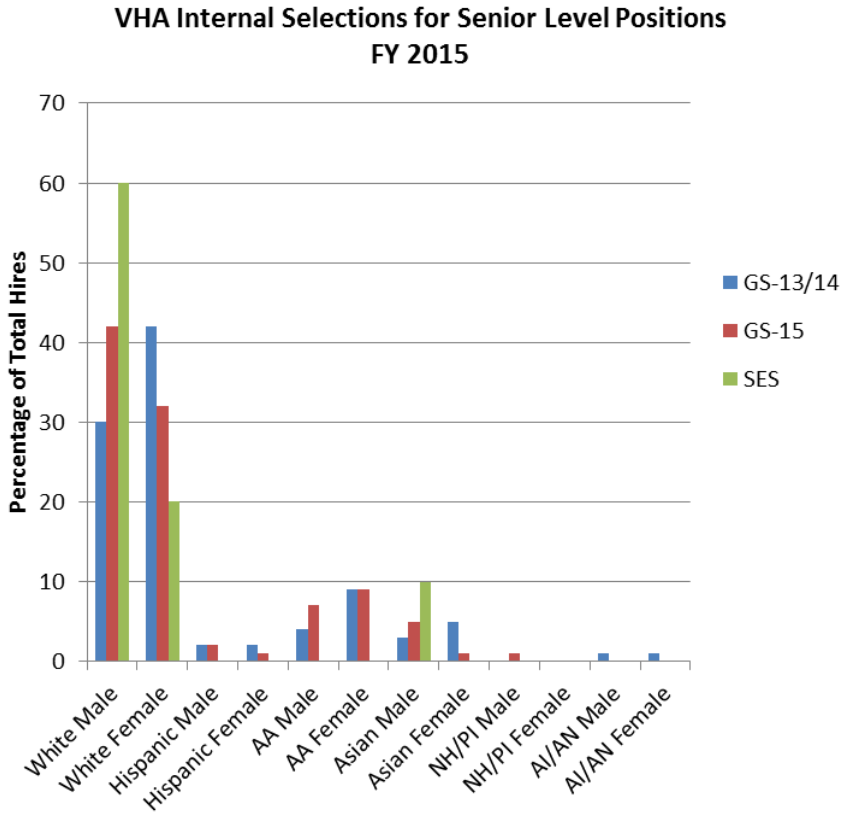
[409] Ibid.
[410] Ibid.
[411] Ibid.
[412] Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A,* November 23, 2015.
[413] Ibid.
[414] Eric Krell, "Staffing Management: Look Outside or Seek Within?" *HR Magazine,* January/February 2015.
[415] "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, http://www.nchl.org/static.asp?path=2852,3238.
[416] Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.
[417] Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A,* November 23, 2015.
[418] Ibid.
[419] Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.
[420] VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

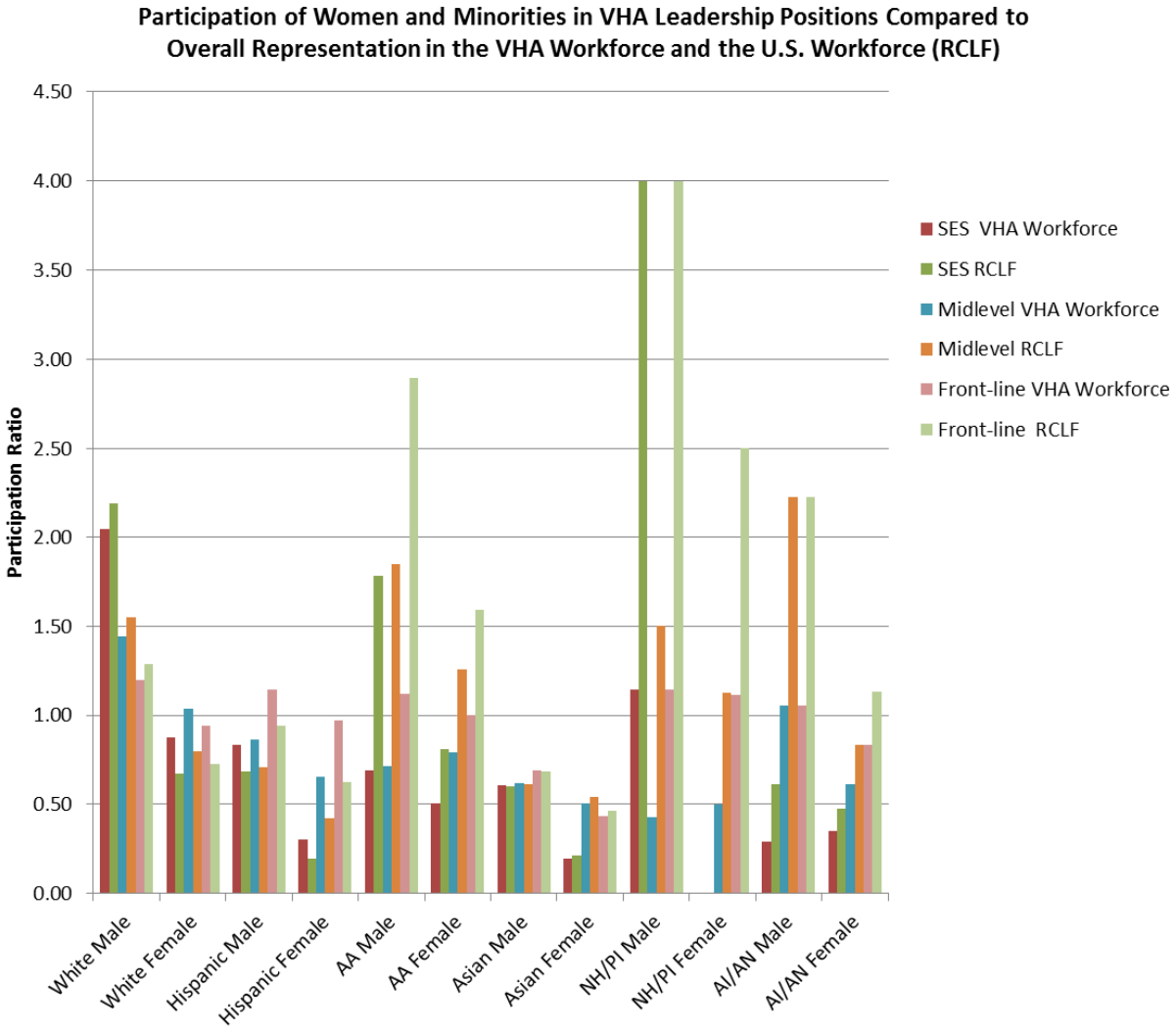
Figure 6. Diversity of Senior-Level Hires in VHA



AA = African American
NH/PI = Native Hawaiian/Pacific Islander
AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American
NH/PI = Native Hawaiian/Pacific Islander
AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program.
TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.[421]

[421] Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

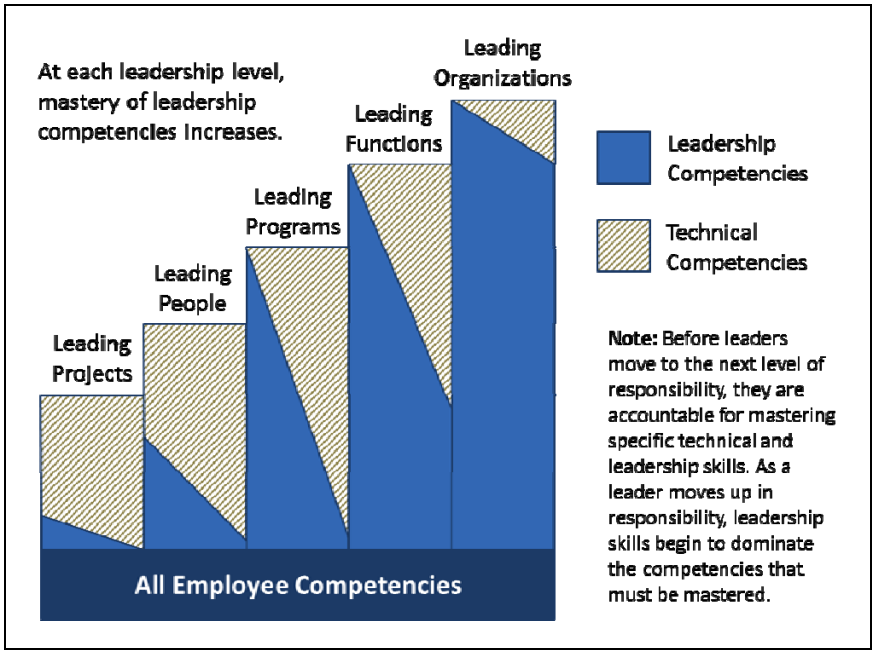
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases



Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.

- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.

- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.

- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.

- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.[422] An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."[423] It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."[424] In an organization the size of VHA, with a budget of $69 billion,[425] more than 300,000 employees, and more than 1,000 sites of care,[426] strong leadership systems are essential.

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[422] Baldridge Performance Excellence Program, *2015-2016 Baldridge Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care),* (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.
James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't,* (New York, NY: HarperCollins, 2001), 17-64.
[423] Ibid.
[424] Ibid.
[425] Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf.
[426] "About VHA," Department of Veterans Affairs, accessed February 5, 2016, http://www.va.gov/health/aboutVHA.asp.

In the last successful reorganization of VHA in 1995,[427] the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations[428] and VHACO program offices were responsible for policy, guidelines, and outcomes.[429] The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics[430] was also established that was supported by centralized functions that benefit from economies of scale.[431] As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.[432] Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it "is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities."[433] The *Independent Assessment Report* included the following findings about the VHA operating model:[434]

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs' ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs' operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA's increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.[435] The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

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[427] Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berret-Koehler Publishers, Inc., 2012), 54.
[428] Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, "Restoring Trust in VA Health Care,"*New England Journal of Medicine*, 371, (2014): 295-297.
[429] Ibid.
[430] Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.
[431] Ibid., 33.
[432] Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System, Objective 3 and 17,* 1996.
[433] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[434] Ibid.
[435] Ibid., 98.

offices and new staff infrastructure to support it.[436] A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.[437]

One symptom of the top-down management is VHACO control of budgeting and resource management. "Support funding is outside local control" and the "increasing share of Specific Purpose funding hinders" local leaders in their ability to use resources effectively. [438] In FY 2015, specific-purpose funds were spread across more than 450 line items,[439] taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls. [440] For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.[441] In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.[442] In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.[443] Greater Congressional control of VHA spending is understandable in light of VA's lack of adequate management systems and data analytic capabilities to track expenditures in real time[444] and report them to Congress and central office. The only means available to hold the medical centers

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[436] Ibid., 96-99.
[437] Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health,* (Washington, DC, Veterans Health Administration, February 2015), 7-9.
[438] The MITRE Corporation*, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership),* 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[439] Ibid., 107.
[440] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership),* 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[441] PL 105-65, October 27, 1997.
[442] Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, http://www.va.gov/budget/products.asp.
[443] On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran's Affairs "Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA's budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines." accessed June 10, 2016, http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf
[444] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

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."[445] VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:[446]

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

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes 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 in VHACO 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. 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 take the opportunity to align functions to achieve its stated priority of 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

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[445] Ibid., ix.

[446] Baldridge Performance Excellence Program, *2015-2016 Baldridge Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care),* (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must 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. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. 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 CVCS, VISN directors, and program office leaders must 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 CVCS must 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.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.[447] The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular stoplight reports (red, yellow, green) to leadership.[448]

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

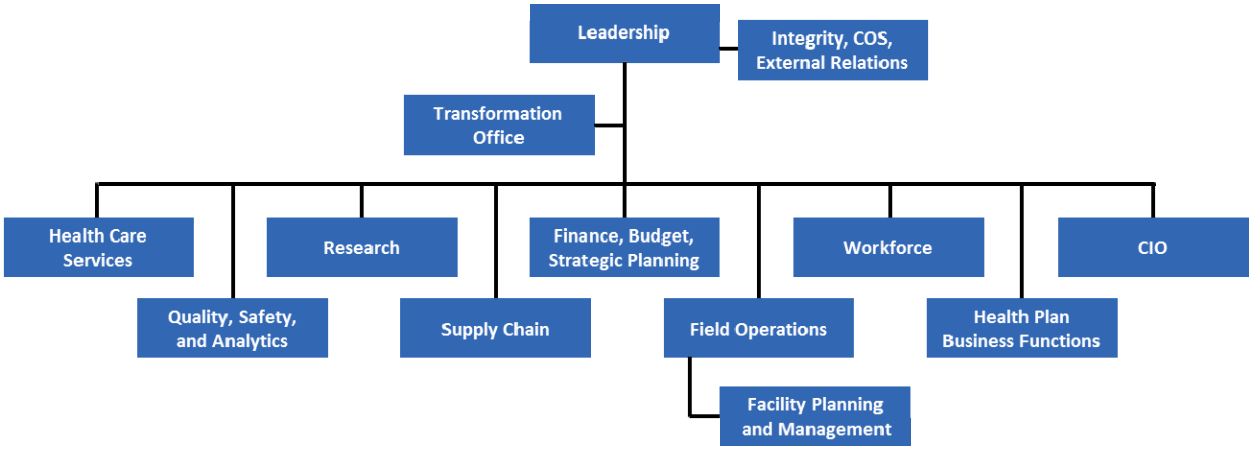
VA Administrative Changes

The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

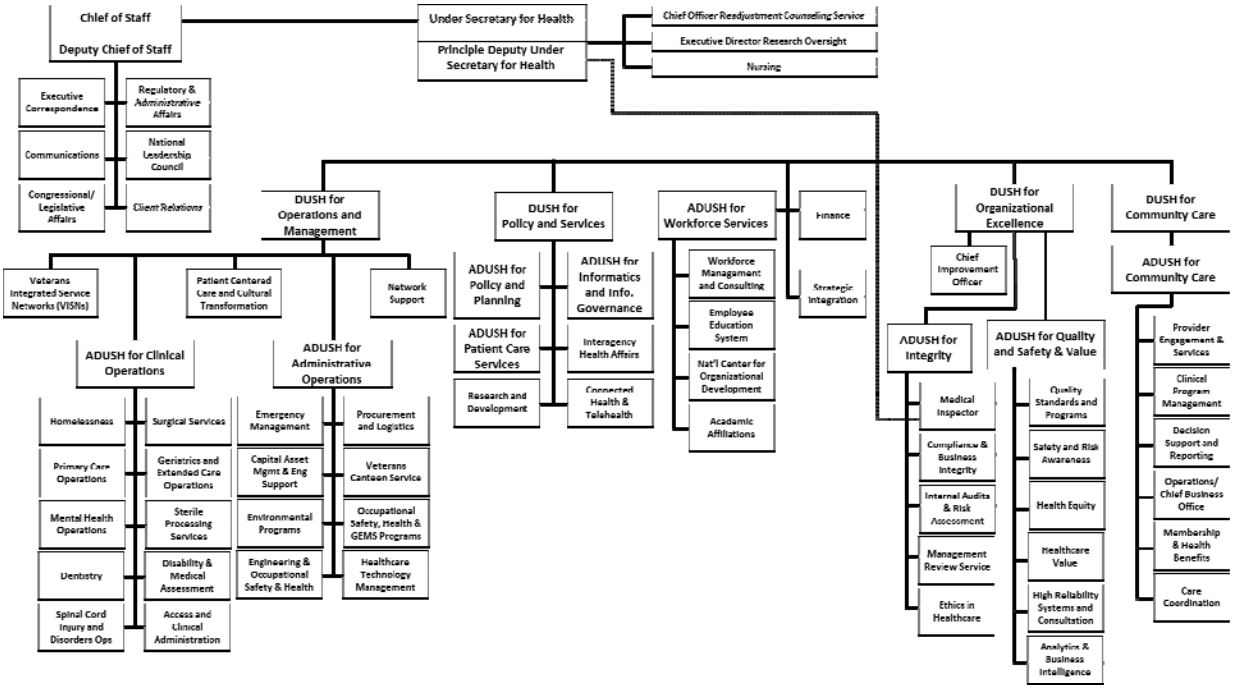
[447] For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,
[448] "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

Figure 9. Proposed VHA Organizational Chart[449]



Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart[450]



[449] Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health,* (Washington, DC, Veterans Health Administration, February 2015), 41.
[450] Ibid.

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates delayering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

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

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.[451] Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.[452] Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

[451] Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.
[452] Ibid., 20.

health care delivery and the achievement of action plans.[453] Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.[454] Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.[455] ACHE and other leading practitioners[456] emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals[457] and promote high performance through rewards, recognition, and incentive practices.[458] Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.[459] As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.[460]

Analysis

One of the findings in the *Independent Assessment Report* was that "hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important." More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

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[453] Ibid.
[454] "Policy Statement: Evaluating the Performance of Hospital or Health System CEO," November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, https://www.ache.org/policy/ceo-perf.cfm.
[455] Ibid.
[456] Ibid. NeuroLeadership Institute's "Reengineering Performance Management: How Companies are Evolving Beyond Ratings" webinar, scheduled on January 14, 12-1.
[457] "Implementing FCAT-M Performance Management Competencies: Differentiating Performance," Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/.
[458] Baldrige Performance Excellence Program, *2015-2016 Baldridge Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care),* Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.
[459] Office of Personnel Management. Proficiency Levels for Leadership Competencies. https: www.opm.gov/policy-data-oversight/proficiencylevelsfor leadership competencies/. "Joint Medical Executive Skills Institute," Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, https://www. Joint Medical Executive Skills Institute. JMESI Competency Model. https://jmesi.army.mil/documents.asp, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. www.nchl.org/static.asp?path=2852,3238.
[460] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.[461]

Distinct from performance measurement, the performance management process[462] is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, "Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards."[463] Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,[464] metrics are hard to track in real time and lack the detail required for individual performance assessment,[465]and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.[466] The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.[467]

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.[468] The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.[469] The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).[470] It is critical that these aspirations become policy.

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[461] Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.
[462] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[463] Ibid., 82.
[464] Ibid., 82.
[465] Ibid., 84.
[466] Ibid., 84.
[467] Ibid., 87.
[468] David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).
[469] Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.
[470] Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.[471] As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.[472] These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.[473] Former USH Kizer believes this reporting is insufficient, noting

> *the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*[474]

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.[475] The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.[476] To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

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[471] "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation.
[472] "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, http://www.va.gov/qualityofcare/apps/mcps-app.asp.
[473] Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.
[474] Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014
[475] Baldrige Performance Excellence Program, *2015-2016 Baldridge Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care),* Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.
[476] See the proposed organizational chart at end of Recommendation #12.

These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,[477] although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.[478] The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.[479]

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational 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.[480] The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that 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 by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

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[477] Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template,* Network Directors and Medical Center Director, November 20, 2015.
[478] Baldrige Performance Excellence Program, *2015-2016 Baldridge Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care),* Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.
[479] Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.
[480] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector[481] and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.[482] This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to 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 CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.[483] 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 performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. 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 who deserve further investment and development as leaders from VHA.

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[481] The American College of Healthcare Executives, *2016 Competencies Assessment Tool,* accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 http://www.nchl.org/static.asp?path=2852,3238.

[482] Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

[483] Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

Implementation

Legislative Change

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.

- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.

- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following: [484]

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

[484] Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly,* 84, (2013), 53-64.

- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.[485] The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.[486] This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.[487] Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

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[485] Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians,* accessed June 12, 2016, http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf.
[486] "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, http://vaww.publichealth.va.gov/exposures/index.asp
[487] G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.[488] As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.[489] To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.[490]

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.[491] VA has substantially reduced gender gaps in care,[492] but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.[493]

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

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[488] "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, http://www.womenshealth.va.gov/.
[489] U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care,* April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.
[490] Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.
[491] Ibid.
[492] Ibid.
[493] "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, http://www.womenshealth.va.gov/.

that require health care systems to couple strong policies with appropriate training.[494] In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.[495] VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.[496] VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LBGT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

[494] "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, http://theweek.com/articles/450361/how-va-leading-way-lgbt-patient-care.
[495] "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHEQUITY/Healthcare_Equality_Index.asp
[496] "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, http://theweek.com/articles/450361/how-va-leading-way-lgbt-patient-care.

Workforce

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

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act[497] to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,[498] yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does 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.
  - Promotes veteran preferences and hiring.
  - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, 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/processes.
  - Provides due process and appeals standards to adverse personnel actions.
  - 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 ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

[497] Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).
[498] GPRA Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

component of modernizing the management of federal programs is still missing: reform of human capital management.[499]

The Civil Service Act was initially passed in 1883 and revised in 1978.[500] The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, "the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills."[501] As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.[502]

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

> *the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*[503]

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.[504] The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.[505]

> *The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*[506]

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[499] U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, http://www.gao.gov/assets/80/76520.pdf. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium,* accessed April 11, 2016, http://www.gao.gov/assets/200/197256.pdf.
[500] The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).
[501] Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18.
[502] Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.
[503] Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, https://ourpublicservice.org/publications/download.php?id=18.
[504] Ibid.
[505] Ibid.
[506] Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.[507] DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,[508] President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,[509] and Congress is considering whether the time is right for civil service reform.[510]

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;[509] and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.[510] Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.[513] Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.[514]

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.[511] In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist—all positions critically important to VHA's mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.[512] According to a report from Deloitte, which examined broad human resource (HR) trends, "HR is redesigning almost everything it does—from recruiting to performance management to onboarding to reward systems" to learning and development.[513] Younger workers are driving many of these

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[507] U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff,* GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, http://www.gao.gov/assets/670/664772.pdf.

[508] "Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System," Jared Serbu, Federal News Radio, accessed April 8, 2016, http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/.

[509] "Obama's Budget Touts Progress Within Federal Workforce, but Offers It Nothing New," Eric Katz, Government Executive, accessed April 8, 2016, http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf.

[509] "Brace Yourselves: Congress Preps Civil Service Reform," Andy Medici, Federal Times, accessed April 8, 2016, http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/.

[510] Ibid.

[511] *See, e.g.*, 38 U.S.C. § 7401(1).

[512] *See, e.g.*, 38 U.S.C. § 7401(3).

[513] Joleen Clark, Jack Hetrick, and Donna Schroeder, "Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers," Alternative Personnel System (2014).

changes with expectations for meaningful work, learning opportunities, and career progression.[514] These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).[515] In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.[516]

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.[517] VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.[518] This problem occurs in the face of acknowledged national shortages of physicians[519] and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.[520] Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.[521] Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.[522] During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.[523] In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

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[514] U.S. GAO, The Excepted Service: A Research Profile, GAO/GGD-97-92, accessed April 12, 2016, http://www.gao.gov/assets/80/79968.pdf.
[515] Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, https://ourpublicservice.org/publications/download.php?id=18.
[516] Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015,* 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.
[517] "VA Struggles to Fill Medical Center Positions in Arizona, Across Nation," Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.
[518] Joleen Clark, Jack Hetrick, and Donna Schroeder, Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers, *Alternative Personnel System* (2014).
[519] IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, https://www.aamc.org/download/426242/data/ihsreportdownload.pdf.
[520] "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations," U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, http://www.hrsa.gov/shortage/.
[521] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[522] Ibid., vii.
[523] Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.[524]

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.[525] For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.[526] The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).[527] In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.[528]

The general schedule system also has been identified as a barrier to career advancement.[529] Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series. [530] Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.[531]

The hiring process in VHA is acknowledged to take too long.[532] "HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

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[524] "MyVA, Putting Veterans First," MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.
[525] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[526] Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.
[527] Veterans Health Administration, "Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers," VHA Classification Workgroup, 2014.
[528] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.
[529] Ibid.
[530] "Classification and Qualification: Classifying General Schedule Positions," U.S. Office of Personnel Management, accessed November 24, 2015, https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/.
[531] Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).
[532] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

to 62 days." Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.[533]

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. "The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes."[534] One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.[535]

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA's workforce.[536] An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

> *The existing Personnel system does not meet today's market or demand. With VHA's tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce… An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*[537]

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work–life balance, and for research and teaching in a system that serves the important role of caring for the nation's veterans, lower salaries reduce VHA's competitive edge in the marketplace when trying to attract top talent.[538] For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians' long-term earning potential is dramatically less in VHA than that of their private-sector peers. "At the top of the salary ranges, VHA providers made less than their counter parts

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[533] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical),* 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.
[534] Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans,* 12, accessed April 25, 2016, http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf.
[535] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.
[536] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[537] Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report,* August 2014.
[538] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to $310,000 and on average, $74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry."[539] In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.[540] As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.[541] VHA can offer up to a maximum of $60,000 for 2 years ($30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to $50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to $120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.[542] These amounts range broadly from $80,000 in Arizona and Arkansas, $90,000 in Colorado, $100,000 in Georgia and Alabama, and $190,000 in California.[543]

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans' needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.[544] VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.[545]

These restrictions can make it hard to meet policy requirements for night and weekend schedules[546] without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

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[539] Ibid., 40.
[540] Increases in Rates of Basic Pay, 38 U.S.C. § 7455.
[541] Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report,* August 2014.
[542] "Loan Repayment Program," U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, http://nhsc.hrsa.gov/loanrepayment/.
[543] "Physician Loan Repayment Guide," Jimmy Karnezis, accessed April 13, 2016, https://www.credible.com/blog/physician-loan-repayment-guide/.
[544] Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.
[545] VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.
[546] Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, "Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company's culture and values, its goals and history and its power structure."[547] To make up for inadequate on-boarding and to fill current staff's understanding of VA, VHA is providing *VA 101* training for current employees, with 60 facilities having completed the training in FY 2015.[548] Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.[549]

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.[550] VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.[551] Currently HR professionals in VA are largely focused on compliance with a complex set of rules,[552] rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. 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 organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

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[547]Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success,* 2010, 9-10, accessed May 13, 2016, https://www.shrm.org/about/foundation/products/documents/onboarding percent20epg-percent20final.pdf.
[548] Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.
[549] "MyVA, Putting Veterans First," MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.
[550] McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[551] Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.
[552] Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- 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 who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

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. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

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 consider outsourcing the process as much as practicable through centralized mechanisms.

- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

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

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology 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.

Background

As recognized by GAO, "to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency's people define its character and its capacity to perform."[553] Human capital management, although often viewed as a cost, must be viewed as an investment in business success.[554] For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.[555]

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA "needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

[553] U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, http://www.gao.gov/assets/80/76520.pdf.
[554] Ibid.
[555] U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, http://www.gao.gov/assets/220/217512.pdf.

Veterans."[556] Governance and responsibility for human capital management is fragmented and complicated.[557] Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.[558] Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.[559] Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.[560] Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.[561] Insufficient resources are devoted to training,[562] leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.[563] Transforming HR will require "redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems."[564]

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.[565] HRA has also started a new HR Academy.[566] The academy is intended to demonstrate alignment between training resources and competency requirements[567] and to describe the experience needed to advance to the next position level in human resources.[568] VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

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[556] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[557] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[558] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[559] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[560] Ibid., 110.
[561] Ibid., 61.
[562] Ibid., 67.
[563] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[564] Ibid.
[565] Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.
[566] Ibid.
[567] Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist,* accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUsereIDPChecklist.pdf.
[568] "VA HR Academy: Resources," Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide,* accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;[569] however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work. [570] Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation. [571]

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.[572] (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management 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, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.[573]

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated 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. Top leadership must 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 CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

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[569] Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.
[570]The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.
[571] Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.
[572] Ibid.
[573] Ibid.

The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- 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 that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management[574]
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

[574] U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders,* GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, http://www.gao.gov/assets/80/76520.pdf.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, 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 SECVA must mandate.

HRA must 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 new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must 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.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.[575] The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.

- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

[575] Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

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

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,[576] and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.[577] The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.[578]

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.[579] VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:
(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

[576] Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, https://www.fas.org/sgp/crs/misc/R43928.pdf.
[577] Veterans Benefits, 38 U.S.C. § 101(2).
[578] Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, https://www.fas.org/sgp/crs/misc/R43928.pdf.
[579] Certain Bars to Benefits, 38 U.S.C. § 5303(a).

spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.[580]

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.[581] Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.[582]

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.[583] Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.[584]

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.[585]

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.[586] For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.[587] VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,[588] and willful and persistent misconduct.[589] Neither of those two regulatory terms, which originated in 1944,[590] are defined; neither provides

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[580] Characters of Discharge, 38 C.F.R. 3.12(d).
[581] Certain Bars to Benefits, 38 U.S.C. § 5303(b).
[582] Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, https://www.fas.org/sgp/crs/misc/R43928.pdf.
[583] Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).
[584] Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).
[585] Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review,* 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.
[586] Ibid., 13.
[587] Ibid.
[588] Characters of Discharge, 38 C.F.R. 3.12(d).
[589] Ibid.
[590] Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,[591] with great potential for different VA regional offices reaching different outcomes on the same facts.[592] VA officials have acknowledged that these terms are broad and imprecise,[593] and advocates have documented the resultant disparities in VA adjudicative decisions.[594]

The only specific mental-health exception to the bar-to-benefits rules—that the person was insane at the time of the commission of offense[595]—is very limited. VA regulations define the term *insane*, as follows:

> *An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*[596]

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

> *The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'*[597]

Armed Forces," *Military Law Review,* 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

[591] Ibid., 164, 186.

[592] Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,* accessed May 26, 2016, https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf.

[593] Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review,* 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

[594] Ibid., 68-70.

[595] Characters of Discharge, 38 C.F.R. 3.12(b).

[596] Determinations of Insanity, 38 C.F.R. 3.354(a).

[597] "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/ogc/opinions/1997precedentopinions.asp. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, http://www.va.gov/ogc/docs/1997/Prc20-97.doc.

As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,[598] is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,[599] impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).[600] Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.[601] Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.[602]

- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.

- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

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[598] Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf.

[599] Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews,* 37, no. 1, (2015): 196-212, http://doi.org/10.1093/epirev/mxu006.
Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, http://dx.doi.org/10.1186%2F1471-244X-10-88.

[600] Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241.

[601] Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, http://dx.doi.org/10.1186%2F1471-244X-10-88.

[602] Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

> but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.[603]

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,[604] depression,[605] homelessness,[606] premature mortality,[607] and suicide.[608] Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."[609]

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,[610] yet many former service members are reluctant to seek treatment for behavioral health problems.[611] Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.[612]

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[603] Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,* 42, 44, accessed May 26, 2016, https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf.

[604] Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, http://www.sciencedirect.com/science/article/pii/S0376871612003328.

[605] Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine,* 79, no. 2 (2012): 92-97, http://doi.org/10.3949/ccjm.79a.11069.

[606] Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, http://doi.org/10.7205/MILMED-D-13-00080.

[607] Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, http://www.science direct.com/science/article/pii/S1047279705001109.

[608] Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, http://www.sciencedirect.com/science/article/pii/S0165032714001189.

[609] Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review,* 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

[610] Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, http://www.ncbi.nlm.nih.gov/pubmed/10761674.

[611] American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans.

[612] Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,* 74-78, accessed May 26, 2016, https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf.

Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.[613] In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.[614] This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

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 thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.

- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

[613] Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).
[614] Tentative Eligibility Determinations, 38 C.F.R. 17.34.

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

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.[615] Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.[616]

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.[617]

- The World War Veterans Act of 1924, which established the Veterans Bureau[618] (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.[619]

- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.[620]

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[615] The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[616] Ibid., 25.
[617] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.
[618] The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.
[619] World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).
[620] Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).[621]

- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,[622] exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.[623]

- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.[624]

- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.[625]

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,[626] VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.[627] It essentially provided that all veterans are eligible for VA hospital care and *medical services*.[628]

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[621] Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).
[622] Pub. L. No. 91-500.
[623] S. Rep. No. 91-481.
[624] Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).
[625] Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.
[626] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).
[627] Ibid.
[628] The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.[629] This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.[630] The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.[631] The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.[632]

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.[633] Although law and VA regulation require a system of annual patient enrollment,[634] VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.[635] In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.[636]

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comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

[629] Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

[630] Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would…provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment…Enrollment…would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary…to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No.104-690, 6-7.

[631] Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

[632] Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

[633] H. Rep. No. 104-690, 16.

[634] Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

[635] Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

[636] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

Table 8. Priority Groups

Priority Group	Definition
1	▪ Veterans with VA-rated service-connected disabilities 50% or more disabling ▪ Veterans determined by VA to be unemployable due to service-connected conditions
2	▪ Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	▪ Veterans who are former prisoners of war ▪ Veterans awarded a Purple Heart medal ▪ Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty ▪ Veterans with VA-rated service-connected disabilities 10% or 20% disabling ▪ Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" ▪ Veterans awarded the Medal of Honor
4	▪ Veterans who are receiving aid and attendance or housebound benefits from VA ▪ Veterans who have been determined by VA to be catastrophically disabled
5	▪ Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits ▪ Veterans receiving VA pension benefits ▪ Veterans eligible for Medicaid programs
6	▪ Compensable 0% service-connected veterans ▪ Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki ▪ Project 112/SHAD (shipboard hazard and defense) participants ▪ Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 ▪ Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 ▪ *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 ▪ Veterans who served in a theater of combat operations after November 11, 1998 as follows: – Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. – **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for. *Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income. *Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits
7	▪ Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays **Veterans eligible for enrollment:** Noncompensable 0% service-connected: – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less Non-service-connected and: – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less **Veterans not eligible for enrollment:** Veterans not meeting the criteria above: – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan[637] where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.[638] Post-9/11-era veterans are enrolling for VA care at historically high levels.[639]

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.[640] As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

[637] Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File,* (Dec. 31, 2015).
[638] Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families,* (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx.
[639] Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.
[640] Veterans Health Administration, *Enrollment Determinations,* VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

statutory service-connected enrollment priority has little practical significance.[641] Future budget constraints could result in more restrictive enrollment criteria[642] or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.[643] All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.[644] It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems[645] or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.[646] It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,[647] it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.[648]

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.[649] Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.[650]

Congress has made only limited provision for VA to cover care for family members of certain veterans,[651] but with research suggesting that long combat deployments can take a

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[641] Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.
[642] Enrollment, 38 C.F.R. 17.36(c)(1).
[643] Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, https://www.govtrack.us/congress/bills/114/hr203/text.
[644] Readjustment Counseling Service, 38 U.S.C. § 7309.
[645] American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans.
[646] Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, http://doi.org/10.1056/NEJMoa1101388.
[647] Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, http://doi.org/10.1161/CIRCULATIONAHA.113.005407.
[648] Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, http://doi.org/10.1161/CIRCULATIONAHA.114.009286.
[649] Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).
[650] Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).
[651] Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,[652] there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.[653] Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.[654]

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.[655] VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.[656] Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.[657] Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,[658] it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.[659]

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

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[652] Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, http://dx.doi.org/10.1186%2F1471-244X-10-88. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,* 42, 44, accessed May 26, 2016, https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf.

[653] H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, http://www.ncbi.nlm.nih.gov/pubmed/21521089.

[654] Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058–1066, accessed June 20, 2016, http://doi.org/10.1542/peds.2009-2856. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families, Pediatrics," 125, no. 1 (2010): 16-25, accessed June 20, 2016, http://doi.org/10.1542/peds.2009-1180.

[655] Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association,* 307, no. 8 (2012): 789-790, accessed June 20, 2016, http://doi.org/doi:10.1001/jama.2012.196.

[656] Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

[657] "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, http://explore.va.gov/health-care-affordable-care-act?show=all.

[658] Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association,* 307, no. 8 (2012): 789-790, accessed June 20, 2016, http://doi.org/doi:10.1001/jama.2012.196.

[659] "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.[660]

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.[661] Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.[662] 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[663] as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. 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.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

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[660] Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.
[661] Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care,* 13, no. 5 (2004): 379-383, http://doi.org/10.1136/bmj.38030.642963.AE. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association,* 277, no. 11 (1997): 892–898, http://doi.org/10.1001/jama.1997.03540350042031.
[662] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.
[663] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 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 Agency Administrative Changes

- None required.

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APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

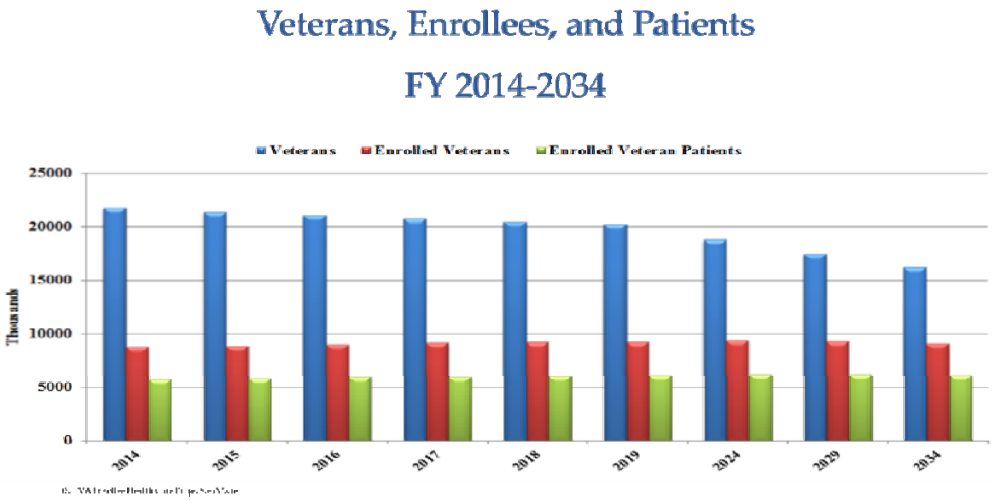
utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.[664]

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from $53 billion in 2014 to $125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

[664] Veterans qualifying based on wait times or excessive travel burdens are not included.

utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.[665] In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see Recommendation 1) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-

[665] Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

managed networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.[666] We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.[667] A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

[666] CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.
[667] Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.[668] We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.[669]

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative* 3 and the

[668] Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly,* 90(1) (2012), 107-134.

[669] Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251–77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and* 2.[670] Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).[671] In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

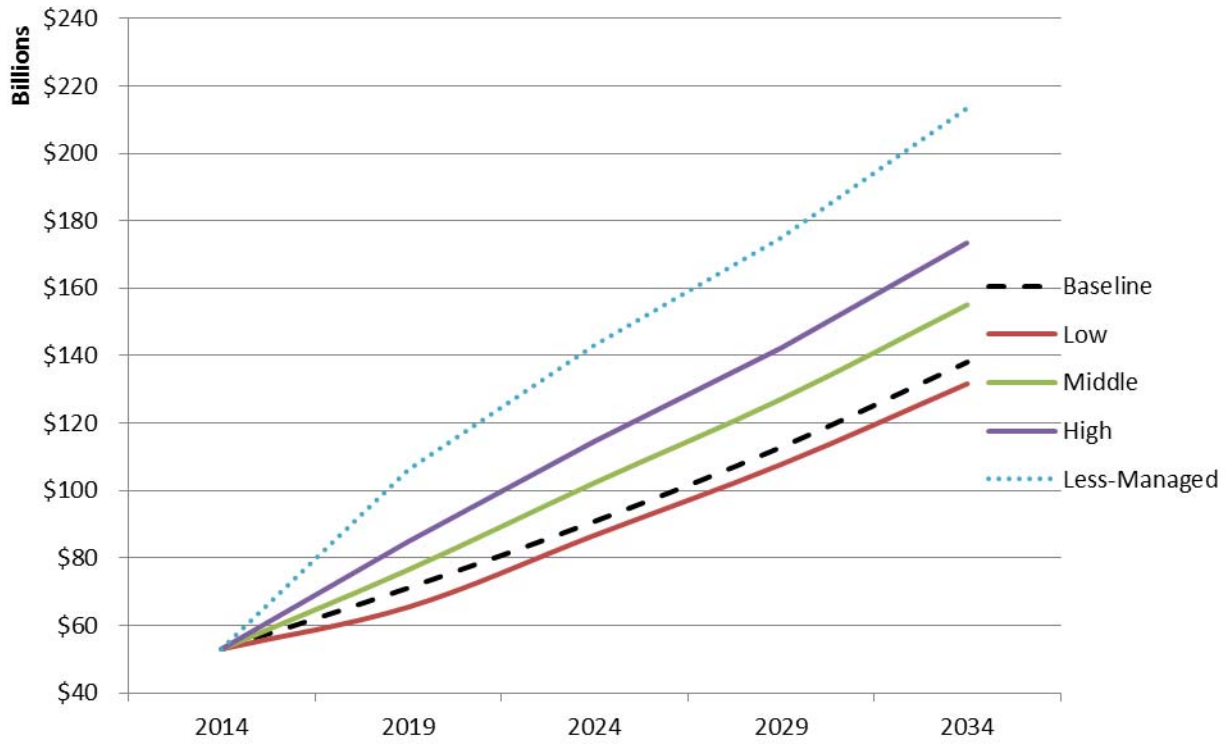
We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

[670] Assumptions based on previous analysis by VHA and Milliman.
[671] Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from $65 billion to $85 billion in 2019, with a middle estimate of $76 billion. The middle estimate is moderately above the baseline projection of $71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is $106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	$53	$ 71	$ 138
Recommended (low)	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%		$ 65	$ 132
Recommended (middle)	same	same	15%	50%		$ 76	$ 155
Recommended (high)	same	same	20%	60%		$ 85	$ 173
Recommended (less-managed)	same	same	50%	60%		$ 106	$ 213
Alternative 1 (low)	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%		$ 66	$ 128
Alternative 1 (middle)	same	same	5%	35%		$ 73	$ 140
Alternative 1 (high)	same	same	10%	50%		$ 78	$ 151
Alternative 2 (low)	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%		$ 97	$ 191
Alternative 2 (middle)	same	same	10%	80%		$ 123	$ 243
Alternative 2 (high)	same	same	20%	100%		$ 154	$ 307
Alternative 3 (low)	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%		$ 167	$ 320
Alternative 3 (middle)	same	same	85% (level)	90%		$ 206	$ 395
Alternative 3 (high)	same	same	95% (level)	100%		$ 250	$ 479
Keep Selected Services (low)	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%		$ 64	$ 128
Keep Selected Services (middle)	same	same	4%	25%		$ 70	$ 136
Keep Selected Services (high)	same	same	8%	40%		$ 75	$ 145
Premium Support	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%			$ 82	$ 158
Eligibility Expansion	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%			$ 72	$ 140
Initiatives	Nurse navigators for CDS care					$ 71	$ 138
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated					$ 72	$ 139

Additional Sample Cost Models

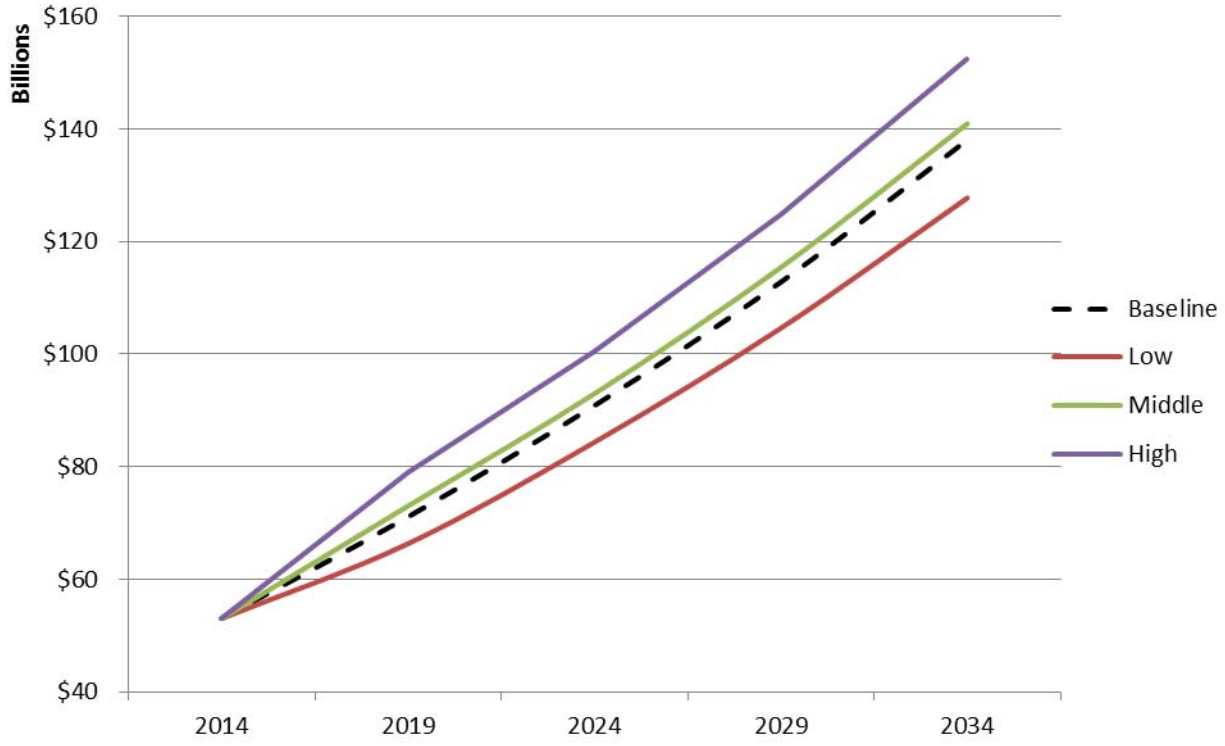
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option,* we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from $66 billion to $78 billion in 2019, with a middle estimate of $73 billion. As in the *Recommended Option,* the middle estimate is close to the baseline projection of $71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

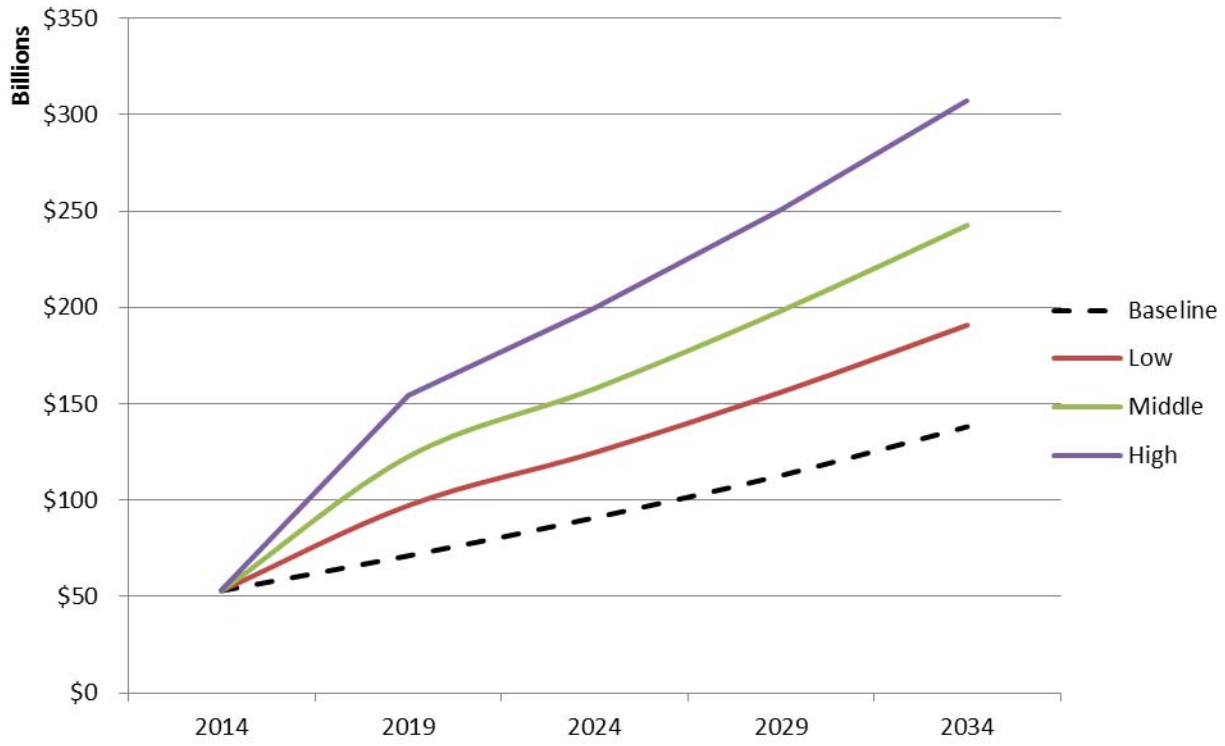
Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

Estimates are displayed in Figure A-4. In 2019, the baseline projection is $71 billion. *CDS Alternative 2* estimates range from $97 billion to $154 billion, with a middle estimate of $123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

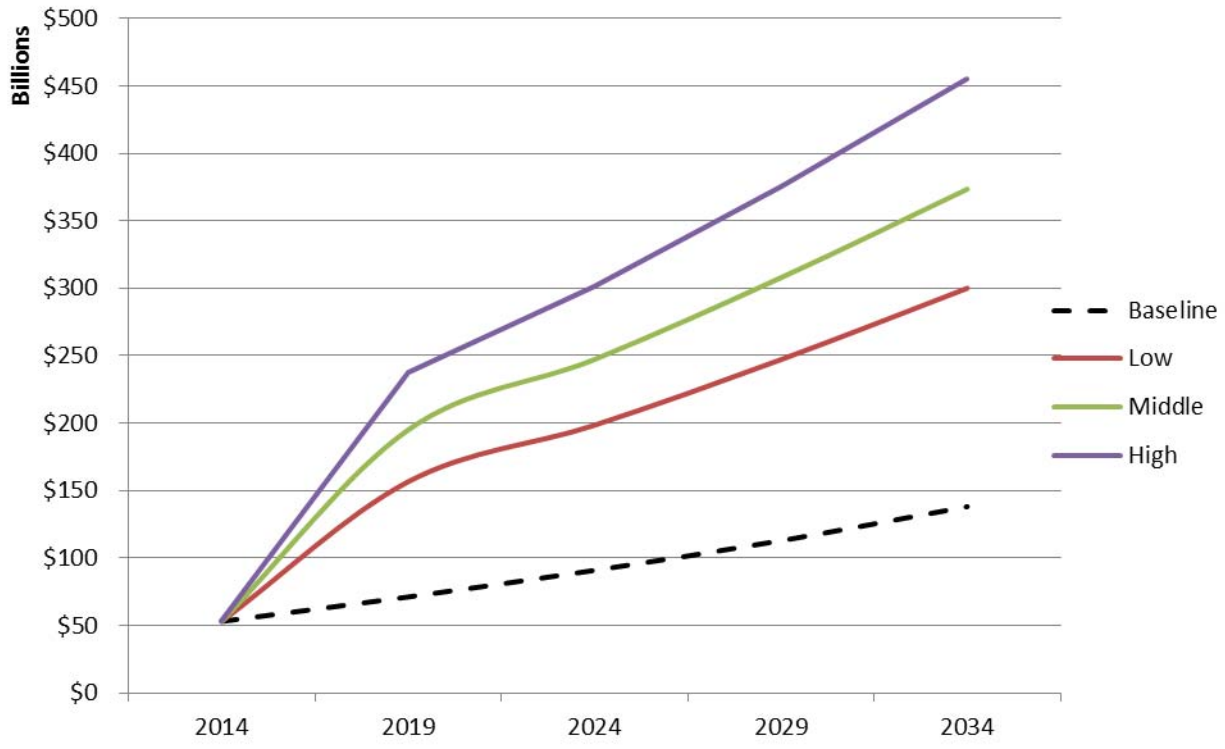
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,[672] and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from $156 billion to $237 billion, with a middle estimate of $195 billion. This compares to a baseline projection of $71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and *CDS Alternatives 1 and 2*.

Figure A-5. Projected Costs of CDS Alternative 3



[672] Yu-Chu Shen and Stephen Zuckerman, "The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries," *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

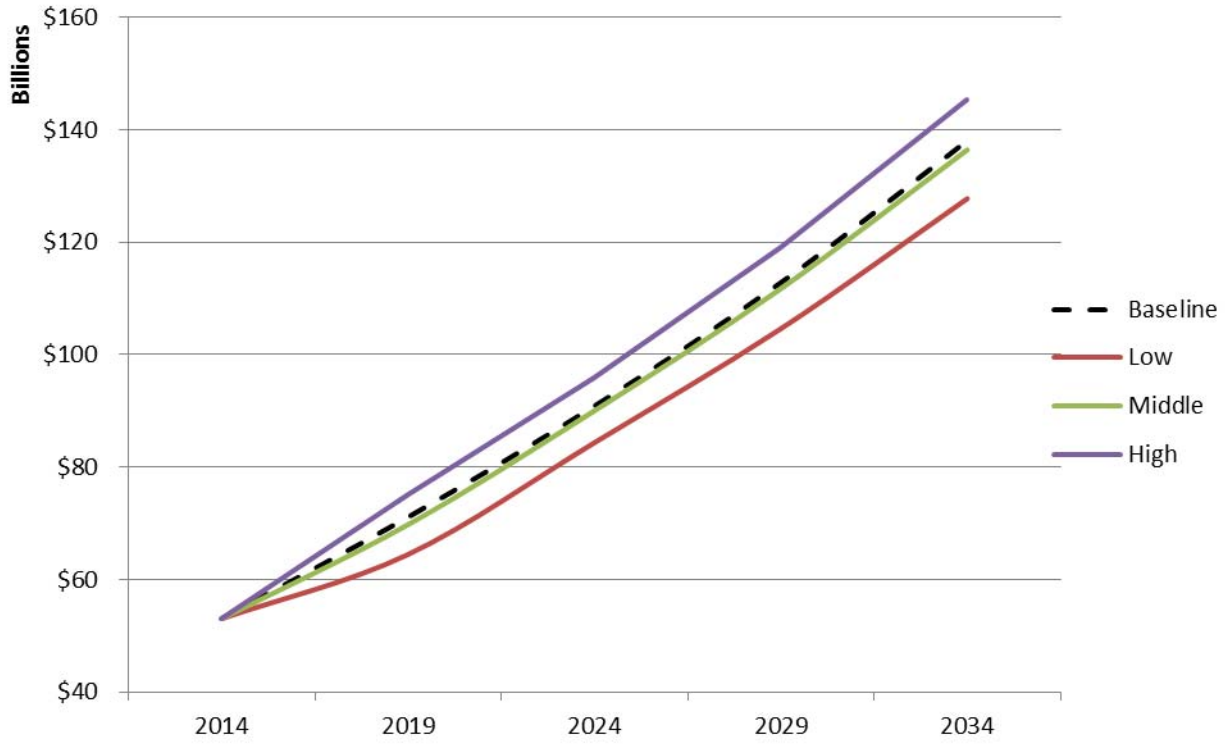
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from $64 billion to $75 billion, with a middle estimate of $70 billion. This estimate compares to a baseline projection of $71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support[673]

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

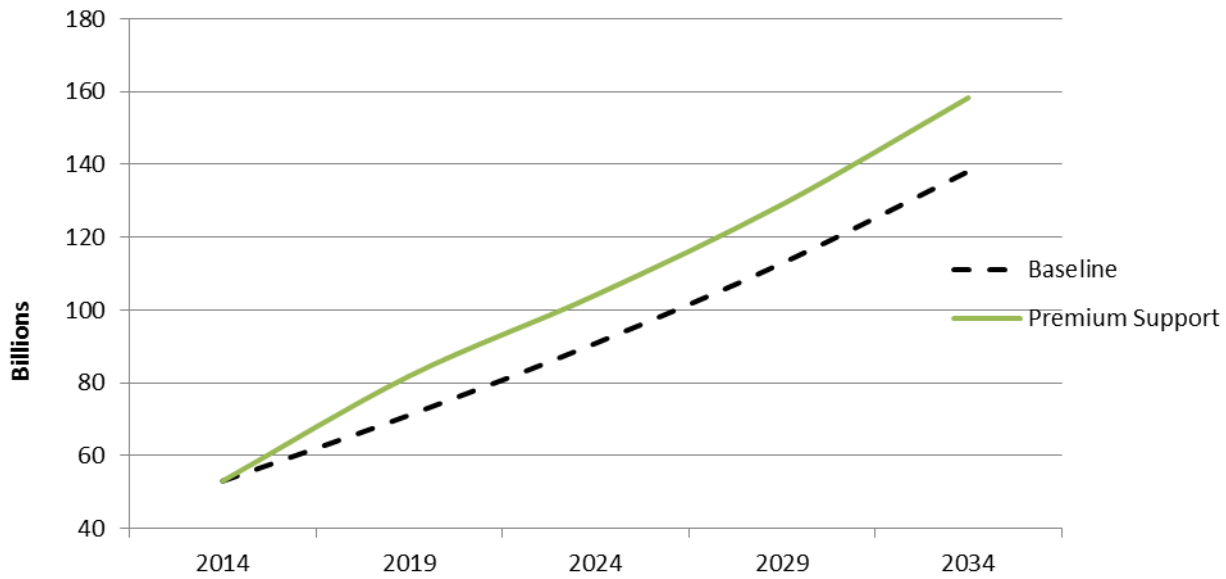
For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

[673] Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion[674]

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,[675] and 8d were enrolled, representing a 50 percent *market share*,[676] with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

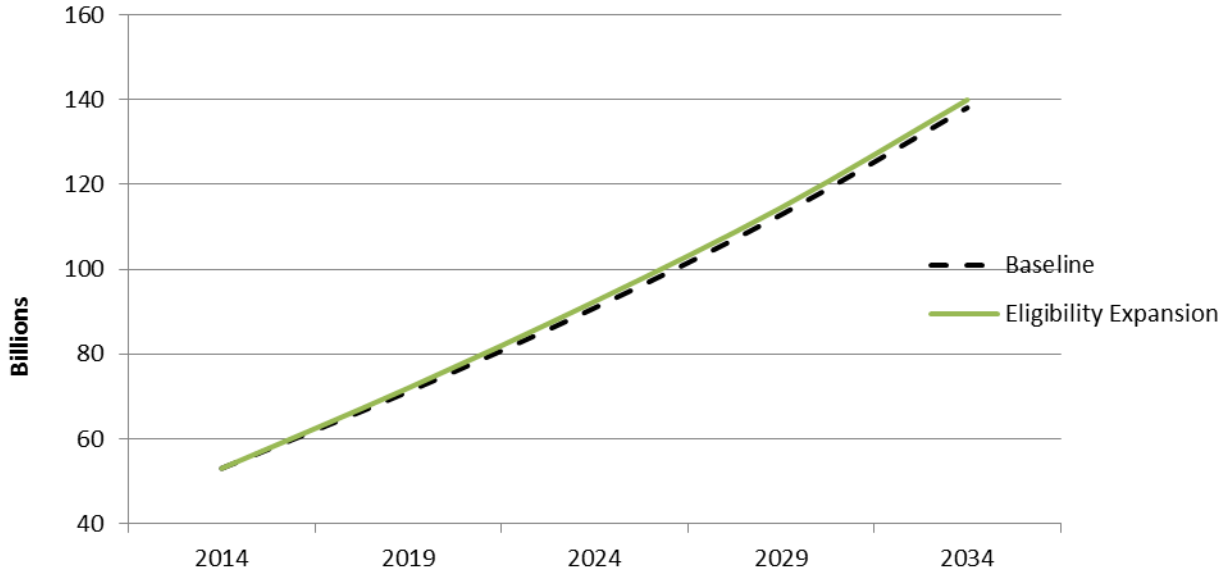
Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

[674] Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.
[675] Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.
[676] Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional $1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

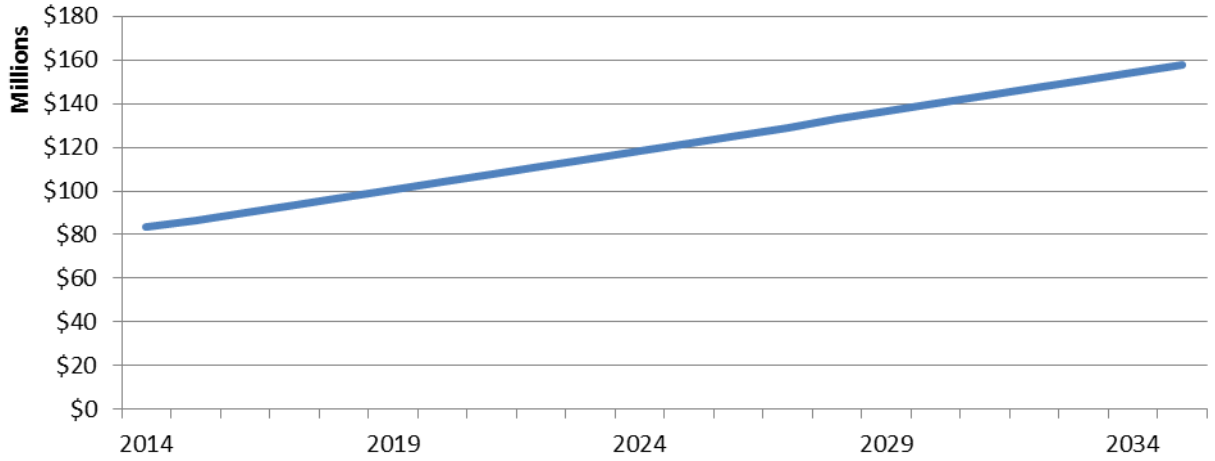
VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase community care such as that associated with the CDS scenarios.[677] Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers ($94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is $100 million in 2019 and rises to $158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

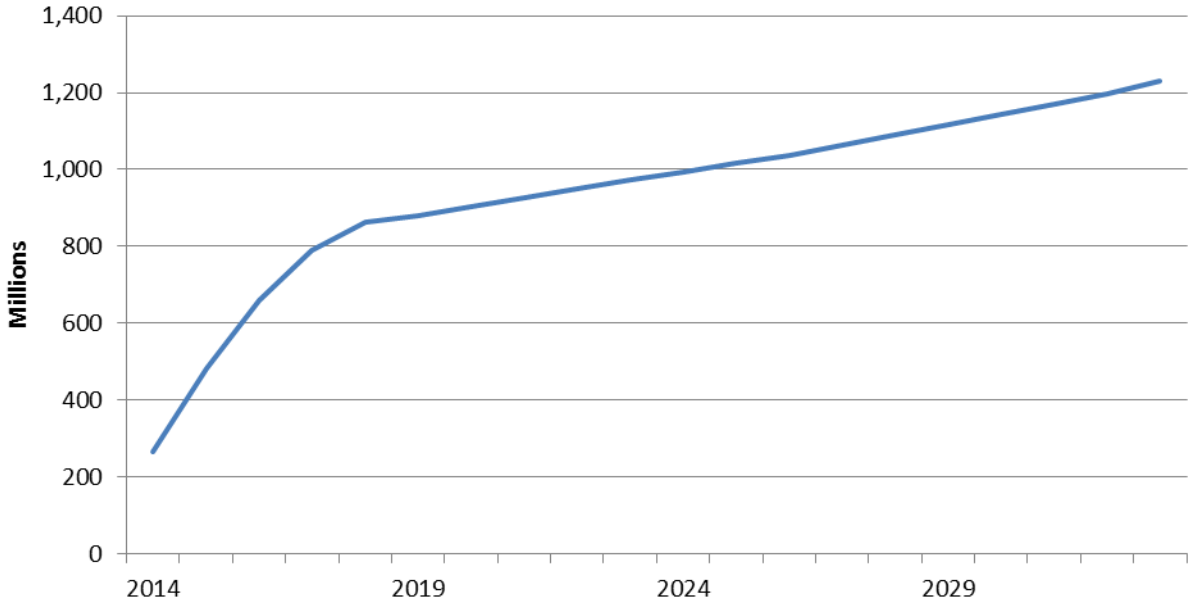
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

[677] These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from $264 million in 2014 to $1.23 billion in 2033. Fully phased-in, the cost is $864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B: LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

Table B-2. Recruitment, Retention, Development, and Advancement

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on $)

Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
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 delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage 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.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the 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. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/ OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/ DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA 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).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.[678]

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytruama unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

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[678] Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care,* 13, no. 5 (2004): 379-383, http://doi.org/10.1136/bmj.38030.642963.AE. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association,* 277, no. 11 (1997): 892–898, http://doi.org/10.1001/jama.1997.03540350042031.

Background

Current Nonveteran Access to VHA Care

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of $1.9 billion in 2015,[679] or 3.6 percent of total VHA obligations.[680]

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law "consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with" the veteran's treatment.[681]

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.[682] In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans' programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

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[679] Allocation Resource Center, information provided to Commission on Care, December 8, 2015.
[680] Department of Veterans Affairs, "Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations," accessed May 27, 2016, http://www.va.gov/budget/products.asp.
[681] Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.
[682] Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf.

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

Demonstration Projects to Assess VHA's Capability to Treat Nonveteran Spouses and Ineligible Priority 8 Veterans

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any "profit" associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving "level of effort" in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

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APPENDIX D: HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.[683]

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."[684] At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.[685]

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.[686] With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.[687]

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[683] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.
[684] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.
[685] Ibid., 19.
[686] Ibid., 21.
[687] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.[688]

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.[689] Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

> *The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.*[690]

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.[691] Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,[692] with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.[693] By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.[694]

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

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[688] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.
[689] Ibid., 23-25.
[690] Ibid., 22.
[691] "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38.
[692] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.
[693] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.
[694] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,"[695] according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.[696] VA was operating 162 hospitals, with an average census of more than 104,000 patients.[697] A VA historian observed that "waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals."[698] At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.[699] Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.[700]

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.[701] During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.[702]

The expiration of the incumbent CMD's term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S' statutory role to include medical research.[703] During Middleton's tenure, from 1955 to 1963, VA research funding grew from some $6 million to more than $30 million.[704] Middleton's work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.[705] The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

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[695] Ibid., 29.
[696] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.
[697] Ibid.
[698] Ibid.
[699] Ibid., 253.
[700] Ibid., 253-254.
[701] Ibid., 256.
[702] Ibid., 258.
[703] Ibid., 262-263.
[704] Ibid., 263-264.
[705] Stanley Zucker et al., "Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists," *The FASEB Journal,* 18, no. 13, (2004): 1481-1486, http://doi.org/10.1096/fj.04-1573lfe.

of chemotherapy for tuberculosis.[706] Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.[707]

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).[708]

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.[709] Some 59 percent responded, and nearly two-thirds of respondents preferred VA.[710] At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.[711]

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.[712] The commission's recommendation for integrating the VA system into the nation's civilian health care program[713] provoked objection, particularly in Congress.[714] Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

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[706] Ibid.
[707] Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.
[708] Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.
[709] Ibid., 390.
[710] Ibid.
[711] Ibid.
[712] *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs,* 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.
[713] J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, http://doi.org/10.1056/NEJM199006283222605.
[714] *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs,* 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).[715] The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.[716] The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a $12 billion budget.[717]

Facing an aging veteran population[718] expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.[719] Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.[720]

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.[721] Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.[722]

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[715] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.
[716] Ibid., 33-40.
[717] Ibid., 50.
[718] As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000-a 50percent increase over the 1988 level. U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, http://www.gao.gov/assets/150/149139.pdf.
[719] U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, http://www.gao.gov/assets/150/149139.pdf.
[720] U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, http://archive.gao.gov/f0902a/153054.pdf.
[721] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.
[722] "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html.

Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.[723] Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.[724] With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.[725]

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.[726] His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."[727] At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.[728] He set the tone for what was to come at a meeting with senior managers at which he stated,

> *The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*[729]

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.[730] Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.[731] The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.[732]

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[723] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.
[724] Ibid., 92.
[725] Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.
[726] Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, http://doi.org/10.1056/NEJMsa021899.
[727] Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.
[728] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.
[729] Ibid., 105.
[730] Ibid., 110.
[731] "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, https://psnet.ahrq.gov/perspectives/perspective/31.
[732] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.[733] Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.[734]

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,[735] and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.[736]

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,[737] and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.[738] These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.[739]

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi–campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.[740]

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "…places like Florida, Arizona, and the

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[733] Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, http://doi.org/10.1146/annurev.publhealth.29.020907.090940.
[734] Ibid., 318-323.
[735] VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.
[736] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.
[737] Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, http://doi.org/10.1146/annurev.publhealth.29.020907.090940.
[738] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.
[739] Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, http://doi.org/10.1146/annurev.publhealth.29.020907.090940.
[740] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect."[741] Kizer's team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.[742]

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law's priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.[743] The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.[744] That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans "to keep the system solvent."[745] At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that "maintaining obsolete or duplicative structures diverts $1 million a day, every day, every year, away from the care of veterans." Principi did not want to repeat Kizer's experience and hoped to avoid political backlash.[746]

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.[747] As the then USH later recounted, "CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts."[748]

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans' health care system continue to be heralded for several years.[749] A cascade of other events muddied, and even blackened, VHA's reputation:

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[741] Ibid., 133-134.
[742] Ibid., 168-169.
[743] Veterans Affairs Comm., Veterans' Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, https://www.congress.gov/congressional-report/104th-congress/house-report/690/1.
[744] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.
[745] Ibid., 194.
[746] Ibid., 195.
[747] Ibid., 196.
[748] Ibid.
[749] "The Best Care Anywhere," Phillip Longman, Washington Monthly, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;[750] hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

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http://www.washingtonmonthly.com/features/2005/0501.longman.html. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot.

[750] James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

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APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.[751] IBM Center for Applied Insight reports that there are 18 trends to watch in health care.[752] These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topic addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.[753] The industry will see more high profile mergers and acquisitions in the second half of 2016.[754] The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.[755] With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.[756] Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

[751] Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs,* 15, 4, (1996): 93-104.
[752] "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IMB Center for Applied Insights, March 1, 2016, accessed June 20, 2016, https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016.
[753] "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf.
[754] Ibid.
[755] Ibid.
[756] "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all.

modified for future changes and medical advances.[757] VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.[758] During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.[759] This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.[760] Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.[761]

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

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[757] "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, http://www.healthcaredesignmagazine.com/article/small-hospital-future.
[758] "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care.
[759] "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, http://www.nationalpartnership.org/issues/health/macra.html.
[760] "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html.
[761] "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.[762] Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.[763] As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."[764] Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.[765] Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.[766] As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."[767] In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.[768] These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.[769] Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."[770] Telemedicine includes a growing variety of applications and

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[762] Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, http://www.ncbi.nlm.nih.gov/pubmed/21183845.
[763] "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, https://hbr.org/2013/10/the-strategy-that-will-fix-health-care.
[764] "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/.
[765] Ibid.
[766] "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf.
[767] "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, http://advamed.org/page/74/value-in-medical-technology.
[768] "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, http://hinj.org/value-of-medical-innovation/.
[769] Ibid.
[770] "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ.

services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.[771] The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.[772] Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.[773] These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

[771] "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.
[772] "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html.
[773] "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, https://hbr.org/2013/10/the-strategy-that-will-fix-health-care.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.[774] Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed[775] and people are living longer.[776] Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.[777] Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.[778] The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.[779] The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.[780] Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

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[774] "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/.
[775] "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx.
[776] National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, http://www.cdc.gov/nchs/data/hus/hus15.pdf.
[777] National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, http://www.cdc.gov/nchs/data/hus/2011/022.pdf.
[778] Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, http://www.avpowell.com/docs/Fall1997.pdf.
[779] "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, https://hbr.org/2013/10/the-strategy-that-will-fix-health-care.
[780] "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, http://www.cdc.gov/chronicdisease/overview/.

most to be a chronic disease.[781] The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.[782] Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.[783] Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.[784] Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.[785]

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).[786] Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.[787] Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.[788] In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.[789] Using CHNA and CHIP could be part of VHA's ongoing planning process.

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[781] Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.
[782] "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.
[783] D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.
[784] "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/.
[785] "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC.
[786] "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act.
[787] "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/.
[788] "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/.
[789] District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010,* accessed May 3, 2016, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.[790] This law lead to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system. [791] VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.[792] Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.[793] Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."[794] Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.[795] Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."[796] Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

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[790] "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016, http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all.
[791] "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act.
[792] "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page.
[793] "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/.
[794] Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.
[795] "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/.
[796] "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf.

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APPENDIX F: THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015	
Assessment A: Demographics	RAND Corporation ▪ Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation ▪ Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs ▪ Bob McDonald, Secretary ▪ Sloan Gibson, Deputy Secretary ▪ David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation ▪ Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP ▪ Lane Jackson ▪ Aamir Syed ▪ Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company ▪ Kurt Grote, MD ▪ Alex Harris ▪ Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company ▪ Kurt Grote, MD ▪ Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP ▪ Peter Erwin, PhD ▪ Hillary Peabody ▪ Erik Shannon
Assessment J: Supplies	McKinsey & Company ▪ Kurt Grote, MD ▪ Robin Roark, MD
Assessment K: Facilities	McKinsey & Company ▪ Vivian Riefberg ▪ John Means

September 21-22, 2015 (continued)	
VHA Leadership	Department of Veterans Affairs ▪ Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care ▪ Stephen Kirin ▪ Jay Schnitzer, PhD, MD McKinsey & Company ▪ Vivian Riefberg
Assessment H: Health IT	MITRE Corporation ▪ Aparna Durvasula ▪ Glenn Himes McKinsey & Company ▪ Celia Huber ▪ Vivian Riefberg
October 6, 2015	
Eligibility	Veterans Health Administration ▪ Stephanie Mardon, Chief Business Officer ▪ Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration ▪ Stephanie Mardon, Chief Business Officer ▪ Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration ▪ Joe Dalpiaz, Director, VISN 17 ▪ Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs ▪ Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration ▪ Robert Jesse, MD, Chief, Office of Academic Affiliations ▪ Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care ▪ Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015	
Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council ▪ Ken Mullins
Scheduling	Veterans Health Administration ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services
November 16–17, 2015	
Health Care Economics/Finance	▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

December 14-16, 2015	
Minority Affairs and Health Equity	Department of Veterans Affairs ▪ Barbara Ward, Director, Center for Minority Affairs Veterans Health Administration ▪ Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	▪ Garry Augustine, Disabled American Veterans ▪ Carl Blake, Paralyzed Veterans of America ▪ Carlos Fuentes, Veterans of Foreign Wars ▪ Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	▪ Louis Celli, The American Legion ▪ Renee Campos, Military Officers Association of America
National Health Information Operability	▪ Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	▪ Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	▪ Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration ▪ Dr. Harry Leider, Chief Medical Officer, Walgreens ▪ James Wood, VP-Federal, Walgreens ▪ Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	▪ LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	▪ Charles Rossotti, Former Commissioner, Internal Revenue Service
January 19 and 21, 2016	
VHA Leadership	▪ Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration ▪ Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	American Federal of Government Employees ▪ Marilyn Park National Association of Veterans Affairs Physicians and Dentists ▪ Samuel Spagnolo Nurses Organization of Veterans Affairs ▪ Joan Clifford ▪ Sharon Johnson

January 19 and 21, 2016 (continued)	
Behavioral Health	Association of Veterans Affairs Psychologist Leaders ▪ Thomas Kirchberg ▪ Russell Lemle ▪ Edgardo Padin-Rivera ▪ Antonette Zeiss American Psychiatric Association ▪ Jenny L. Boyer Association of Veterans Affairs Social Workers ▪ LeAnn Bruce ▪ Jerry Satterwhite
Homeless Veterans	▪ Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	▪ Branford Adams
February 8-9, 2016	
Construction Management	▪ Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	▪ Joleen Clark, Former Network Director, VISN 8 ▪ Jon Gardner, Former Medical Center Director, Tucson VA Medical Center ▪ Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the *Choice Program*	▪ Billy Maynard, President HealthNet Federal Service ▪ David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	▪ Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	▪ Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee
February 29 – March 1, 2016	
Economist Briefing	▪ Gideon Lukens, PhD, Staff Economist ▪ Jamie Taber, PhD, Staff Economist
March 21-23, 2016	
Conversation with HVAC Chairman	▪ Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	▪ Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	▪ Dr. David Shulkin, Undersecretary for Health ▪ Barbara Manning, Office of Policy and Planning ▪ Lyn Stoesen, Office of Policy and Planning

March 21-23, 2016 (continued)	
Economist Briefing	▪ Gideon Lukens, PhD, Staff Economist ▪ Merideth Randles, FSA, MAAA, Milliman, Inc. ▪ Jamie Taber, PhD, Staff Economist
April 18-19, 2016	
Veterans Service Organizations	▪ Garry Augustine, Disabled American Veterans ▪ Peter Dickinson, Disabled American Veterans ▪ Verna Jones, American Legion ▪ Rick Weidman, Vietnam Veterans of America ▪ Bill Rausch, Got Your 6 ▪ Ray Kelley, Veterans of Foreign Wars ▪ Rene Campos, Military Officers Association of America
Economist Briefing	▪ Gideon Lukens, PhD, Staff Economist ▪ Jamie Taber, PhD, Staff Economist
VA Leadership	Department of Veterans Affairs ▪ Bob McDonald, Secretary ▪ Sloan Gibson, Deputy Secretary
Community Care	▪ Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA
May 9-11, 2016	
VA Office of General Counsel	▪ Leigh Bradley, General Counsel ▪ Jessica Tanner, Staff Attorney
Economist Briefing	▪ Gideon Lukens, PhD, Staff Economist ▪ Jamie Taber, PhD, Staff Economist
June 7-8, 2016	
No speakers	

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance	▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick	▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity	▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster	▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities	▪ Blom ▪ Harvey ▪ Steele	▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	▪ Organizational Health ▪ Leadership Systems	▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele	▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	▪ Market Trends ▪ Technology ▪ Financing ▪ Vision	▪ Blom ▪ Johnson ▪ Schlichting	▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved. Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E=email review M=face-to-face meeting		EXPERT INPUT S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E=email review M=face-to-face meeting		EXPERT INPUT S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Other-Than-Honorable Discharge	1/28/2016	C	Bradford Adams	1/20/2016	F
	2/18/2016	C			
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Organization of Provider Networks	1/28/2016	C	Peter Hussey	9/21/2015	F
	2/25/2016	C	Joe Dalpiaz	10/6/2015	F
	3/10/2016	C	Baligh Yehia	10/6/2015	F
	3/17/2016	C	Gene Migliaccio	10/6/2015	F
	4/7/2016	C	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E= email review M= face-to-face meeting		EXPERT INPUT S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
			Dr. Melanie Vielhauer		
			Rosemary Conlon		
Best Practices	1/6/2016	C	McKinsey Co	9/22/2015	F
	1/20/2016	M	Dr. Theresa Cullen	12/2/2015	W
	2/25/2016	C	Dr. Daniel Bochicchio	12/3/2015	S
	3/14/2016	E	David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E= email review M= face-to-face meeting		EXPERT INPUT S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council, Chris Miller, Brian Burns	10/27/15	HVAC Hearing
	3/7/2016	C	Brookings Institution	11/6/2015	S
	3/14/2016	C	LaVerne Council	11/25/2015	S
	3/21/2016	M	Dr. Theresa Cullen	12/2/2015	W
	4/4/2016	C & E	Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E= email review M= face-to-face meeting		EXPERT INPUT S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E= email review M= face-to-face meeting		EXPERT INPUT S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
Recruitment, Retention, Development, and Advancement	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
Organizational Structure and Function	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Robin Hemphill	¾/2016	S
Performance Management and Performance Measurement	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

WORKGROUP TOPIC	WORKGROUP ACTIVITY C=call E= email review M= face-to-face meeting		EXPERT INPUT S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.[797] The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.[798] Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.[799]

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers. [800] Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report,* to contribute to an environmental scan of the VHA, and to inform the development of recommendations.[801]

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

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[797] Kenneth W. Kizer, M.D., M.P.H/Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System,* accessed March 1, 2016, http://www.va.gov/healthpolicyplanning/rxweb.pdf.
[798] Kicab Castaneda-Mendez/Quality Digest, Performance Measurement in Health Care, accessed, March 1, 2016, http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#.
[799] Ibid.
[800] Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, http://vaww.ush.va.gov/.
[801] The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.[802]

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.[803] Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

[802] "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.
[803] "Veterans Integrated Service Networks (VISN)", Department of Veterans Affairs, VHA, accessed March 14, 2016 http://www.va.gov/directory/guide/division.asp?dnum=1.

dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. SWOT Analysis of Commissioner Site Visit Observations

Strengths	Weaknesses	Opportunities	Threats
▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs	▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules	▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders	▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report,* the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."[804] The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

[804] Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.[805]

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.[806]

Survey of Healthcare Experiences of Patients[807]

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

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[805] "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, http://www.va.gov/QUALITYOFCARE/apps/contact.asp. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.
[806] Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.
[807] For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.[808] VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)[809] concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.[810] The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

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[808] Ibid.

[809] Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

[810] U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014,* accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

Table G-1. Veteran Profiles Developed by the VA Center for Innovation[811]

THE LIFER	THE TRANSACTIONAL
Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans. **Expectations** ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime **Needs** ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care	Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised. **Expectations** ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network **Needs** ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

[811] Ibid.

THE JUST-IN-CASE	THE INFREQUENT
Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan. **Expectations** ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease **Needs** ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question	Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website. **Expectations** ▪ That VA is slow—like any bureaucracy ▪ That VA is for "other, injured veterans who need it more" ▪ That someone will tell veterans when and if they are eligible for something **Needs** ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA's Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.[812]

Veterans' Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

[812] "Vantage Point: Official Blog of the U.S. Department of Veterans Affairs," Department of Veterans Affairs, accessed June 20, 2016, http://www.blogs.va.gov/VAntage/.

The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.[813] The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.[814] In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.[815] Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.[816] Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

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[813] Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans,* accessed June 20, 2016, https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

[814] Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care,* September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

[815] Ibid., 4.

[816] "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.[817]

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems. [818]

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.[819]

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.[820] This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

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[817] "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment.
[818] ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report,* March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.
[819] "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/.
[820] Westat, *2015 Wounded Warrior Project Survey, Report of Findings,* August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.[821] Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual "conversations" with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.[822] The Commission's review of the material showed that a majority of the veterans' comments were positive in nature. DAV's own analysis concluded that 82 percent of the comments could be categorized as "overall positive experiences."

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans' health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.[823] This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans' healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

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[821] Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community,* Swords to Plowshares, Institute for Veterans Policy, April 2016.
[822] Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.
[823] Concerned Veterans for America, Fixing Veterans Health Care, A Bipartisan Policy Taskforce, accessed June 20, 2016, http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

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APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report,* http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities),* http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now,* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership),* http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.
www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.
http://deploymentpsych.org/online-courses
http://deploymentpsych.org/military-culture-course-modules

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.
http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December 2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.
https://www.swords-to-plowshares.org/combat-to-community

VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**
  The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**
  This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**
  This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**
  This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**
  This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
  This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.

- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
  This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

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APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT.—

(1) ASSESSMENT.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(1) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third- party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS.—

(A) SCHEDULING ASSESSMENT.—In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department—

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT.—In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING.—The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED.—A private entity described in this subsection is a private entity that—

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR.—

(1) IN GENERAL.—If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES.—The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT.—

(1) IN GENERAL.—Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION.—Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED.—In this section, the term ''non-Department facilities'' has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION.—

(1) IN GENERAL.—There is established a commission, to be known as the ''Commission on Care'' (in this section referred to as the ''Commission''), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP.—

(A) VOTING MEMBERS.—The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS.—Of the members appointed under subparagraph (A)—

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than $50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE.—The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT.—

(A) IN GENERAL.—Members shall be appointed for the life of the Commission.

(B) VACANCIES.—Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING.—Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS.—The Commission shall meet at the call of the Chairperson.

(6) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON.—The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION.—

(1) EVALUATION AND ASSESSMENT.—The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED.—In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS.—The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on—

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION.—

(1) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS.—

(1) COMPENSATION OF MEMBERS.—

(A) IN GENERAL.—Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES.— All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF.—

(A) IN GENERAL.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION.—The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION.—The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING.—The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION.—

(1) ACTION ON RECOMMENDATIONS.—The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

implement each recommendation set forth in a report submitted under subsection (b)(3) that the President—

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS.—Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]
[[Page 130 STAT. 292]]
Public Law 114-131
114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking "Not later than 180 days after the date of the initial meeting of the Commission" and inserting "Not later than June 30, 2016".

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care

2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.

3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.

4. DUTIES OF THE COMMISSION:

   A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
   B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
   C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.

5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

   VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.

6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.

7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at $3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.

8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.

9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

10. DURATION: The Commission is subject to the termination date as specified below in section 11.

11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.

12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:

A. APPOINTMENT AUTHORITY:

i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
v. Three members appointed by the President, at least two of whom shall be Veterans.

B. QUALIFICATIONS: Of the members appointed under 12(A) –
i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than $50,000.000;
iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.

13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.

14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

15. DATE CHARTER IS FILED:

Approved: _____ Date 7/21/15

Robert A. McDonald
Secretary of Veterans Affairs

APPENDIX J: COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson
Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized $5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, Unconventional Leadership, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

Delos M. (Toby) Cosgrove, MD, Vice Chairperson

Appointed by Speaker of the House John Boehner

Toby Cosgrove, CEO of Cleveland Clinic, presides over a $6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker

Appointed by House Minority Leader Nancy Pelosi

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from $75,000 to nearly $16 million. He has a nationwide reputation for dedicated service and as an authority on

veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals—Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital—while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)
Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and date monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate – Honoring Dr. Ikram Khan"— on April 25, 1994.

Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as "Most Influential Man in Southern Nevada" in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a "Distinguished Community Service Award" from Anti-defamation League of B'nai B'rith (1994).

November 30, 1999 was declared "Dr. Ikram U. Khan Day" by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department's emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery.* Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson–Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of $150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

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APPENDIX K: COMMISSION STAFF

Susan M. Webman, Esq.
Executive Director

Michael Bargmann ..... Program Analyst
Robert Burke, PhD ..... Program Analyst
Donald Cicotte ..... Program Analyst
Pauline Cilladi-Rehrer ..... DFO
John Clinton ..... Staff Assistant
Monica Cummins ..... Program Analyst, ADFO
Christopher Danns ..... Program Analyst
Stephen Dillard ..... Program Analyst, ADFO
Susan Edgerton ..... Program Analyst
Beth Engiles ..... Program Analyst
Sharon Gilles ..... Program Analyst, DFO
Wilmya Goldsberry ..... Program Analyst
John Goodrich ..... Executive Officer, DFO
Sherri Hans, PhD ..... Program Analyst
Daniel Huck ..... Program Analyst
Ralph Ibson, Esq. ..... Program Analyst
Wendy J. LaRue, PhD ..... Editor-in-Chief
Gideon Lukens, PhD ..... Economist
Sonia Mastrogiuseppe ..... Staff Assistant
Jennifer E. McKinney ..... Document Specialist
Osita Osagbue ..... Program Analyst
Bernadette Philpot ..... Staff Assistant
Patrick Ryan, Esq. ..... Program Analyst
Jamie Taber, PhD ..... Economist
SaKeithia Taylor ..... Staff Assistant
Linda (Yvonne) Williams ..... Staff Assistant

DFO – Designated Federal Officer
ADFO – Assistant Designated Federal Officer

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APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project